List of Twenty Three Principles for the Delivery of Ethical, Efficient and Effective Services in Addiction Outpatient-Outreach Services

Principle Focus	Description
1. Collaborative practices	Services and service relationships should be founded upon and flow from collaborative practices. **Collaborative practices** intentionally and actively invite and integrate the views, values, needs, preferences, knowledge, dignity and strengths of the client. These practices do not necessarily exclude input from other perspectives, such as the professional, but emphasize the central and active role and preferences of the person served. These practices include the spectrum of client-centred approaches. Collaboration is crucial to effective helping relationships (Duncan et al, 2004; Miller & Rollnick, 2002)
2. Client retention	Program philosophy and practices should strive towards **client retention**. The aim of retention is not to foster dependency or increase volume of services delivered, but rather to build a quality of client engagement over an adequate period of time. It is recognized that retention is not limited to current service (I.E. outpatient), but appropriate retention across the continuum of services. In general, the more severe and persistent the presenting concern, the more crucial retention is to good long-term outcomes (Darke et al, 2007 & 2008; Simpson et al, 1997; Teeson et al, 2008)
3. Socio-cultural diversity	Programs should be responsive to the **socio-cultural diversity** of persons served. The meaning and effects of problems, helping relationships, potential solutions and clinical modalities are very much dependent on values and beliefs rooted in not just a client's personal history, but in their socio-cultural membership, gender, sexual orientation, race, ethnic origin, economic status, and other characteristics. These histories and social memberships have a strong bearing on service relationships, treatment planning and outcomes (Jiwa & St. Pierre-Hanson, 2008; Bernal & Saez-Santiago, 2006; Matthews et al, 2006; Rastogi & Wadhwa, 2006)
4. Treatment planning	**Treatment planning** and delivery should match the needs, capacities and goals of the client. A range of service formats and intensities need to be offered. Factors such as age, socio-cultural membership, problem severity and physical/mental health status need to match services. Appropriate treatment matching has a strong effect on outcomes (McLellan et al, 1999; Nsimba, 2007)
5. Client input and feedback	Service planning and delivery will include ongoing **client input and feedback** (client directed, outcome informed). Feedback and input should not just happen at routine intervals (E.G. formal review every 30 days), but be invited and incorporated continuously (E.G. before/after each session). This principle reflects a key active component of effective collaborative practice (Duncan et al, 2004).

Principle Focus	Description
6. Therapeutic alliance	Program philosophy and activities should support the development of a strong working **therapeutic alliance** with clients. These alliances are not directed at building client dependency on the helper or services, but rather relationships where client goals, capacities, and strengths are served by well-informed professionals offering evidence-based help. Strong therapeutic alliances are characterized by clients reporting that their helper appreciates their personal experience (is validating), is on their side (respects their hopes), exhibits caring and warmth (genuine empathy and compassion) and is skilled within their scope of practice (competent). Program structure and clinical supervision supports the development of good therapeutic alliances. Therapeutic alliance is a powerful program variable in supporting good outcomes (Baldwin et al, 2007; Horvath & Symonds, 1991).
7. Family-based counselling	When consistent with the goals, preferences and capacities of the client, ideas and practices associated with **family-based counselling** should be employed. With adults, couples' counselling, in particular, has a demonstrated effect towards positive outcomes. Overall, couple's and family counselling can make important contributions towards good outcomes (Becker & Curry, 2008; Health Canada, 2001; Fals-Stewart & Lam, 2008; Mueser & Fox, 2002).
8. Cognitive Behavioural Therapy	When consistent with the goals, preferences and capacities of the client, ideas and practices consistent with **Cognitive Behavioural Therapy** (CBT) should be explored. There is a strong body of evidence demonstrating the efficacy of CBT in treating substance misuse (Becker & Curry, 2008; CARMHA, 2007; Maude-Griffen et al, 1998)
9. Motivational Interviewing, Motivational Dialogue and Change Talk	When clinically appropriate, ideas and practices associated with **Motivational Interviewing**, **Motivational Dialogue** and **Change Talk** should be incorporated into clinical interactions. Alone, or in conjunction with a comprehensive treatment plan, sound motivational dialogue has a well demonstrated positive effect on outcomes (Becker & Curry, 2008; Miller & Rollnick, 2002)
10. Group formats	For many client needs, **group formats** are an effective means of supporting progress towards goals. Groups covering key program elements such as Relapse Prevention and various social skills, such as healthy relationships or parenting, can be offered to promote good treatment outcomes (Graham et al, 1996; Health Canada, 2001).
11. Self-help groups	Existing **self-help groups** (E.G. NA, AA) can be an effective form of support either alone or as an adjunct to outpatient/outreach services. Client capacities, preferences and values will strongly determine the effect of self-help groups. Services should provide information and neutral support for client exploration and engagement with self-help groups. For many, self-help groups support good outcomes (Knack, 2009; Humphreys et al, 1999; Witbrodt & Kaskutas, 2005).

Principle Focus	Description
12. Mental health	Clients with histories, or suspected histories, of significant **mental health** concerns (co-occurring disorders) should be supported in seeking consultation with professionals qualified to assess and treat mental health disorders. Outpatient services should work collaboratively with mental health service providers (including primary care physicians) and the client. Responding to the unique and specific needs of those diagnosed with co-occurring disorders improves global outcomes (Drake et al, 2004; Minkoff, 2001; Muesser, 2004; Ouimette et al, 2007; Sacks et al, 2008).
13. Harm reduction	Services should be consistent with the ideas and practices associated with **harm reduction**. This includes active attention to minimizing perceived service barriers for clients who are contemplating or participating in harm reduction measures (Teeson et al, 2008; Brink & Haasen, 2006).
14. Case management	Clinical services should be founded on **case management**. Case management refers to the systematic activities between a helper (Case Manager) and client that identify treatment needs, plans and resources. Case management can enhance outcomes and emphasizes utilization of community resources (McLellan et al, 1999).
15. Community reinforcement	**Community reinforcement** elements significantly enhance outcomes. Community resource information, life skills training, referrals and links to employment training and search, recreation, volunteer work and other community activities are incorporated in treatment planning and implementation. These opportunities lead to decreased substance misuse, greater client personal fulfilment and holistic well-being (Higgins et al, 2003; Secades-Villa et al, 2008; Smith et al, 2001)
16. Self-help manuals /other front loaded services	If clients face a waitlist or other service demand related delays in receiving counselling services, **self-help manuals** or other **front-loaded** services (E.G. support groups) are provided. This practice alone can contribute greatly to good outcomes (Harris & Miller, 1990; Miller et al, 1996).
17. Brief interventions	**Brief interventions** (E.G. 8 or fewer sessions) are utilized when serving individuals with low to moderate levels of substance misuse. This approach is not distinguished as much by service limitations ((E.G. session limits), but by clinical activities that emphasize client strengths and attainable goals and solutions. For many clients, these approaches can make a strong contribution toward good outcomes (Health Canada, 2001; Duncan et al, 2004; Fals-Stewart & Lam, 2008).
18. Stress management	**Stress Management** and associated wellness skills (E.G. meditation) are included in the range of clinical services offered. Stress management can be a key part of maintaining client gains; particularly over the long-term (Finney & Monahan, 1996; Health Canada, 2001; Monahan & Finney, 1996).
19. Relapse prevention	Groups, information and counselling specific to proven **Relapse Prevention** strategies should be offered (E.G. Gorski or Marlatt models). Clients learn to identify particular personal and environmental risks and to develop skills to prevent or better manage challenging circumstances. Relapse prevention skills are crucial to good outcomes (Larimer et al, 1999; Witkiewitz & Marlatt, 2005)
20. Social skills training	**Social Skills Training** should be incorporated in program services. For example, psycho-educational programming targeted at managing conflict, dealing with anger or building healthy relationships (Forys et al, 2007; Health Canada, 2001; Rohsenow et al, 2005; Tsuang et al, 2006).

Principle Focus	Description
21. Specific services for youth	**Specific services for youth** should be provided. Service includes opportunities for family, peer and other supports involvement. Outreach contact is available for youth who are challenged with engaging in site-based services. Information, literature and activities should be designed to respectfully appeal to and engage youth. Outcomes can be improved by responsiveness to the unique needs and strengths of youth (Health Canada, 2001).
22. Status of women	Program services should be sensitive to the **status of women** in society. The challenges of economic autonomy, disproportionate burdens of care giving, physical and sexual victimization and other social justice concerns are uniquely located in the lives of women. Service approaches should emphasize activities that embrace the direction of the empowerment of women. Ideas and practices that take into account the status of women and specific treatment needs are crucial to good outcomes (Anderson, 1998; Carter et al, 2008; Health Canada, 2001).
23. Seniors	Good outcomes with **seniors** are supported by services that enhance accessibility and relevance to this population (Cummings, 2004). Effective practice includes outreach and partnership with senior specific community resources.

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