

Drug and alcohol treatment guidelines for residential settings

February 2007



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Terms of reference

1.1 Aims of the guidelines

These guidelines provide recommendations for residential treatment of people with drug or alcohol dependence. The intent of the guidelines is to increase the effectiveness of treatment and to improve treatment outcomes. They are based as far as possible on the evidence reported in peer reviewed literature.

The guidelines differentiate between services which provide residential *care* and those which provide residential *treatment* and make a further distinction between *residential treatment services* and *therapeutic communities*.

1.2 What is treatment?

According to the NSW Health Department Treatment Data Collection Guidelines, a treatment episode is:

a period of contact, with a defined date of commencement and cessation, between a client and a provider or team of providers that occurs in one setting and in which there is no major change in either the goal of intervention or the predominant treatment activity.

A National Campaign Against Drug Abuse working party defined treatment in a drug and alcohol context as:

any person to person intervention which is designed to identify and minimise hazardous, harmful or dysfunctional drinking/drug taking behaviour.

(Ali et al 1992)

As the terms “clinician” and “clinical” are strongly associated with medical treatment, and these guidelines are about improving the quality of treatment in non-clinical settings, they are called “treatment guidelines” rather than “clinical guidelines”.

In these guidelines, “residential treatment” is the intervention period from assessment through intake to the residential program and finally reintegration back into the community through continuing care. The three phases of intervention which these guidelines cover are commonly known as *assessment*, *treatment* and *reintegration*. These guidelines do not address the residential stay in a detoxification or withdrawal program.

1.3 What is a drug and alcohol residential treatment service?

In this document, “residential treatment service” is a general term for 24-hour, staffed, residential treatment programs that offer intensive, structured interventions after withdrawal from drugs of dependence, including alcohol.

Residential treatment is based on the principle that a residential setting free of non-prescribed drugs and alcohol provides an appropriate environment in which to address the underlying causes of dependence. Residential treatment services aim to effect lasting change and to assist with reintegration back into the general community after treatment.

Distinctions do need to be made between residential *treatment* intended to produce therapeutic change and residential *care* intended as a welfare intervention. Residential care may be a necessary precursor to residential treatment for some potential residents whose level of dependence, social isolation and dysfunction have been barriers to entering treatment in the past. Some residential facilities provide welfare functions such as beds and a drug and alcohol-free living environment but do not provide treatment for drug and alcohol problems. A stay in this sort of residential care will usually provide respite from drug and alcohol use, but will not give residents the skills to remain drug/alcohol free once they have left the facility.

Residential programs that do intervene to change an individual's drug or alcohol use have in the past been colloquially referred to as "rehab". "Rehabilitation" is a term that accurately reflects the objectives of treatment, ie:

to educate and help (a person affected by accident or disease) to take up normal activities again. To re-establish (a person, character, name, etc) in a position of respect. To return formally to an earlier position, rank, rights etc
(Macquarie Dictionary)

Differences of opinion over the aetiology of drug and alcohol dependence mean that "rehabilitation" is not always the accepted term for all residential treatment. In this document, the term "residential treatment" is used.

1.4 Residential treatment modalities

Various modalities or treatment approaches for residential treatment are available in New South Wales, reflecting the range of philosophies and interventions available and the range of special populations served by different programs.

Residential programs generally include living skills training, parenting skills, case management and counselling using cognitive behaviour therapy or motivational interviewing. Most programs use group work as part of a structured program.

The main distinction that has emerged among residential treatment programs is between therapeutic communities and other residential programs.

- *Therapeutic communities* emphasise a holistic approach to treatment and address the psychosocial and other issues behind substance abuse. The "community" is thought of as both the context and method of the treatment model, where both staff and other residents assist the resident to deal with his or her drug dependence.
- *Other residential programs* deliver regular treatment to residents, such as counselling, skills training and relapse prevention, to address the psychosocial causes of drug dependence. Types of residential programs include:
 - Short term residential treatment, often provided in conjunction with a medically supervised withdrawal program
 - Longer term residential treatment over 12–52 weeks
 - Low intensity residential treatment and extended care, in which clients live semi-independently with support
 - Opioid substitution treatment tapering to abstinence.

(NSW Health Drug and Alcohol Program Strategic Directions 2005–2010).

A brief history of residential treatment in NSW

2.1 Introduction

Residential treatment programs in NSW have a long history and were, until the early 1980s, characterised by disease concepts, “Twelve Step” approaches and treatment models imported from overseas. Treatment responses to illicit drug use have evolved since the 1970s with the introduction of methadone and the first long-term residential treatment programs. The long-term programs were established primarily for heroin users, some of whom were bonded by the courts to programs.

In the last two decades, shorter term residential treatment programs have arisen to suit the needs of people with less severe alcohol and drug problems, and with a focus on cognitive/behavioural and relapse prevention interventions. In NSW about one third of the residential beds available fall into this category, with a program duration of about one month.

For both short and longer-term treatment programs, it is the residential setting that is crucial to the treatment process.

There are three types of residential treatment service providers in NSW:

- 1 Government administered agencies provided by Area Health Services
- 2 Private for-profit providers, mainly private hospitals
- 3 Incorporated not-for-profit agencies, including charities, benevolent institutions under the tax act and organisations incorporated under the following provisions:
 - Associations incorporated under the *Associations Incorporation Act 1984*
 - Co-operatives under the *Co-operation Act 1992*
 - Companies under corporations law.

2.2 Range and type of service provision

In NSW there are 34 health funded residential treatment services providing more than 900 beds. All but two are provided by non-government organisations (NGOs) and are members of the Network of Alcohol and Drug Agencies (NADA).

NGO residential treatment programs and their locations are listed on the NADA website www.nada.org.au

The provider NGOs exhibit differences that can be described in part by their origin, in part by their affiliations and in part by their practice:

- **Major charities:** Some major charitable organisations provide alcohol or drug treatment services as part of a larger social welfare commitment. They often have strong religious affiliations and are well known to the community. They are large organisations which can influence Government and tend to maintain high public profiles. Grant funding supplements the main charitable income source for these agencies.
- **Community-based services** These agencies are mostly independent organisations that have arisen through community effort and successfully sought funding at some time after they were initiated. The most common examples are the therapeutic communities. These services largely emerged in response to the growth in illicit drug use since the 1970s.
- **Government initiated NGOs** These services are a more recent phenomenon where Government has determined a need for a specific type of service and has sought to have it provided by a non-government organisation. These services have emerged in the last 10 to 15 years.

Most residential treatment services are in or near the Sydney metropolitan area. Historically, regions which did not have adequate withdrawal and ambulatory services usually did not provide residential treatment services, as there was no “feeder” system. This is gradually changing as new rural withdrawal units are built or NGOs establish their own withdrawal units.

There are relatively few dedicated services for women, women and children, families, or people from non-English speaking backgrounds.

Some of the larger residential treatment programs do provide services for people from non-English speaking backgrounds and Aboriginal and Torres Strait Islander people, and a small number of services provide separate women’s programs that can also accommodate children. There are also eight dedicated Aboriginal and Torres Strait Islander residential treatment services in NSW (Brady 2002).

2.3 Residential services provided by Area Health Services

Two Area Health Services provide adult residential treatment services (25 beds in total). The services were designed to provide brief intensive support and to focus on the transition phase of supported accommodation, outreach counselling and social support. Successful outcomes for these programs are predicated on intensive follow-up after discharge from the residential setting.

Effectiveness of residential treatment

3.1 Evidence of effectiveness

Despite the popularity of various residential treatment programs, most of the literature about this type of treatment focuses on the therapeutic community model. There is little available on the effectiveness of residential treatment modalities other than the therapeutic community (Ernst & Young 1996).

The 12-month and 24-month findings of the Australian Treatment Outcome Study suggest that residential treatment services do see people who are “harder cases” – that is, people with longer-standing drug problems and/or a history of failed treatment, lack of social support, psychological comorbidity (Ross et al 2004).

The 24-month follow-up study found that 71 per cent of study participants were abstinent in the month before their follow-up interview and that changes in other drug use from baseline were most evident in the residential treatment group (Darke et al 2006).

Residential treatment is thought to be the most appropriate treatment for alcohol dependence when the person is a chronic drinker with a long history of drinking and a high level of dependence. Similarly, for other drug dependencies residential programs are usually indicated for dysfunctional, long-term drug users who suffer significant harms from use and whose social networks are supportive of continued drug use (Dale & Marsh 2000). People in residential treatment have a significantly higher number of previous treatment episodes, a lower age of first intoxication, have used and injected more classes of drugs, experienced more overdoses and have significantly higher levels of previous suicide attempts and psychopathology than clients in methadone maintenance or withdrawal programs. Despite these client characteristics, residential treatment services were found to have good levels of short and long term retention in treatment (Ross et al 2004). After 12 months,

residential treatment produced significantly higher levels of abstinence than either methadone maintenance or withdrawal programs, while non-treatment had a 0 per cent rate of abstinence. These findings indicate that residential treatment is an effective option, especially for those people with more severe drug use and psychological issues (Ross et al 2004).

Although residential treatment has success with “harder cases”, this group should not be considered the sole treatment population for residential services or therapeutic communities. People with less entrenched histories and less dysfunctional lifestyle also benefit from residential treatment.

3.2 Principles for effective treatment

The US National Institute on Drug Abuse has developed general principles for effective treatment of people with a drug dependency (NIDA 1999). These principles are relevant to residential and other forms of treatment:

- 1 **No single treatment is appropriate for all individuals.**
 - Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace and society.
- 2 **Treatment needs to be readily available.**
 - Because individuals who are dependent on drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

- 3 **Effective treatment attends to multiple needs of the individual, not just his or her drug use.**
 - To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
- 4 **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.**
 - An individual may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counselling or psychotherapy, an individual at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity and culture.
- 5 **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.**
 - The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most people, the threshold of significant improvement is reached at about three months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep people in treatment.
- 6 **Counselling (individuals and/or group) and other behavioural therapies are critical components of effective treatment for people with drug dependence.**
 - In therapy, people address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioural therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.
- 7 **Medications are an important element of treatment for many people in treatment, especially when combined with counselling and other behavioural therapies.**
 - Methadone, and buprenorphine are very effective in helping individuals dependent on heroin or other opioid drugs stabilise their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opioid-dependent people and some people with co-occurring alcohol dependence. For tobacco-dependent individuals, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For people with mental disorders, both behavioural treatments and medications can be critically important.
- 8 **Dependent or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
 - Because dependence disorders and mental disorders often occur in the same individual, people presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
- 9 **Medical detoxification is only one stage of treatment and by itself does little to change long-term drug use.**
 - Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help those dependent on drugs achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective treatment of drug dependence.

10 Treatment does not need to be voluntary to be effective.

- Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions. This does not imply “boot camps”, detention or forced labour camps for young people, but the use of external pressure to encourage young people to enter and complete appropriate treatment.

11 Possible drug use during treatment must be monitored continuously.

- Lapses to drug use can occur during treatment. The objective monitoring of an individual's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the individual withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to people who test positive for illicit drug use is an important element of monitoring.

12 Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis and other infectious diseases, and counselling to help modify or change behaviours that place those being treated or others at risk of infection.

- Counselling can help those receiving it avoid high-risk behaviour. Counselling also can help people who are already infected manage their illness.

13 Recovery from drug dependence can be a long-term process and frequently requires multiple episodes of treatment.

- As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Substance dependent individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

3.3 Minimum standards for residential treatment programs

Programs offering residential treatment for people with drug or alcohol problems should include:

- a comprehensive initial assessment of the potential resident (see section 4.1)
- a treatment matching procedure which addresses the presenting problem and the needs of the individual (see section 4.2)
- clearly identified and published aims and objectives
- a clearly articulated treatment approach
- an evaluation component built into the program (see section 9.4)
- relapse prevention strategies and continuing care strategies for the period after residential treatment (see section 8.1).

Who should receive residential treatment?

4.1 Assessing the needs of people seeking treatment

All people seeking entry into a drug and alcohol residential treatment program need to be properly assessed for their treatment needs. An adequate, unbiased assessment should cover a number of domains, including:

- demographics: gender, ethnicity, income, mobility, accommodation, children, key friends, and so on
- drug use, including perceived reasons for use, how and when initiated, substances used, mode of administration and any changes over time, periods of non-use, frequency of use, last use, quantity used, cost of drugs, where and with whom they use drugs
- effects of use requiring attention: immediate (eg complicated withdrawal with possible fitting), or less acute (eg respiratory conditions)
- previous treatment received and experiences of this previous treatment
- family life
- general health and any serious current health concerns
- trauma history
- mental health
- history of abuse (physical, emotional and sexual)
- education level and needs for remediation
- vocational training level and needs
- employment history
- income (legal and illegal)
- psychological functioning
- interpersonal functioning
- criminal activity and its links to drug use
- risk behaviours (eg, injecting drug use, sharing injection equipment, unsafe sexual activity)
- leisure activities
- peers, and whether they use drugs and whether they are a positive or negative influence
- positive supports
- strengths
- needs and wants
- any positive and the less positive aspects of their drug use.

The above list is rather daunting, but, depending on the decision to be made, not all of the domains may need to be covered.

Different services are likely to use different modes of assessment. Some services may conduct phone-based assessments, while others will use face-to-face interviews at induction centres. Irrespective of the means of conducting the interview, an initial assessment should be used to assess the degree of risk to the client and others as well as the potential suitability of the client for the particular residential service.

- The initial assessment should be focused on deciding whether the service can meet the client's needs
- Co-morbidities of all kinds should be assessed when a client is considering treatment and if the facility cannot provide the level of treatment or safety required for that client they should make an appropriate and effective referral
- Where appropriate, the client's needs should be discussed with the referring agency
- A discussion with the client's medical practitioner (with the client's consent) may be appropriate, particularly if the client is receiving medication for the treatment of other physical or mental illness
- Residential treatment programs need to publicise their policy on the use of psychotropic medications by residents and discuss this policy with potential residents before arrival
- Effective referrals should also be made for those people who are assessed as being unsuitable for the service but who are still in need of some form of treatment or support.

4.2 Treatment matching

A primary consideration in any assessment is matching the level and type of intervention to the treatment needs of the individual.

Individuals seeking treatment for drug or alcohol dependence will have different patterns of risk and protective factors, different psychological and social problems and varying cultural backgrounds. Identifying relevant client characteristics enables clients to be better matched to specific treatments and programs. Treatment matching facilitates more effective treatment delivery and can improve the effectiveness of treatment (Project Match Research Group 1997).

Treatment options range from early intervention through to tertiary residential treatment for people seeking non-pharmacotherapeutic treatment. People seeking treatment need to be matched to the most appropriate level of intervention based on current need, previous treatment experience and the intake criteria of individual programs.

Four major considerations in treatment matching (Eliany & Rush 1992):

- 1 *Problem severity* – more intensive treatment to meet more severe problems may take the form of residential treatment or non-residential treatment that includes access to self help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) (Dale & Marsh 2000).
- 2 *Cognitive factors* – people with some degree of cognitive damage are likely to benefit more from intensive, highly structured residential treatment (Moore 1998). This treatment should also include a strong life skills component addressing issues such as finance, accommodation and domestic duties.
- 3 *Life problems* – specific problems in various aspects of a client's life, such as high levels of anxiety or anger, may indicate the need to match the client to specific components of broad based treatment (eg anger management counselling).
- 4 *Individual choice* – research suggests that treatment is more effective when it is the client's choice, so it is important that clients make informed choices from a range of plausible treatment alternatives.

In treatment matching the following client characteristics should be considered:

- Severity of dependence and type of substance use

- Gender, age and cultural issues
- Cognitive factors
- Support networks
- Life problems
- Previous treatment
- Personal treatment preferences.

4.2.1 Suitability for shorter term residential programs

Typically these programs are of one month to six weeks duration and are provided to people immediately after withdrawal. They may be located in the same facility as a post-withdrawal living skills or treatment program. These programs are provided by both government and non-government providers and cater for the needs of people who require short-term supervision after withdrawal, with an emphasis on cognitive/behavioral and relapse prevention interventions.

The available evaluation literature suggests that this type of service is appropriate for people who have:

- a less entrenched history of drug dependence
- a history of unsuccessful treatment in a non-residential setting
- no previous history of unsuccessful treatment in a residential setting
- no significant cognitive impairment
- less severe co-morbidity (ie, mild depression, anxiety disorders)
- better psychosocial support, including employment opportunities.

There is some evidence that the short term residential treatment programs have a higher success rate, in terms of completion of treatment and post treatment outcomes, for clients with primary alcohol dependence than for clients with primary opiate dependence. In terms of the treatment approach, a review of the literature suggests that such programs are not effective as a post detoxification intervention unless they incorporate a progression to structured options such as supervised half-way house accommodation or daily/weekly participation in a non-residential treatment program.

(The NSW Drug Treatment Services Plan 2000–2005)

4.2.2 Suitability for longer term residential programs

Longer-term residential treatment programs have been identified in practice and in the research literature as providing significant benefit for people with severe alcohol and drug use problems and complex needs, and to the community (Ernst & Young 1996). The most common predictor of successful outcome has been length of stay in treatment (Ernst & Young 1996).

The available Australian literature (Ernst & Young 1996) suggests that longer-term treatment services (60 days or more) are most appropriate for people:

- with severe alcohol and drug use problems, in particular primary opioid dependence, where these problems pose a significant risk to the health and welfare of the individual and others
- for whom non-residential or short term treatment options have failed to address their treatment needs in the past
- whose home setting or social circumstances are not supportive of non-residential treatment options, to the extent that such treatment options are unlikely to succeed
- with significant co-morbid disorders.

People who meet all four of these criteria should be given the highest priority for admission to longer-term residential treatment.

4.3 Administrative requirements for assessment procedures

The assessment tools used in residential treatment centres will vary from agency to agency, but there are generic requirements common to all residential treatment providers:

- The program should have a written intake policy which clearly sets out the eligibility and exclusion criteria
- The intake policy and practice should be free from any discriminatory influence
- There should be a written intake/orientation procedure which is used for all incoming residents
- Pre-admission interviews should always be conducted by appropriately qualified or trained staff.

- At the interview, potential residents should be informed of the following:
 - program objectives
 - treatment methods
 - program rules
 - obligations of residents
 - rights of residents
 - role of program staff
 - facilities
 - visiting rights
 - income support arrangements
 - (if applicable) fees for the program and payment methods
 - privacy policy.
- The potential resident's details, as listed below, should be recorded at the interview:
 - identification and personal details
 - socioeconomic background
 - general health background
 - particulars of alcohol and drug problems
 - history and results of previous treatments
 - other relevant personal history
 - mental health issues
 - physical health issues
 - legal circumstances.

Written or electronic records of all assessments should be made and kept in a secure location.

4.4 Non-acceptance into a program

If a potential resident is not to be accepted for a program, a full explanation of the reasons for rejection should be provided to the potential resident and, where feasible, to the referring agency.

If a potential resident is not accepted, an appropriate referral needs to be made. The staff of treatment programs therefore need to be aware of appropriate alternative services for referrals.

Induction

Induction should occur as soon as possible once a person has been accepted into a residential program. If a waiting list exists, services should:

- actively manage waiting periods where practicable
- consider assigning priority according to individual need and not simply on a first-in-first-served basis.

It is desirable that a person entering a residential treatment program is admitted directly from a residential withdrawal program in which the withdrawal has been monitored by medical staff. This requires a coordinated transfer from the withdrawal unit to the residential treatment program when withdrawal is complete.

This pathway into a residential program may not always be possible, in which case the residential program needs to have policies and procedures to ensure that new arrivals have withdrawn from all non-prescribed drugs or alcohol.

When advising potential residents who are waiting for admission to residential treatment, the risk of relapse following early withdrawal before admission must be balanced against the risks associated with continued drug or alcohol use. Information on harm minimisation practices and encouragement to access support services while waiting for admission should be provided whenever it is practical to do so.

Efforts should be made by all parties involved to foster regular communication between the residential treatment program and the referring agency or withdrawal unit.

When requested (and when the client has consented), information from the intake assessment should be fed back to the referring agency or withdrawal unit.

Treatment

6.1 Best practice

The interventions provided within the residential treatment service should be evidence-based.

Residential programs are more effective when a broad range of treatments and interventions are involved, such as individual and group counselling as well as life skills training, employment or training options and recreation options (Moore 1998).

Best practice within residential treatment

Appropriate treatment methods:

- cognitive-behavioural treatment
- motivational interviewing
- social skills training and cognitive restructuring techniques
- relapse prevention and active practice of relapse prevention skills during therapy
- preparation for re-integrating residents into the community

Levels of treatment tailored to the particular needs of individual residents

Good communication:

- treatment plans discussed and negotiated with residents
- residents informed of the outcome of any reviews
- communication style enhances residents' self respect and shows respect for the free will and volition of the resident
- positive communication fosters the development of positive behaviour and values in the treatment program.

Complete documentation:

- a contract for participation, to be signed by new residents once they are accepted into a program and informed of the conditions of stay
- appropriate treatment and management plans for each resident
- resident records updated regularly with details of treatment, progress and any changes to the original goals
- a completion summary on the resident's record at the end of the program (advise the resident of its contents).

Safety and amenity:

- procedures for the dispensing and administering of prescribed medication
- resident access to medical care
- access to education and parent/child support services if children are accommodated in facilities
- procedures for detecting the non-prescribed use of drugs or alcohol
- a psychologically and physically safe learning and living environment.

Follow-up:

- referrals to community support
- continuing resource contacts.

For more on treatment methods, see chapter 10, *Guidelines specific to therapeutic communities*.

6.2 Duration of and retention in treatment

Given the demands of maintaining change in the face of the challenges residents may experience in the broader community, a period of intensive involvement is necessary to ensure that the residential treatment values are internalised (especially in the case of therapeutic community values). Time in treatment has a key influence on recovery. Ernst and Young (1996) report that clients themselves regarded three months in treatment as the minimum period required for significant change to occur. In some cases stays as long as 12 months may be necessary before enduring changes in substance use can be expected.

Client engagement can be thought of in terms of the intensity and duration of treatment participation. Higher levels of engagement can predict more positive treatment outcomes (Shand et al 2003). Factors that retain clients in treatment include client variables:

- motivation before treatment
- higher drug or alcohol consumption before treatment
- more arrests before treatment
- higher levels of concentration and treatment variables
- strength of the therapeutic relationship
- perceived helpfulness of the treatment service and usefulness of the treatment
- empathy of the service staff
- inclusion of relapse prevention training.

To improve retention in treatment, the key time to focus on clients is the first 72 hours. This is when they are most likely to drop out of treatment. Dropping out continues to be relatively frequent during the first three weeks in treatment. Early drop-out from residential treatment may be related to a lack of program engagement, the client's unpreparedness to change or a lack of motivation.

Retention in the early stages of residential treatment may be improved by providing information sessions covering themes such as:

- 1 the service's approach to treatment and recovery
- 2 the service's philosophy and expectations
- 3 the service's retention and health outcomes
- 4 problems of staying in treatment and client concerns.

It is recommended that services employ the following strategies to address a lack of motivation, ambivalence to change or lack of direction:

- respond rapidly to requests for treatment in order to maximise the client's motivation
- provide more intense support to clients during their first 72 hours in treatment through methods such as closer observation, increased general interaction or the use of a "buddy system" (pairing of new resident with an established resident)
- focus on the client's immediate concerns, not those of the program
- provide an objective, caring and respectful approach, as confrontation often results in denial
- provide objective feedback about the problem and the processes of change that may foster credibility and trustworthiness
- develop motivational strategies that focus on the individual
- develop realistic treatment goals that reflect the client's stage of change and that are flexible enough to shift as the client progresses
- create an awareness of the heterogeneity of clients, particularly in the group treatment process
- identify multiple strategies for clients with multiple problems
- intervene early to reduce confusion and to clarify expectations and roles
- case-manage clients to provide holistic and ongoing support.

Other strategies that may be employed by residential treatment programs in an attempt to improve client retention include:

- relocating programs to metropolitan settings
- providing a short-term residential assessment and education period before any decision to undertake long-term residential treatment
- providing accommodation for children
- reducing the length of the long-term residential treatment component and providing halfway accommodation and continuing care.

6.3 Harm reduction

Given the high rates of relapse among clients and the different treatment goals clients may have, all treatment programs should pay attention to harm reduction strategies in the delivery of their service (Dale & Marsh 2000). Harm reduction strategies can be incorporated into even the most rigid abstinence-based program and aim to reduce problems associated with continuing use, such as:

- overdose (eg avoid mixing drugs, avoid using alone)
- family violence (eg not to use when you are feeling angry or aggressive, or to have an escape plan for potential victims of family violence)
- driving under the influence of alcohol and other drugs (eg think about alternative methods of transport)
- blood borne viruses (eg use clean injecting equipment, have routine medical checkups which include assessment of HCV and HBV)
- tobacco-related illness and dependence (eg providing quit kits or nicotine patches).

The literature recommends that treatment services use an approach that goes beyond the simple dissemination of information and involves attempting to work with clients to find strategies that are acceptable and that they are willing to put into practice.

Assessment during and after treatment

7.1 Assessing progress during treatment

The capacity to measure or assess clients' progress is crucial to investigating and understanding the elements of effective drug and alcohol treatment (Kressel et al 2000). Currently, measuring the effectiveness of residential treatment relies on broad indicators of outcome at the completion of treatment or some period thereafter. The stage of treatment achieved by the client provides another indicator of individual progress, but criteria regarding the stages may vary between different services. Toumbourou et al (1998) suggest that it is probably progress in treatment rather than actual time in treatment that is predictive of positive outcomes.

Services should compare information from resident satisfaction surveys with assessments of progress to help identify any barriers to progress or reasons for positive progress.

In one of several models of change, Di Clemente and Scott (1997) outline five stages that make up the process of change in relation to drug and alcohol treatment (*precontemplation*, where there is no intention to change; *contemplation*, where change is intended sometime in the future; *preparation*, where change is intended in the immediate future and steps are taken to help the change; *action*, where modifications to behaviour have been made; and finally, *maintenance*, which is the stage reached when change is established). For most individuals with drug dependence the path to recovery is not linear but rather cyclic, with repeated stages of relapse and renewed progress.

The process of setting and reviewing goals during treatment is an effective method of assessing an individual's progress in treatment as well as having the potential to identify issues, cues or "triggers" which may feature in an individual's relapse dynamic (ie the cause and effect of relapse).

7.2 Common/consistent assessment forms and outcome measures

Evaluation of outcomes using standardised tools to gather data can be an integral part of a treatment system (Dale & Marsh 2000). Standardised assessment can increase accountability by providing an objective measure of treatment success, comparability between treatment approaches and comparability between clients accessing treatment services. Movement towards a common measurement of agreed outcomes has the potential to enhance our knowledge of what works for whom.

Standardised assessment should be completed upon entry and exit from a treatment program, as well as at follow-up.

It is important that staff are trained to use and interpret any formal assessment tools employed by the service. There should be routine administration of reliable and valid assessment tools during treatment to monitor progress.

After completing assessment procedures, results should be interpreted in relation to the client's personal history, and feedback should be provided to all clients.

Services should consider using pre-treatment (during the initial assessment process) and post-treatment (follow-up when the client leaves the service) health outcome measures such as the SF-36, plus standardised assessment questions on issues such as risk taking, criminality and quality of relationships.

For more on the evaluation of treatment programs, see section 9.4.

Completion of treatment and continuing care

Before leaving residential treatment, decisions should be made about the client's continuing needs. When clients are referred back to local services for further treatment these services need to be included in treatment planning as part of a combined case management approach. When a client transfers to other mental health or social care services a joint review should, where practical, be undertaken to ensure that effective handover takes place. Discharge summaries will assist these services to tailor ongoing treatment plans to the needs of clients.

Discharge planning is an essential part of ensuring continuity of care. It should be an ongoing part of the program, offered from the point of initial assessment at admission, and not a task relegated to the time immediately before discharge into the community.

Although the evidence supporting extended care is mixed (see Shand et al 2003 for a discussion), highly structured and scheduled assistance after initial treatment does appear to have some benefits. Extended care can be provided one-on-one, in group sessions (such as Alcoholics Anonymous or Narcotics Anonymous) or via the telephone.

Residential treatment services should strive to meet these guidelines for continuing care, but if this is not possible, attempts should be made to develop relationships with other service providers who can support clients in both planned and unplanned post-discharge situations.

8.1 Continuing care and support programs

Continuing care is defined as "structural interventions that assist clients who have completed residential treatment to remain drug free and continue the development of their psychosocial functioning" (Mattick et al, 1993, p. 55). Appropriate continuing care and continuity of care for clients completing residential treatment have been positively associated with improved treatment outcomes (Dept of Human Services Victoria 1999).

As a minimum standard all services should provide clients who are leaving the service with a basic exit package or safety kit containing updated support information, such as free call telephone numbers and internet sites.

The Twelve Step approach should not be considered a formal treatment program, but an adjunct to treatment. Clients should be encouraged to investigate Twelve Step programs as part of a range of post treatment options, particularly in continuing care.

Examples of other continuing care activities currently used by Australian residential treatment services include:

- providing a drop-in facility
- support and practical assistance in resuming an independent community life
- providing a mobile team of counsellors (for isolated communities)
- coordinating recreational activities
- support for individuals in voluntary work and training courses
- encouraging former residents to return to participate in occasional sessions and activities at the service
- organising groups addressing living skills and peer support for former residents
- referral and case management support.

Structured and scheduled continuing care is needed for clients leaving residential treatment. Ernst and Young (1996) suggest that best practice in continuing care sessions requires the inclusion of three primary components:

- 1 an emphasis on the importance of continuing care and a mechanism for increasing the likelihood of contact between the client and the treatment facility
- 2 a means of including both the client and his/her family in continuing care
- 3 a forum for helping the client and his/her family to use behavioural problem solving skills.

8.2 Social rehabilitation

Social rehabilitation is an important objective of treatment, and there should be greater emphasis on reintegration of clients into society after treatment, particularly on vocational and employment services, post-treatment support groups and family counselling.

Social rehabilitation includes considerations such as:

- education and vocational training
- adequate housing and maintenance of acceptable living standards
- enhancement of leisure time
- restoration of relationships with family and friends.

8.3 Follow-up after treatment

The importance of follow-up in improving outcomes for the client has been acknowledged in the literature, although it can be difficult and time consuming to implement given the transient nature of some clients (Dale & Marsh 2000). However, it is valuable as it can provide useful support for the client as well as information regarding treatment efficacy, effective components of treatment and relapse rates.

The following guidelines for follow-up are recommended:

- Despite the difficulty of following up many drug-using clients, it should be given high priority.
- The format for follow-up procedures should be explained to clients before discharge. Clients have the option of not participating in follow-up, but its importance should be emphasised to them.
- The first follow-up session should be scheduled before the client leaves the service.
- Advise the referring agency of the outcome of treatment and of your intentions regarding follow-up.
- Preference should be given to face-to-face (individual or group) or telephone follow-up, although even written contact has benefits.
- Follow-up should be arranged at periodic intervals after departure – the frequency may depend on agency resources.

Management issues for treatment programs

9.1 Organisation, policy and procedures

The residential treatment service should have a comprehensive operational policy document containing clear policies aimed at acknowledging risks and ensuring the health and safety of all staff and residents.

9.2 Philosophy and approach

Services should have policies that represent the working philosophy of the program, the value statement or the code of practice used.

Service standards and protocols should be detailed in treatment manuals and protocols which give full specifications of the treatment procedures advocated and complete instructions as to how the interventions are to be implemented.

9.3 Quality assurance mechanisms

The service should have appropriate governance procedures for ensuring the quality of its service. These should include, for example:

- A designated practitioner who ensures that steps and procedures are in place to assure the quality of therapy
- Procedures and resources to support audit processes and research within the service
- Random examination of case files by a supervisory staff member to ensure quality of record keeping and apparent quality of practice
- Regular administration of client satisfaction surveys.

Services with Quality Improvement Council (QIC) Accreditation should adhere to their outlined guidelines and standards in regards to quality assurance.

9.4 Evaluation of treatment programs

Residential treatment programs should include procedures for evaluation of outcomes. Assessment of outcomes should not focus exclusively on clients: staffing variables must be factored into any analysis of retention and outcomes. This is a difficult research issue, as it is understandable that staff may not want to receive the same scrutiny and assessment as the people in treatment. However, for thorough studies to be undertaken, these difficulties need to be overcome. Likewise, clear descriptions of program components and changes over time need to be documented so that any changes in resident response and outcome can be investigated alongside any changes in program components, staff or style of service delivery.

Clients interviewed during an evaluation of residential treatment services in Victoria did not consider achieving abstinence after a first admission to be an exclusive measure of the success of residential treatment (Dept of Human Services Victoria 1999). Decreased substance abuse and criminal behaviour, and increased employment, physical and psychological health are other important outcomes of residential treatment.

As the effectiveness of residential treatment cannot be determined solely on the basis of achieving abstinence, factors such as time in treatment, client retention and continuing care services are other useful measures of effectiveness.

Residential treatment services can be evaluated for their effectiveness in reaching these essential objectives for treatment programs:

- Providing a safe, drug-and-alcohol-free environment
- Providing a time and place for clients to withdraw from a high risk lifestyle or situation
- Providing peer support and encouragement to withdraw from drug use
- Educating residents regarding strategies for maintaining a drug-free lifestyle
- Providing additional networks and supports, particularly among others recovering from drug dependency
- Encouraging open reflection and discussion of personal issues related to use
- Providing a healthy lifestyle and balanced diet during residence
- Assisting residents with other issues associated with community living.

9.5 Case management

Dale and Marsh (2000) define case management as the process that oversees or directs the administration, planning, coordination and delivery of services to the client by the case worker/case manager and/or by other workers.

Primary case management involves one case manager who personally establishes a series of separate relationships with other professionals or services as required. The case manager retains full and autonomous control over the case and is responsible only to the parent agency.

Combined case management is shared care case management, in which several professionals (often interagency) work collaboratively to provide multiple services for clients on a case by case basis. The responsibility for meeting client needs is shared although accountability for the provision of each service remains with the relevant agency/individual.

When adopting a case management approach it is recommended that the service:

- identify clients' treatment and service needs
- obtain written, informed consent from clients before sharing any client-related information with associated professionals
- locate service options
- link clients with other appropriate services
- monitor clients' progress in treatment
- evaluate services provided to clients.

Effective primary and combined case management requires:

- clear and open communication between the professionals involved
- knowledge of the other professionals involved and the nature of their involvement in the case
- clarification of the requirements and boundaries of each specialist, which includes what information will be communicated to and from the case manager
- having a contract that outlines expectations and boundaries of service provision, methods for ensuring continuity of care during staff turnover and a formal record of agency agreements and responsibilities
- keeping clients informed of their case management plan.

9.6 Risk management

Services must manage risks within their treatment facilities. This should involve providing regular reports on risks and incidents to learn from them and to provide a safer environment.

Services with QIC Accreditation should refer to their standards for risk management requirements.

Services should also be familiar with the requirements of the *Occupational Health and Safety Act 2000* and use them as a guide in developing risk management policies and practices.

Useful references that provide guidance on risk management practices include:

- www.ourcommunity.com.au
- www.riskmanagement.qld.gov.au
- www.ncoss.org.au

9.7 Duty of care

Services should be familiar with the requirements of the *NSW Occupational Health and Safety Act 2000* and use them as a guide in developing policies on duty of care.

Under the *NSW Occupational Health and Safety Act 2000* and OHS Regulation 2001 (under section 20 of this Act) service providers must:

- provide or maintain equipment and systems of work that are safe and without risks to health
- ensure that equipment and substances are used, stored and transported safely and without risks to health
- provide information, instruction, training and supervision that ensures the health and safety of employees and others
- maintain the workplace(s) in a safe condition, including entrances and exits
- ensure the health and safety of visitors to the workplace.

Useful references for developing a duty of care policy for agencies include:

- www.nohsc.gov.au/OHSLegalObligations/DutyOfCare/dutycare.htm
- www.csu.edu.au/faculty/arts/humss/bioethic/duty1.htm
- www.workcover.nsw.gov.au/FAQs/OHSResponsibilities/DutyCare/default.htm

9.8 Clients with HIV or hepatitis

Services should offer education and counselling to provide as much information as possible about human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infection and attempt through education and on-site harm minimisation practices to reduce high-risk behaviour and to minimise the spread of any viruses. Clients should be advised against sharing injecting equipment as well as razors, combs, toothbrushes or other instruments that may be vehicles for the exchange of blood.

Residents in treatment programs need:

- education on the viruses and the means of infection
- information on treatment options and their outcomes
- access to testing and opportunities to evaluate the function of their liver and immune system and to seek appropriate treatment when necessary
- access to pre-test and post-test counselling, provided either by the residential agency staff or by the medical service collecting blood for testing.

Testing policies for HIV, HCV and HBV are currently being revised by the Australian Government and these will provide clear pathways for assisting discussion with clients.

HBV vaccination is recommended for all clients who are found to have no immunity to HBV.

Clients who are HIV-positive should (if possible) be managed in collaboration with specialist services and community-based support services.

Guidelines for managing HCV infection are available in: *A model of care for the management of hepatitis C infection in adults* (ANCAHRD 2003).

The *National Hepatitis C Resource Manual* provides useful information for health care workers on assessment, testing and treatment of people with HCV (Australian Institute for Primary Care 2001).

Guidelines specific to therapeutic communities

Distinctions do need to be made between residential treatment intended to produce therapeutic change and residential care intended as a welfare intervention. There is also a distinction between residential programs and therapeutic communities. Both are designed to produce therapeutic change, but with therapeutic communities the emphasis is on the community as the “method of change”.

Therapeutic communities emphasise a holistic approach to treatment. The focus is on the psychosocial issues behind a person’s drug or alcohol dependence.

10.1 Definition and theoretical basis of a therapeutic community

The defining characteristic of the therapeutic community is its emphasis on the community created by the staff and residents as both the forum and catalyst for individual behaviour change. In therapeutic communities, the social environment, peer support and staff guide residents through the recovery process (DeLeon 1995).

Common characteristics of a therapeutic community are:

- Use of community as therapy
- Peer support
- Resident participation in program structure
- Staff facilitation, not direction
- Residents providing role modeling for each other
- Strong emphasis on self-help and self-responsibility
- Community meetings
- Structures clearly defined and peer driven
- Holistic view of person
- Community-based change
- Community more important than individual

- Reintegration process
- Sense of mutual respect
- Accountability extends to staff and peers
- Buddy system
- Residents seen as members rather than clients or patients
- Clear boundaries
- Progress in the program based on peer evaluation and support
- Community self-regulating and self-supporting
- Daily plans
- Involvement in continuing care support
- Bill of rights
- Independent board of directors
- Cardinal rules.

The 2002 Australasian Therapeutic Communities Association report *Towards better practice in therapeutic communities* (Gowing et al 2002) provides an outline of the essential elements of therapeutic community programs in Australia. These elements were identified in a “modified essential elements questionnaire” derived from the United States “survey of essential elements questionnaire” (Melnick and De Leon 1999). The essential elements of therapeutic communities identified in the report are not unique to therapeutic communities but are considered to be important in defining the therapeutic community approach.

The essential elements are ordered into three broad categories:

- Ethos
- Aspects of program delivery
- Quality assurance.

10.2 Ethos of the therapeutic community

10.2.1 Nature of substance abuse and recovery

Substance abuse is:

- a complex condition combining social, psychological, behavioural and physiological dimensions
- a symptom of underlying social, psychological or behavioural issues which need to be addressed if recovery is to occur.

Recovery from drug dependence:

- requires establishment or renewal of personal values, such as honesty, self-reliance, and responsibility to self and others
- involves learning or re-establishing the behavioural skills, attitudes and values associated with community living
- involves personal development and lifestyle change consistent with shared community values.

The recovery process of the therapeutic community encourages a life-long commitment to personal development.

10.2.2 Broad concept of therapeutic community approach

Therapeutic communities:

- focus on the social, psychological and behavioural dimensions that precede and arise from substance abuse
- provide a safe, supportive environment for residents to experience and respond to emotions and gain understanding of issues relating to their drug use
- provide therapeutic involvements between residents and staff and among residents (especially senior and junior residents), combined with the experience of living in a caring and challenging community as the principal mediums to encourage change and personal development.

Treatment is multidimensional, involving therapy, education, values and skills development.

Patterns of drug use can be used to indicate underlying issues, but are not the primary focus of treatment.

Discussions and interactions between residents outside of structured program activities are an important component of therapy.

The self-contained nature of therapeutic communities, with residents performing routine chores such as cooking and cleaning, is important in encouraging residents to become self-sufficient and responsible for themselves and others.

10.2.3 Dimensions of socialisation

Encouraging a sense of participation in and belonging to the community is critical to the effectiveness of the therapeutic community approach.

Living skills to support recovery develop from commitment to the values shared by the therapeutic community.

Work is used to enhance the sense of community, to build self-esteem and social responsibility, and to develop communication, organisational and interpersonal skills.

The therapeutic community approach involves supporting and acting responsibly towards other individuals and the community.

10.2.4 Psychological/behavioural dimensions

Therapeutic communities support the development of individual responsibility for actions and their consequences.

Therapeutic communities foster the development of supportive relationships between residents to facilitate individual change.

Peer support and constructive feedback are integral to addressing negative behaviour and attitudes and affirming positive achievements of residents.

Treatment involves learning and becoming committed to shared community values, including respect for self and others, honesty, willingness to attempt personal growth, and responsibility to self and others.

10.3 Aspects of program delivery

10.3.1 Ensuring a safe environment

Therapeutic communities require abstinence from alcohol and other psychoactive drugs (unless authorised).

There are cardinal rules which, if violated, can lead to termination from the program (eg no drug use, no violence, no stealing, no sexual relations with other residents).

There are clear procedures for responding to breaches of community values, with differing levels of response to reflect the specific circumstances.

Contact outside the therapeutic community is monitored or supervised, and restricted, particularly in the early stages of treatment.

Program includes regular drug screening, including where there are grounds for suspecting possible drug use.

10.3.2 Encouraging community spirit and a sense of belonging

Meetings:

- are scheduled frequently to provide information on arrangements, matters of functional routine, and special events
- are convened within the community as needed to address significant issues affecting the community, particularly those with a potentially negative impact.

In general, decision-making processes are consultative, with staff as objective facilitators and the final decision-maker only where necessary.

Residents:

- take responsibility for orienting, guiding and supporting new residents
- conduct important peer management functions such as preparing work rosters, organising and running house meetings
- participate in program rituals and traditions, such as major festivals, birthdays and recovery milestones, particularly graduation.

Leisure activities, such as organised sport, are encouraged for physical fitness, developing the sense of community and team work, and to reinforce to residents that it is possible to have fun without drugs.

10.3.3 Program structure

Residential therapeutic community treatment:

- is of medium to long duration, with actual length varied according to individual requirements
- provides a mix of group and individual counselling based on individual need
- includes some use of formal instruction methods to present interpersonal skills and recovery oriented concepts
- provides information and the opportunity for residents to discuss the prevention and control of health issues of particular relevance to drug users
- has distinct stages, generally reflecting a focus on assessment/orientation, treatment, extended treatment or transition, and re-entry.

There is an initial period in which new residents are assigned to senior residents or staff for introduction to the program and initial support.

Progress through stages of treatment:

- by the end of assessment/orientation, residents are aware of the rules and procedures of the therapeutic community, are feeling comfortable as a member of the therapeutic community, and have committed themselves to the treatment program
- by the end of the main treatment stage, residents have gained some understanding of the issues underlying their drug use, are able to emotionally support other residents, and are not behaving in an anti-social manner
- the transition or re-entry stage provides increased contact with the wider community, gives residents increased independence, and focuses on preparing residents to cope with the outside world, including developing supportive friendship networks and, where appropriate, re-establishing communication with their immediate families.

Decisions on progression to the next stage of treatment or discharge from the therapeutic community involve community consultation, but staff retain ultimate responsibility.

The preparation for re-entry involves greater flexibility in the resident's personal program and increased attention to relapse prevention, drawing together the skills, insight and behavioural change gained through treatment, to support maintenance of lifestyle change outside the therapeutic community in a self-reliant manner.

10.3.4 Encouraging behavioural change

Therapeutic communities use groups to encourage change in behaviour and attitudes.

Residents are encouraged to attempt behaviours and activities, even if they doubt their abilities or the reason for the behaviours and activities, as a means of developing a more positive attitude through learning by doing.

Residents are encouraged to experience and appropriately express their emotions.

Treatment encompasses developing a variety of approaches that help avoid the use of drugs, including recreational activities and relapse prevention methods.

Sanctions issued in response to breaches of community standards, guidelines and values aim to provide a learning experience, give the opportunity for behaviour to be adjusted, and give clear warning of further consequences for behaviour that continues to be unacceptable.

The presence in the therapeutic community of staff and volunteers with a history of drug dependence and recovery is encouraged to provide residents with role models.

Residents are expected to develop capacity to be a positive role model as they progress through the program.

10.3.5 Treatment planning

Residents are individually assessed, including consideration of background issues, drug use history, physical health and mental health.

There is a written, agreed upon and periodically updated treatment plan for each resident.

Treatment plans identify goals for each stage, and achievement of these goals is assessed when considering applications to move between stages.

The treatment program includes a process of setting individual goals that provides positive affirmation of strengths and capabilities but also acknowledges boundaries to what is achievable.

Planning during the re-entry stage includes establishing links with appropriate continuing care services and support networks.

Residents who leave without completing the program are assisted with alternative treatment arrangements.

10.3.6 Treatment components

The therapeutic community program:

- includes opportunities for residents to discuss progress, emotions and experiences in a safe, supportive environment
- emphasises listening, speaking and communication skills
- supports the development of personal decision-making skills
- identifies and subsequently addresses family issues, engaging family members and significant others in treatment in a positive way, if possible.

Residents:

- learn conflict resolution skills through discussion of principles in group sessions and the practical experience of grievance and mediation procedures within the therapeutic community
- facilitate some group therapy or educational sessions with the support of staff
- perform different tasks and acquire increasing responsibility and privileges as they progress through the program.

Job functions are selected according to each resident's capacity, developmental and vocational needs and the demands of his or her individual treatment plan.

Support is given to residents who wish to seek education or training as part of their treatment program, and all residents are encouraged to develop a vocational plan, particularly in the latter stages of treatment.

10.3.7 Staffing dimensions

Through active participation in all aspects of the therapeutic community, staff:

- develop and maintain the safe environment and positive functioning of the community
- encourage resident participation and interaction
- provide appropriate therapeutic interventions.

Staff may involve themselves in activities such as recreation, meal preparation, dining and chores on an equal footing with residents as a means of emphasising their membership of the community and their participation as role models.

Interactions between residents and staff in an informal context during daily activities help establish a relationship that facilitates therapeutic interactions.

Staff serve as role models for shared community values.

Staff offer personal experience as part of the therapeutic interaction.

10.4 Quality assurance

Access to health care is a routine part of the program in therapeutic communities.

There are documented policies on aspects relevant to quality assurance, such as occupational health and safety, equal employment opportunity, sexual harassment, confidentiality of residents' records, staff training and staff qualifications.

There are written, agreed upon and well known procedures for managing residents' affairs, such as admission and discharge, management of residents' finances, arrangements for outings and visitors, complaints and appeals procedures.

Residents are given a document clearly identifying their rights, and have these rights explained to them on entry to the therapeutic community.

The right of residents to control the extent of disclosure in group settings of sensitive personal information that is relevant to treatment is respected.

Residents are informed of the consequences of breaches of rules and guidelines, and reasons for decisions.

Specific processes are available and clearly explained for appeals of decisions and resolution of conflicts.

Residences are inspected at least weekly for cleanliness and completion of tasks, with occasional additional inspections if needed to respond to issues such as theft or suspected drug use. (Gowing et al 2002).

Groups with particular needs

Several client groups have special needs that should be considered during treatment, but which often are not met within current residential treatment services.

The guidelines in this chapter apply to services offering treatment to:

- women
- families (men or women with children)
- young people
- people with mental illness
- Aboriginal and Torres Strait Islander peoples
- people from culturally and linguistically diverse backgrounds (CALD)
- clients receiving pharmacotherapies in residential treatment.

11.1 Women

This section draws on research conducted by Swift, Copeland and Hall (1995) and the practices at Kamira Farm and Odyssey House NSW.

Research has shown that the social stigma associated with drug and alcohol problems is worse for women than men. Thus women are particularly likely to experience intense feelings of shame and guilt that can lead them to cover up and remain silent about their drug and alcohol problems. Swift, Copeland and Hall (1995) suggested that “even if a decision had been made to seek help, ignorance of the services available, fear of what was involved in the help seeking process or a sense of hopelessness were potent barriers to further action”.

11.1.1 Overcoming barriers to treatment

Residential treatment programs for women should:

- advertise widely
- provide information and outreach where feasible – maybe in the form of continuing care
- provide childcare facilities
- be as flexible with financial arrangements as funding will allow
- provide a safe, supportive environment.

Agencies should offer women a flexible approach and a range of treatment options, and should not impose a rigid treatment philosophy.

Programs that cater to both men and women should attempt to attract and retain women by providing sensitive, appropriate services:

- a pleasant, safe environment
- separate facilities for men and women
- provision for childcare
- some opportunity for time-out with other women, such as women-only groups
- the opportunity to see a female counsellor
- the opportunity to receive information about and assistance for matters of women’s health and other issues, such as sexual assault.

Women-only services should be supported and maintained as options for substance-dependent women. They should not be considered simply as duplications of existing mixed-sex services.

11.1.2 General clinical issues

Treatment approaches should:

- be non-confrontational
- consider gender differences when identifying cues to relapse prevention
- provide education on the risks for HIV infection.

Women should be discharged to a safe environment, and informed of support networks available. Providing supported accommodation may assist in this process.

11.1.3 Sexual and physical abuse

Disclosure of sexual assault should be handled with support and reassurance. The necessity for, timing and extent of ongoing counselling should be examined during a non-confrontational assessment of the client's needs, taking into account the immediacy of the reported abuse and the extent to which crisis intervention is necessary.

Female staff should be available if the client wishes to speak to one.

Professional development should be encouraged to enable staff to receive training in issues pertinent to sexual and physical assault.

11.1.4 Psychological and medical concerns

All women should be screened early in the treatment process to establish any major physical and mental health problems.

If agencies are not able to provide ancillary services on site, clients should be referred to relevant services in their area.

11.1.5 Childcare

Childcare should be made available by all residential treatment services, either on site or through negotiations with local child care agencies.

11.2 Men or women with children

11.2.1 Child development program

Many children are harmed by their parents' drug dependency. Treating the parent for their dependency does not necessarily treat the harm caused to the child and the harm caused to their relationship. Nor does it provide for the development of a new relationship with the recovered parent.

Implementing a child development program within a residential treatment program enables the treatment approach to be all encompassing in its approach to breaking the cycle of drug dependency and achieving best practice.

A child development program provides activities for the children such as dexterity and motor skills activities, games requiring coordination, visual and auditory memory and recognition skills, interactive games with other children, fun educative sessions for those preparing for school, exploring the environment we live in, art and craft, and so on. The child development program may use local playgroups, kiddies gym, libraries and Child Health Services.

Assessments of the child–parent relationship should be conducted upon admission and worked upon in individual counselling sessions with the child care worker. The development of the parent–child relationship is also improved by involving parents in the child development program. This may mean that at some times during the week, parents may be excused from other activities of their residential treatment program to attend the child development program with their children.

Young children should be in the care of their parents except for the time that parents attend groups or counselling, at which time they are in the supervision of the child care worker. School age children may attend school in the local area.

11.2.2 Parent effectiveness training

Parent Effectiveness Training (Gordon 2000) should be considered a core function of residential programs assisting parents with children.

11.2.3 Accommodation

Parents entering treatment with children should be given a bedroom large enough to accommodate themselves and their child or children.

11.2.4 Play equipment

Adequate, safe, entertaining and hard-wearing child play equipment should be provided, both for indoor and outdoor play. Parental supervision and involvement in children's play must be a practical part of the residential treatment program. This is especially important in programs which have swimming pools in the facility or where parents attend a swimming pool with their children.

11.2.5 Safety

Physical and psychological safety are primary concerns in residential programs catering to parents with children. Strict policy guidelines need to be in place defining appropriate behaviour and the consequence of a breach of the guidelines.

The physical layout and structure of residential facilities should consider the risks to the safety of children. Audits should be regularly conducted by resident parents and staff to ensure that such risks are minimised. These audits may inform the development of new rules with the safety of children in mind.

All clients of residential treatment programs which accommodate parents with children have a responsibility for the safety and care of the children, regardless of whether they have children themselves.

11.2.6 Visits

Non-resident parents and other loved ones play an essential part in the parent and child's life. Consequently, a lot of time and care should be taken in organising appropriate visits, ensuring that the child's needs are met. At times this may require supervision by a staff member.

11.2.7 Discharge from program

Mandatory reporting to the Department of Community Services needs to be completed on the discharge of parents with children where appropriate (ie, if there is any risk to the safety of children). The safety of the child is the primary concern upon discharge, particularly if the parent is exiting the program prematurely.

Although it is difficult for an agency to control what happens outside its premises, reasonable steps should be taken to determine whether the child will be safe in the care of the parent on discharge.

11.3 Young people

The immediate aim when treating young people may be cessation of use, or controlled use, or withdrawal management. There are usually broader objectives, such as reducing criminal activity, increasing involvement in education, employment or training, improving family functioning, improving interpersonal skills and improving physical and mental health. Treatment includes prevention, in that it aims at preventing further harm.

11.3.1 Treatment outcome studies

The literature evaluating treatment of young people is limited and only a few tentative conclusions can be drawn (Beschner 1986; Catalano et al 1990–91; Gowing et al 2001):

- some treatment is usually better than no treatment
- few comparisons of treatment method have consistently demonstrated the superiority of one method over another
- achieving at least brief periods of abstinence is readily achievable, but maintaining abstinence or avoiding relapse is difficult
- post-treatment relapse rates are high (35 per cent to 85 per cent)
- reduced use is a more likely outcome when heroin is the drug of concern than for alcohol, tobacco, cannabis and methamphetamines.

In the few controlled trials of treatments, positive outcomes were found for cognitive-behavioural, skills training and residential treatments. For residential treatment, three months' residence appeared to be the optimal period, and longer stays appeared to produce little additional benefit. However, providing continuing care after the residential period appeared to improve outcomes.

11.3.2 Towards more effective treatment

A suitable goal for residential treatment may be: *to increase the capacity of the young people involved in treatment to manage their lives more effectively.*

The traditional abstinence goal of many programs may need to be reconsidered in situations other than those which already involve organ or other physical damage. Young people are often not ready for abstinence and a harm minimisation approach will be more readily received by them. Whatever the goal, it needs to be clearly articulated, and take into account various local, national, or broader cultural and religious factors.

Possible objectives for consideration include:

General:

- Increasing clients' capacity to recognise any negative consequences of substance use for themselves, their families and significant others, and the community
- increasing motivation to address significant issues in their lives.

Substance use and related behaviour:

- reducing the number and quantity of substances used and the frequency of use
- reducing binge use patterns
- reducing risky use (eg reducing or eliminating sharing of injecting equipment and a change to safer modes of administration, reducing the risk of overdose)
- reducing the number and severity of problems associated with substance use, particularly criminal activities.

Health and general functioning:

- improving general health
- reducing risky behaviour (eg promoting safer sexual behaviour, especially via increased condom use)
- increasing involvement in non-drug related activities
- increasing life satisfaction
- improving psychological health, reducing the frequency of negative mood states (eg depression and anxiety) and increasing the capacity to recognise the onset of and manage the course of any negative mood states associated with use
- increasing involvement with non-drug using peers
- improving family functioning, or achieving satisfactory disengagement from the family if necessary.

Interpersonal and other skills:

- remediating any educational deficits and increasing skills relevant to improving employment possibilities
- increasing access to and participation in education, training or employment
- improving interpersonal, communication, problem solving and coping strategies and skills, including those related to self-care and management (life/living skills).

Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life (WHO 1994). It has been claimed that the life skills approach, which is mostly used in schools, has a positive impact which lasts (Botvin et al 1990; Dusenbury et al 1997). The WHO publication *Skills for health* (2003) identifies these essential life skills:

- communication
- interpersonal skills
- empathy skills
- advocacy skills
- negotiation/refusal skills
- decision making skills
- critical thinking skills
- coping skills
- self-management skills
- skills for increasing personal confidence
- goal setting skills
- self assessment skills
- abilities to assume control, take responsibility, make a difference and bring about change.

The objective of building life skills is part of a comprehensive (holistic) approach to treating people with a drug dependency. It is not being suggested that all young people who use drugs and develop drug-use related difficulties are deficient in intellect, education and interpersonal skills and are psychologically disturbed. Residential treatment interventions need to build on strengths and identify and address deficits.

The general principles of effective treatment developed by NIDA (1999) and quoted in section 3.1 have relevance for the residential treatment of young people.

11.3.3 Assessment

All residential treatment interventions must be preceded by adequate, unbiased assessment (see section 4.1). The assessment can be staged over time, where possible, and ideally conducted in an environment friendly to young people. It should identify strengths and areas requiring attention. Motivational Interviewing appears helpful in engaging young people in assessment and treatment (Miller and Rollnick, 1991).

11.3.4 Interventions for young people

Interventions need to be *developmental (sub)stage specific*, and take into account the needs and capacities of young people and the young person's stage of development; particularly cognitive capacity, developmental/maturational lags, and the need for recreation and fun. Much adult treatment is very serious business, and young people tend to react to such approaches by acting out and acting up. Unfortunately, this sometimes means that they are discharged from treatment for their "unsatisfactory" behaviour, apparent lack of motivation or because they are "in denial".

Improving the friendliness of programs to young people increases accessibility. Accessibility implies more than location; it has to do with a perception of a non-discriminatory, non-judgmental, non-marginalising, welcoming program.

One model which can inform residential treatment is *relapse prevention*. This model identifies intrapersonal and interpersonal variables and environmental situations and cues which are associated with use and return to use of drugs. Assessment of individuals and groups leads to personalised treatment interventions for the individual or group (Heather and Tebbutt 1989 and Jarvis et al 1995).

For example, young people can develop the following understanding: "I am more likely to use heroin, when I feel sad, am alone and at home", or "I am more likely to use methamphetamines when I am bored, with my friends and at a disco". Program interventions can then target the development of specific skills and alternatives to the benefits gained from using drugs, such as recognising the onset of negative mood states earlier and having strategies to deal with them more appropriately in a positive way. Likewise, family interventions may be necessary if drug use has an association with issues within the family. Teaching living skills, such as self-care,

and interpersonal skills (social and communication) may assist those whose drug use is associated with interpersonal conflict, peer influence or peer pressure and social anxiety. Any skills which are taught need to be usable in the general community, and not merely to do with making life in an institutional or other treatment environment easier.

The relapse prevention model appears to offer the most useful framework for residential treatment, and a range of treatment options is helpful, including:

- *Short-term residential* (usually less than three months), especially for withdrawal or assessment and respite when the young person's life circumstances are chaotic or dangerous and they meet criteria for drug dependence. Interventions during short-term residential treatment include individual, group and family counselling, educational and vocational activities and the development of life/living skills.
- *Longer-term residential* (usually three months) intensive treatment, with interventions similar to those for short-term residential, for those whose drug dependence is more intense, whose social supports may be more limited and where health (including mental health) concerns may be elevated. Longer-term residential treatment is often within a therapeutic community, usually adapted to better suit young people. Interventions include group work, individual counselling/therapy, family work, vocational and educational activities, recreation and leisure activities, and living skills.
- *Semi-supported residential*, such as hostels or group homes. These can be used to accommodate young people who are attending a day program, or exiting a residential one.

11.3.5 Treatment matching

Matching a young person to the most appropriate treatment may enhance outcome. Residential treatments are expensive, and should only be used when other interventions have not been beneficial, or are assessed as inappropriate. Group treatments tend to be preferred, and are usually more cost-effective. Case management strategies which provide for a coordinated approach aimed at increased access to services, advocacy, and support are essential to ensure a planned, accountable treatment process (Godley et al 1994).

11.3.6 A model of residential treatment

Guiding treatment (residential or other) by a comprehensive and coherent model is crucial. Otherwise, components can be added or removed at whim, making the treatment environment confusing and incoherent, and research extremely difficult.

The Ted Noffs Foundation has developed and adapted the Texas Christian University model of treatment process and outcomes (Simpson et al 1997). This model emphasises that treatment does not just occur, but is constructed around the combined influences of the individual, their family and other significant people, events and circumstances, and the similar characteristics of the staff and the treatment environment, processes and components. Some of the relevant characteristics of young people and staff include: motivation, previous experience of treatment, education, family and peer influences, beliefs and attitudes.

(See figure below).

Residential treatment has an initial stage where developing a working alliance and program participation are the goals, and a later stage where behavioural compliance and psychosocial improvement in functioning occur. With sufficient retention in treatment, the young person should enter the post-treatment environment (where some of the more significant post-treatment variables, such as the family relationships, peer relationships, education and vocation have received attention during treatment) with better coping skills and strategies.

Program components, then, are understood as having a clearly defined role in the total program experience, and monitoring and evaluation activities can be clearly linked.

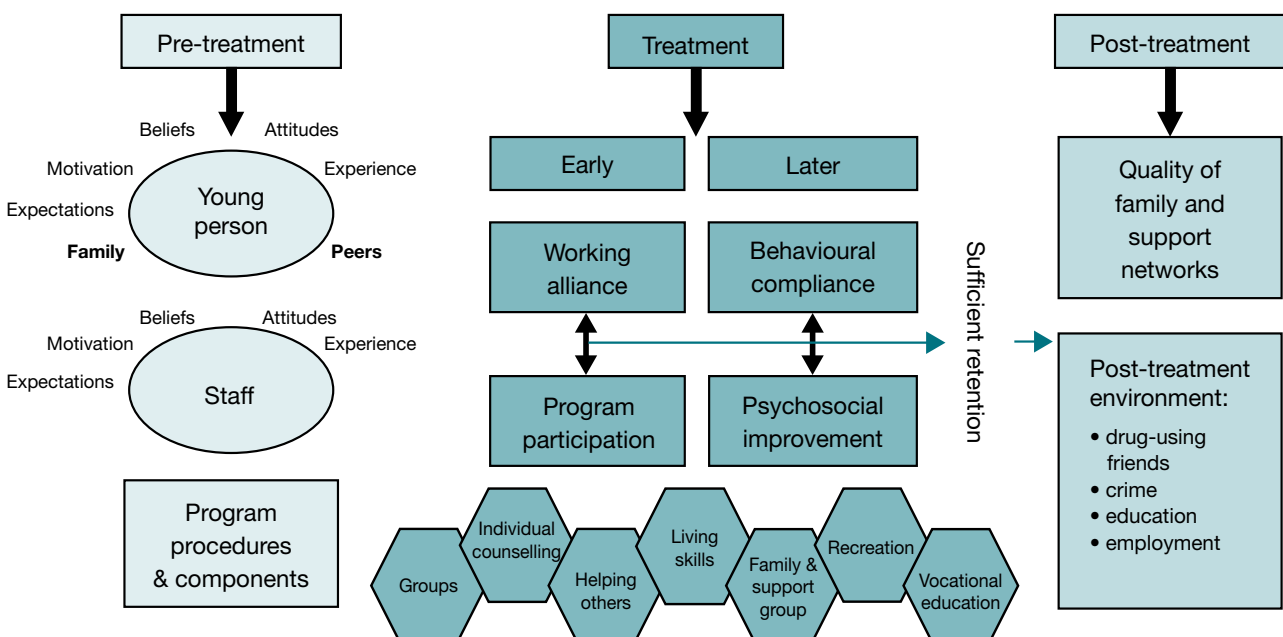
This model recognises that staff do not come with equal characteristics, no matter how well trained and inducted. This highlights the fact that staffing variables must be factored into any analysis of retention and outcomes.

The model also shows that treatment actually occurs in many aspects of the daily program (eg chores, groups, counselling, helping others, skill development, peer interactions in the program, staff interactions, recreation) and outside the residential facility (among family, peers and community).

11.3.7 After treatment

Post-treatment variables warrant particular attention, as pre-treatment ones consistently explain little of the variance in treatment outcome, and post-treatment ones have been consistently associated with outcomes. Better outcomes are achieved by following residential treatment with continuing care, including attention to family functioning, educational and/or vocational functioning, and health. The development of social support networks that will remain beyond treatment, particularly those which emphasise peer to peer assistance, are crucial.

All residential treatment should provide options for continuing care, provided by the residential service itself or via other community services.



The Ted Noffs Foundation residential treatment process model (as adapted from Texas Christian University).

11.4 Mental illness and substance abuse

11.4.1 Definition of dual disorder/comorbidity

Dual disorders/comorbidity refers to the co-occurrence of two or more disorders affecting an individual. Dual disorder/comorbidity in this instance refers to the co-occurrence of mental health and drug use disorders.

People with a dual disorder are not a homogenous group. Mental illness and drug use occur on a continuum and an individual's experience of both disorders is unique in its presentation, severity and complexity.

11.4.2 Issues in service delivery

There are gaps in service delivery to this population. People with a dual disorder may not neatly fit inclusion criteria for mental health or drug and alcohol services, with the result being a series of referrals to a range of services. This population is not easy to engage and many therefore fall between the cracks of our current service delivery model.

The *Second National Mental Health Plan* provided a framework for reform in mental health services to 2004. Three key platforms of the Plan were:

- partnerships in service reform
- promotion, prevention and early intervention
- quality and effectiveness.

The *National Drug Strategic Framework 1999–2003: Building Partnerships* identified eight priorities, four of which were directly relevant to the issue of dual disorders:

- building partnerships
- building links with other strategies
- giving access to treatment
- preventing use and harm.

These two major national policy directions provided a strong direction toward integration of mental health and drug and alcohol services.

The NSW Health Department released *The management of people with a co-existing mental health and substance use disorder* (service delivery guidelines and a discussion paper) in 2000. These documents provide the available evidence and a framework for service provision for this population.

Dual disorder combinations, symptom severity and degree of impairment limit the ability of any single model to suit all individuals. Interventions therefore must be provided across a spectrum from health promotion, prevention, early intervention, acute and longer term interventions.

11.4.3 Continuum of interventions

(See figure below).

The available evidence indicates that treatment approaches for people with a dual disorder need to be integrated to optimise outcomes; ie, substance misuse and mental health problems must be addressed concurrently with special attention to the interaction of the two disorders.

Studies that have reported health outcomes for people with dual disorders treated with an integrated service model have found reduced hospitalisations and slight changes in psychosocial functioning and symptoms (Jerrel & Ridgely 1995). A review of the clinical research (Drake et al 1993) identified several elements of successful programs including:

- an assertive style of engagement
- techniques of close monitoring
- integration of mental health and substance abuse treatments
- comprehensive services
- stage-wise treatment
- a long term perspective
- optimism.

Prevention

Early intervention

Treatment

Maintenance



Health promotion

Continuum of interventions

Burdekin (1993) urges the need for the integration of services, including the designation of a “primary care” worker (regardless of discipline or agency) to be responsible for the complete care of a (dual diagnosed) person.

The collaborative model must incorporate:

- treatment teams consisting of cross-trained staff
- improved linkages between existing services
- joint assessments
- co-case management
- cross sector consultations.

For people with dual diagnoses to receive the care and treatment they require, treatment services have to shift away from using exclusion criteria (turning away people with more than one diagnosis) and towards using inclusion criteria (accepting people with one diagnosis regardless of whether they have a second diagnosis).

The NSW Health Department's *The management of people with a co-existing mental health and substance use disorder* (2000) recommends that the integrated care of clients with dual diagnoses must include:

- interagency links and partnerships
- joint assessment and co-management
- a formal process of networking and liaison
- ongoing assessment and assertive follow-up
- regular case reviews
- an identified care co-ordinator or case manager
- an identified service co-ordinator.

Service delivery can be improved by:

Integration:

- integrating service provision under one umbrella organisation
- integrating services in “one-stop shop” community centres
- greater inclusion of consumers and carers in policy and service development and education and training

Collaboration:

- employing a resource team or co-ordinator of services
- establishing links between identified key staff in local services
- formal processes of collaboration and networking in joint meetings and case reviews by service providers in mental health, drug and alcohol, general practice and non-government welfare organisations
- joint financial initiatives between service sectors to fund specific programs
- joint assessment and co-management
- health promotion, prevention and early intervention strategies, including the role of general practitioners
- screening in mental health, drug and alcohol services and general practices.

Workforce development:

- cross-sector secondment or short term placements of clinical staff
- employing staff with drug and alcohol expertise in mental health services, and vice versa
- educating and training primary care providers.

Active case management:

- an identified care co-ordinator or case manager
- ongoing assessment and assertive follow-up
- regular case reviews
- an assertive style of engagement and techniques of close monitoring
- use of case planning and case conferencing items under the Medicare general practice agreements.

Residential treatment for people with mental health and substance abuse co-morbidities should take a flexible approach, be less intense than residential programs for people without co-morbid conditions and focus on the needs of the individual. Sacks (2000) describes in detail the modifications required of a residential program providing treatment to this population.

Modifications to structure	Modifications to process	Modifications to elements (interventions)
Increased flexibility in program activities	Sanctions are fewer with greater opportunity for corrective learning experiences	Orientation and instruction is emphasised in programming and planning
Less confrontation & intensity of interpersonal interaction		Individual counselling is provided more frequently to enable clients to absorb the experience
Greater sensitivity to inter-personal differences	Engagement and stabilisation receive more time and effort	Task assignments are individualised
Greater responsiveness to the special development needs of the individual		Breaks are offered frequently during work tasks
More staff guidance in the implementation of activities and many activities remain staff assisted for a considerable period	Criteria for moving to the next phase are flexible to allow lower functioning clients to move through the program phase system	Individual counselling and instruction are more immediately provided in work related activities
Greater staff responsibilities to act as role models and guides		Engagement is emphasised throughout treatment
Smaller units of information are presented gradually, and fully discussed	Continuing care is an essential component of the treatment process (continuing treatment after leaving residential care)	Activities are designed to overlap
Greater emphasis is placed on assisting individuals		Activities proceed at a slower pace
Increased emphasis is placed on providing instruction, practice and assistance	Clients can return to earlier phases to solidify gains as necessary	Individual counselling is used to assist in the effective use of the community
		The conflict resolution group replaces the encounter group

Sacks (2000), Modifications required of a residential program providing treatment

11.5 Aboriginal and Torres Strait Islander peoples

The 1996 review by Ernst and Young identified that 13 per cent of Australian residential treatment clients were of Aboriginal and Torres Strait Islander descent. This figure is disproportionate to the proportion of Aboriginal and Torres Strait Islander people in the general population, which is approximately 1.5 per cent according to the 1991 Census.

the overall trend for the general population is to use non-residential services, which are now more prevalent than residential services. Aboriginal people are more likely to use residential forms of treatment than are non-Aboriginal Australians (Brady 2002)

Aboriginal and Torres Strait Islander peoples have particular cultural needs that require consideration in the design and delivery of residential treatment services. Program design and content for Aboriginal residential treatment needs to have a broad focus incorporating a diversity of treatment approaches.

According to Brady (2002), a treatment program for Aboriginal people should have the following features:

Treatment:

- withdrawal management (either under medical supervision or with access to such supervision)
- rest and recuperation
- individual counselling (motivating people to change, helping their commitment)
- group counselling
- therapeutic activities (art work, artefact making, gardening, bush trips)
- advice on employment and educational opportunities, job-finding
- follow-up (home visits by staff, a halfway house, continuing care).

Governance:

- a good administrative and management base
- regular quality improvement reviews by accredited reviewers
- a clear definition of the purpose of the program, either as a structured treatment program or a dry recuperative facility
- clear distinctions between the roles and responsibilities of boards and managers

- board members with knowledge and experience of mainstream residential programs
- training of board members, both in governance and alcohol and drug treatment
- rules to cover day release activities for clients, as well as rules of conduct within the program
- having the support of the local community or local population.

Training and networking:

- counsellors who have training to increase their confidence and efficacy and to acquire new skills
- ongoing in-service training, staff exchanges and placements with larger organisations
- staff mentored by outside professionals
- close involvement with a local doctor to provide assessment before, during and after admission, supervision of withdrawal, pharmacotherapy, assistance with care plans, advice to clients
- formal and informal partnerships with local public health professionals and state alcohol and drug services
- membership of and participation in regional networks of alcohol and drug organisations and therapeutic community associations.

Program content:

- a safe drug and alcohol-free environment
- an environment that takes into account people's cultural, familial and social circumstances in an informed and respectful manner
- time and place for clients to withdraw from a high-risk lifestyle or situation
- peer support and encouragement to withdraw from use
- education regarding strategies for maintaining moderate drinking, or a lifestyle free of drugs and alcohol, to match the needs of clients
- encouragement of open reflection and discussion of personal issues related to use
- healthy lifestyle, structured activity, and balanced diet during residence
- assistance with a range of issues associated with community living and daily living skills
- parenting skills training
- vocational, recreational and "cultural" activities

- training in practical skills, through TAFE and other vocational training (eg literacy, carpentry, agriculture, permaculture, art production)
- planning for discharge, provision of continuing care and home visits after treatment or referrals to achieve this.

In an analysis of the needs of Aboriginal and Torres Strait Islander illegal drug users in the ACT, the Australian National University Centre for Epidemiology and Population Health and the Winnunga Nimmityjal Aboriginal Health Service recommended that Aboriginal treatment programs should:

- be run by Aboriginals [or have Aboriginal workers with support from the Aboriginal community]
- include a focus on learning about culture and Aboriginal identity
- acknowledge the unique family structures of Aboriginal and Torres Strait Islander communities by allowing for close contact with family members [for example, allowing phone contact with family members throughout treatment, and providing for regular family visits]
- include life skills training in the program.

11.6 People from culturally and linguistically diverse backgrounds (CALD)

Dale and Marsh (2000) recommend the following principles when working with people who are culturally and linguistically diverse:

- CALD clients should be given the option (where possible) of being referred to an appropriate culturally specific service
- When referral is not possible and the client has a poor understanding of English, services should seek the permission of the client to enlist the help of an interpreter (for example through use of the Telephone Interpreter Service)
- Staff and counsellors should use clear and unambiguous language
- Where appropriate, staff should consult clients about relevant cultural norms and expectations.

11.7 Pharmacotherapies in residential programs

The integration of pharmacotherapies into residential treatment has until recently been considered antithetical to the methods of most residential treatment programs, where abstinence has often been the primary treatment objective, a position usually reflected in organisational philosophy, treatment approaches and goals.

The increasing use of a range of medications in the general community and the availability of pharmacotherapies for treating drug dependence such as methadone, buprenorphine and naltrexone has meant that many people wishing to enter residential treatment are currently taking medications.

11.7.1 Prescribed medications

If a person taking prescribed medication is admitted into residential treatment, the person's prescribing doctor should be informed about the treatment program (provided that the person agrees to this) and involved in the continuing management of the person's medication. If reducing the person's reliance on medication is an objective of treatment, the involvement of the prescribing doctor will be helpful.

Some residential treatment services may require potential residents to withdraw from all medications as a condition of entry into the residential program. Recommending that a person discontinue medication may be hazardous (for example, research has now shown that abrupt discontinuation of some antidepressant medications may result in a withdrawal response) and should be done in consultation with the person's prescribing doctor. If this is not possible, suitable alternative medical advice should be sought and a thorough assessment of the likely effect of withdrawing the medication must be made.

11.7.2 Pharmacotherapies for drug dependence

There are three primary models for the integration of pharmacotherapy into residential treatment programs and therapeutic communities:

- 1 Residential treatment with the use of antagonist pharmacotherapy (eg naltrexone) as an aid to abstinence
- 2 Residential treatment of people on methadone or buprenorphine maintenance treatment, where controlled drug use is the immediate aim, rather than abstinence
- 3 Residential treatment of people seeking to discontinue methadone or buprenorphine maintenance.

11.7.3 Residential treatment with the use of antagonist pharmacotherapy

Antagonist pharmacotherapies, such as naltrexone maintenance for opioid and/or alcohol dependent clients, are an aid to abstinence. Managing clients on these therapies will not affect their performance in a residential treatment program. There is no indication for special needs or for any restriction to admission for clients on antagonist pharmacotherapy.

11.7.4 Residential treatment of people on methadone or buprenorphine maintenance treatment

Agonist pharmacotherapies such as methadone or buprenorphine are an alternative to abstinence for opioid-dependent people and poly-drug users. Some people on methadone or buprenorphine maintenance have social or health-related difficulties that compromise their ability to engage with therapy, and these people may be helped by combining residential treatment with maintenance pharmacotherapy. In some cases, mental health comorbidity or chaotic poly-drug use may mean that community-based pharmacotherapy will be unsuccessful and the client may be lost to treatment.

There are residential programs designed to help people achieve sufficient life stability to effectively engage with methadone or buprenorphine maintenance treatment. These programs are generally accommodation services with case management available to assist clients through the financial, legal, health and social hurdles confronting them. Case management usually remains the responsibility of the pharmacotherapy prescriber, but it may be negotiated and provided by the residential services provider or a third provider.

Many of these clients will have psychological adjustment difficulties that require assistance. Some (not all) people on buprenorphine find themselves unexpectedly clearheaded and confronted by the negative impact of what has happened to their life and relationships.

The development of appropriate residential or day programs for clients on methadone or buprenorphine is an issue of ongoing discussion between the public and NGO sectors.

11.7.5 Residential treatment of people seeking to discontinue methadone or buprenorphine maintenance

A small number of residential programs exist to provide a systematic exit strategy for people on maintenance pharmacotherapy. These programs are modelled on existing therapeutic community models and simultaneously commence a staged withdrawal of pharmacotherapy while engaging the client in the residential therapeutic program. This program type is relatively new in Australia, although there is some longer term experience in the USA.

Agonist pharmacotherapies exist for the treatment of opioid users and are generally provided in community settings. It may not be apparent to people on methadone or buprenorphine maintenance how to end treatment and many become frustrated and feel trapped in the pharmacotherapy maintenance system. This often results in abrupt unplanned exits from the pharmacotherapy program, leaving the client vulnerable to a return to illicit drug use. While it is common practice for pharmacotherapy prescribers to work with clients to reduce maintenance doses, usually at the client's request, the safety, security and support provided by a residential treatment program enables clients to withdraw from the pharmacotherapy in a timely, planned and systematic way.

There are a number of practice issues that differentiate these programs from other therapeutic communities described in this publication:

- Entry into a pharmacotherapy withdrawal program is subject to comprehensive assessment including input from the pharmacotherapy provider
- The client should enter in the residential program and remain on the maintenance pharmacotherapy dose for an initial period of at least seven days. This period allows for extended assessment of the proposed treatment and allows for uncomplicated return to maintenance pharmacotherapy if the planned withdrawal doesn't proceed

- Clear agreements are developed between pharmacotherapy providers and the treatment program for the ongoing shared care of the potential resident. These arrangements include an agreement on scripting the withdrawal regimen, shared case confidentiality (with client consent) on issues related to pharmacotherapy prescription and a capacity for the client to return to maintenance pharmacotherapy for reasons of personal choice or good clinical practice
- Clear partnerships are developed with the dispensing pharmacy to ensure that consistent dosing times, good dosing practice and transparent shared care partnerships (with the client's consent) are in place. It is recommended that the residential program develop partnerships with a prescriber and a pharmacy who provides service for most clients in the program. Apart from the economy of these arrangements, it leads to consistent practice and information exchange across the providers, to the clients' benefit. However, there might be some benefit from clients remaining with their existing maintenance prescribers if the therapeutic relationship is significant
- Programs need to be tolerant of the effects of prolonged, moderate withdrawal symptoms for some residents. These include insomnia, excessive perspiration, restlessness, and day time lethargy. There are marked performance differences between clients in drug free residential treatment and those undergoing slow withdrawal
- Clients in withdrawal programs may not be able to manage all job tasks usually completed by clients in residential programs. Operating machinery is one task that should be limited to clients who are completely drug free
- Standardised withdrawal regimens can be developed that load the bulk of the dose reduction at the front end of the process. These schedules should be developed with appropriate medical specialist advice and coordinated with the prescriber responsible for the client.

Methadone, especially, effectively reduces symptoms of mental illness. Clients must be assessed for symptoms as the withdrawal progresses. Cessation of withdrawal and timely mental health interventions may be required.

SECTION 12

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