**The critical review of the guidelines of drug and alcohol treatment**

[Name of the Writer]

[Name of the Institution]

# **The critical review of the guidelines of drug and alcohol treatment within residential settings.**

# **Introduction**

Drugs and alcohol abuse had long remained an issue of concern throughout the World. It attracts much attention when it involves abuse. Decades before, it was normally considered that the drug or alcohol abuse is the ultimate path towards the end of life. Since the beginning of the treatment of patients that had been affected by drugs or alcohol in any way, it has experienced enough improvements. One of the most practiced ways of such treatment today is within the residential settings(Siegel et al. 2007). In this form of treatments, intensive care is provided to the people who had suffered from any mental illness, or mainly have experienced any form of drug and alcohol abuse. In such an environment, non- prescribed drugs and alcohol are kept away, and an appropriate environment is delivered to solve the basic causes of dependence on ill medications. Such treatment plans are considered long lasting and aim at the re-integration of the affected people into the community again. Such residential treatment center is often referred to as Rehab(Siegel et al. 2007). There are certain guidelines provided by the state from time to time, to these Rehab centers in order to create a common standard throughout the country.

This essay is intended to critically analyze the guidelines practiced for the drug and alcohol treatment within the residential settings. The essay mainly analyses critically the guidelines about the treatment of alcohol or drug abuse patients and evaluates them in comparison to the Agree II guidelines*.* The essay will be divided into three sections. The first section of the essay includes the guidelines for the treatment of patients with drug and alcohol abuse. The second section includes the critical analysis of those guidelines and the third section includes the analysis of the guidelines with the Agree II standards. The conclusion will be part of this section.

**Guidelines for the treatment of drugs and alcohol abuse**

The guidelines are standard forms of clinical practices. These guidelines mainly involve general recommendations for daily clinical decisions in the hospital, procedures of maintaining medical standards at hospitals or clinics, health budget allocations by state governments and by the insurance companies(Gray et al. 2010). For patients that are the victims of drug or alcohol abuse, these guidelines are entirely different as compare to the stands guidelines practices in the world for medical treatment. The Institute of Medicine defines such clinical guidelines as “properly developed rules to help medical practitioners and patients with drug abuse to get into the community life again(Dans and Dans 2010). These guidelines offer appropriate directions about which medical tests to order at first place to detect the presence of alcohol, and how to carry on with further medical services, about the length of the stay of patients in rehabilitation centers or residential settings and many such details about medical practices(Simpson et al. 1997). The main reasons for the development of such guidelines are pressing issues in the treatment of drug and alcohol abuses throughout the world, the rising trends in the costs of such treatment, and the expanding demands for health care, the introduction of expensive technologies in the medical field and the presence of a much larger number of old aged peoples(Levin, Evans, and Kleber 2013). These guidelines are also important in maintaining a general standard in the medical diagnostic and treatment as today there exist wide variations from region to region. Some health care experts opine that these variations exist because of the inappropriate methodologies used in caregiving, the extra reliance over the health care systems or less reliance and mainly because of the desire of the medical specialists to offer best and desired care by the patient(Levin, Evans, and Kleber 2011). The healthcare professionals, the caregivers working in the clinics, the policymakers in the field of medicines and the physicians use these guidelines as a standard tool of consideration in the medical field. It also helps bridge the gap between what is required specifically by the patient or which clinical methodology be used to treat that patient and what the clinician or the health expert is supposed to perform. At present these guidelines have also included the manufacturing and uses of medicine, their evaluations and how and when to use them.

*Uses of Guideline:* The primary use of the guidelines is to maximize the quality of the care given to drug abuse patients. It is generally believed that till date, the guidelines have resulted in improving the quality of the medical facilities being given to the patients throughout the world. The reason for this belief is the different definitions of the quality of medicine throughout the world(Stall et al. 1986). For medically ill persons and for the normal person, the largest outcome of these guidelines are the improvements in the health results. Guidelines also play an important part in the promotion of medical benefits and have intervened in discouraging the ineffective use of health care facilities for the patients(Regier et al. 1990). These guidelines are also used to improve the care been given to the people by through health care programs and the studies carried on in many regions of the world(Steenrod et al. 2012). Guidelines are also used to improve the consistency of care; studies around the world show that the frequency with which medical procedures are carried on by doctors, or medical specialists are much different throughout the world. This is how medical guidelines are important. Guidelines present a remedy, that makes it more likely that patients will be cared for in the same way irrespective of where and by whom they get treated(Sadowski et al. 2009).

*Limitations of the guidelines*: The first and foremost limitation of the guidelines is that the recommendations might get wrong. This could happen for three reasons firstly, by any scientific error, by the over the influence of clinical experiences, and thirdly patients need might not be in proper lining with the guidelines(Kaufman and Kaufmann 1979). The reliance over flawed guideline by practitioners, or encouragement on part of the health care providers for adoption to a lesser known guideline in the treatment of drug abuse. Patients, healthcare experts, and the system may all get harmed(Prendergast et al. 2006).

# **Critical Analysis of the guidelines developed for the treatment of alcohol and drug abuse for residential settings**

The guidelines developed for the treatment of patients with alcohol or drug abuse within a residential settings involve some standard operations. However, there are some medical PR actioners which opine that these medical treatments push the patients into more a kind of segregated environment. Such environments are although designed to keep patients in more a kind of medically customized place, but such an environment often results in making a patient more deprived of what exactly his or her want is.

*Customized treatment:* Customized treatment for every patient is beneficial but there are cases reported which claims that such medical treatments result in turning the immune system of the patient to allergic to other normal medical treatments(Moran, Enderby, and Nancarrow 2011). These patients then develop a not normal medical history. Therefore some standard practices are adapted to treat such patients anywhere.

*Emergency treatments:* Up till now, there have been noticed some observations that within the residential settings the guidelines lack the presence of emergency treatments of the affected patients. These patients can anytime turn themselves up which creates an environment of emergency, this, therefore, requires the development of an emergency mechanism to curtail the chances of anything serious happening to the patient(Schonberg 1993).

*Cardiac issues:* The alcoholic patient is every time at the risk of developing heart problems. Their heartbeat remains not standard as compared to normal people. The treatment of such cardiac issues requires the essence of emergency settings around the patient, which is however not possible within the residential settings(Mortlock, Deane, and Crowe 2011). The guidelines for this suggests that the patient is shifted to a near buy cardiac center, and considering the cardiac history that remains impossible. Therefore, the guidelines must include readiness in the availability as some patients are at risk of cardiac attacks or such other chronic illness sty.

*Other medical issues:* It is much possible that the patient could have developed with time other medical problems, most common remains the HIV or the Hepatitis B or C The guidelines however appears addressing the medical problems that originate from the alcoholic issues, in such conditions the medical specialists opine that this it is possible to treat such all conditions at the same time(Sadowski et al. 2009). The guidelines also need some adjustments in the treatment of such diseases also, which is also a standard medical practice. Therefore, treatments must be designed to address the multiple needs of the individual with such problems. That must not be limited to his or his use of drugs.

*Medical Checkups:* The guidelines offer various kind of medical treatments to treat patients with alcoholic or drug treatments. There is also the programs that include regular medical checkups of such patients. With regard to this, it appears that in some cases the patients get out of the track and gets detached from the medical prescriptions(Dans and Dans 2010). The guidelines must address such problems and should induct a standardized mechanism to avoid patients from getting breaks in the treatments. The healthcare expert’s opinions remain for them of critical importance.

*Specifications in the Guidelines:* The standard medical guidelines of such treatments involve either being too specific or being too through. It is least possible that any such patient could be cured by such designed treatments(Moran, Enderby, and Nancarrow 2011). The guidelines must include a specific set of instructions in regard to the time period in which a patient might get treated. The only reason that there must be standard time period is this that the patient’s relatives and family become sick of going in such flows with the treatments.

*Counseling:* Counselling that might involve individuals or groups are much important in the complete rehabilitation process(Humphreys et al. 2004). There exist standard mechanisms for this but this remains unattended that what type of counseling would be suitable for any patient. As there are customized plans of medical treatments, there must also be such customized plans of counseling which can bring patients early towards life. The applications of standard counseling practices on every patient remain ineffective.

*Regular Medications:* Medications combined with therapy plays a pivotal role in the complete rehabilitation process. The guidelines in this regard offer segregated SOPs for both the medications and hepatic procedures(Moran, Enderby, and Nancarrow 2011), which becomes difficult to practice separately. Further till yet, such guidelines don’t exist which provides a combined mechanism for these two problems. Similarly, it is also not necessary that the complete rehabilitation process should involve the use of medications.

**Guideline Appraisal with the Agree II Appraisal tools**

|  |  |  |
| --- | --- | --- |
| Item No.  | Agree II Content  | Guideline Appraisal  |
| 1. | *The guideline objectives are defined specifically.* | Since the guidelines under analysis are specific for the patients with drug and alcohol abuse, it clearly defines the objectives of the guidelines in the preliminary paragraphs.  |
| 2. | *Questions of health are specifically described.* | Questions regarding the health and other such problems of such patients are clearly described, but they, however, need some clarifications which have been discussed in the critical analysis part.  |
| 3. | *Patient type or group of the people are described precisely.*  | Since the patients sought after are the ones with drug or alcohol abuse, they are clearly described.  |
| 4. | *The guideline includes medical professionals from all backgrounds.* | At some parts, where the guidelines suggest the treatment of patients in line with other medical guidelines, it includes mentioning about the other medical specialists.  |
| 5. | *Views and Preferences of the target population have been sought.* | Since it is an analytical study and does not involves using any quantitative date, therefore it does not involve soughing of the views of such patients.  |
| 6. | *Guidelines clearly define the target audience.* | Guidelines clearly define the target patients which are the patients with drug or alcohol abuse. |
| 7. | *Strengths and weakness have been defined properly.*  | The strength and weakness have been discussed, however, it needs some more clarifications. |
| 8.  | *A procedure for updating the guidelines exist.* | A properly defined procedure lacks but it exists that needs some more modifications.  |
| 9. | *Primary recommendations are easily identifiable* | Primary recommendations in terms of cosmetic procedures are identifiable. Neither part of the guidelines mentions an example of a specific prescription.  |
| 10. | *Are the recommendations unambiguous* | The recommendations are clear and are not unambiguous. However, there are areas which are not properly defined such as for exactly what times the patient be kept under review.  |
| 11. | *Do the guidelines present any monitoring criteria?* | The guidelines mention just the monitoring of the patients either by the family or the medical doctor. |
| 12. | *Do the guidelines involve procedure of continuous review?* | There are ways mentioned as to how the guidelines are kept in a mode of review. |

# **Conclusion**

The guidelines being practiced in Australia conforms to the internationally recognized standards of such guidelines. The guidelines are too specific as they include the guidelines just relevant to the drug or alcohol abuse. As it is generally considered that such patients with time develop other chronic illness, therefore these guidelines must be adjusted with other medical guidelines in order to result in a more thorough set of medical norms.

# **Bibliography:**

Dans, Antonio L., and Leonila F. Dans. 2010. “Appraising a Tool for Guideline Appraisal (the AGREE II Instrument).” *Journal of clinical epidemiology* 63(12): 1281.

Gray, Dennis, et al. 2010. "Managing Alcohol-Related Problems among Indigenous Australians: What the Literature Tells Us." *Australian and New Zealand journal of public health* 34: S34–S35.

Humphreys, Keith, et al. 2004. "Self-Help Organizations for Alcohol and Drug Problems: Toward Evidence-Based Practice and Policy." *Journal of substance abuse treatment* 26(3): 151–158.

Kaufman, Edward, and Pauline Kaufmann. 1979. *Family Therapy of Drug and Alcohol Abuse*. Gardner Press New York.

Levin, Frances R., Suzette M. Evans, and Herbert D. Kleber. 1999. “Alcohol & Drug Abuse: Practical Guidelines for the Treatment of Substance Abusers with Adult Attention-Deficit Hyperactivity Disorder.” *Psychiatric Services* 50(8): 1001–1003.

Moran, Anna, Pamela Enderby, and Susan Nancarrow. 2011. “Defining and Identifying Common Elements of and Contextual Influences on the Roles of Support Workers in Health and Social Care: A Thematic Analysis of the Literature.” *Journal of evaluation in clinical practice* 17(6): 1191–1199.

Mortlock, Kane Saxon, Frank P. Deane, and Trevor Patrick Crowe. 2011. “Screening for Mental Disorder Comorbidity in Australian Alcohol and Other Drug Residential Treatment Settings.” *Journal of Substance Abuse Treatment* 40(4): 397–404.

Prendergast, Michael L., Deborah Podus, Eunice Chang, and Darren Urada. 2006. “Erratum to" The Effectiveness of Drug Abuse Treatment: A Meta-Analysis of Comparison Group Studies"[Drug Alcohol Depend. 67 (2002) 53-72].”

Regier, Darrel A., et al. 1990. "Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse: Results from the Epidemiologic Catchment Area (ECA) Study." *Jama* 264(19): 2511–2518.

Sadowski, Laura S., Romina A. Kee, Tyler J. VanderWeele, and David Buchanan. 2009. "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Trial." *Jama* 301(17): 1771–1778.

Schonberg, S. Kenneth. 1993. 4 *Guidelines for the Treatment of Alcohol and Other Drug-Abusing Adolescents*. US Department of Health and Human Services, Public Health Service, Substance ….

Siegel, Jane D., Emily Rhinehart, Marguerite Jackson, and Linda Chiarello. 2007. “2007 Guideline for Isolation Precautions Preventing Transmission of Infectious Agents in Healthcare Settings.”

Simpson, D. Dwayne, George W. Joe, Grace A. Rowan-Szal, and Jack M. Greener. 1997. “Drug Abuse Treatment Process Components That Improve Retention.” *Journal of substance abuse treatment* 14(6): 565–572.

Stall, Ron et al. 1986. “Alcohol and Drug Use during Sexual Activity and Compliance with Safe Sex Guidelines for AIDS: The AIDS Behavioral Research Project.” *Health Education Quarterly* 13(4): 359–371.

Steenrod, Shelley, Anne Brisson, Dennis McCarty, and Dominic Hodgkin. 2002. “Effects of Managed Care on Programs and Practices for the Treatment of Alcohol and Drug Dependence.” In *Alcoholism*, Springer, 51–71.