**Detoxification and Substance Abuse Treatment**

# A Treatment Improvement Protocol

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

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### What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at [http://store.samhsa.gov.](http://store.samhsa.gov/)

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided. When no citation is provided, the infor­ mation is based on the collective clinical knowledge and experience of the consensus panel.

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# Foreword

The Substance Abuse and Mental Health Services Administration (SAMH­ SA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mis­ sion to reduce the impact of substance abuse and mental illness on America's communities by providing evidence-based and best practice guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation require­ ments. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particu­ lar area of expertise until they reach a consensus on best practices. Field reviewers then review and critique this panel's work.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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# Executive Summary

This Treatment Improvement Protocol (TIP) is a revision of TIP 19, *Detoxification From Alcohol and Other Drugs* (Center for Substance Abuse Treatment 1995d). It provides clinicians with updated informa­ tion and expands on the issues commonly encountered in the delivery of detoxification services. Like its predecessor, this TIP was created by a panel of experts (the consensus panel) with diverse experience in detoxi­ fication services-physicians, psychologists, counselors, nurses, and social workers, all with particular expertise to share.

This diverse group agreed to the following principles, which served as a basis for the TIP:

1. Detoxification, in and of itself, does not constitute complete sub­ stance abuse treatment.
2. The detoxification process consists of three essential components, which should be available to all people seeking treatment:
	* Evaluation
	* Stabilization
	* Fostering patient readiness for and entry into substance abuse treatment
3. Detoxification can take place in a wide variety of settings and at a num­ ber of levels of intensity within these settings. Placement should be appropriate to the patient's needs.
4. All persons requiring treatment for substance use disorders should receive treatment of the same quality and appropriate thoroughness and should be put into contact with substance abuse treatment providers after detoxification.
5. Ultimately, insurance coverage for the full range of detoxification ser­ vices is cost-effective.
6. Patients seeking detoxification services have diverse cultural and ethnic backgrounds as well as unique health needs and life situations. Programs offering detoxification should be equipped to tailor treatment to their client populations.
7. A successful detoxification process can be measured, in part, by whether an individual who is substance dependent enters and remains **in** some form of substance abuse treatment/rehabilitation after detoxification.

Among the issues covered in this TIP is the importance of detoxification as one component in the continuum of healthcare services for sub­ stance-related disorders. The TIP reinforces the urgent need for non-

traditional settings-emergency rooms, medi­ cal and surgical wards in hospitals, acute care clinics, and others-to beprepared to partici­ pate in the process of getting the patient who is in need of detoxification services into treat­ ment as quickly as possible. Furthermore, it promotes the latest strategies for retaining individuals in detoxification while also encouraging the development of the therapeu­ tic alliance to promote the patient's entrance into substance abuse treatment. The TIP also includes suggestions on addressing psychoso­ cial issues that mayimpact detoxification treatment, such as providing culturally appropriate services to the patient popula­ tion.

Matching patients to appropriate care repre­ sents a challenge to detoxification programs. Given the wide variety of settings and the unique needs of the individual patient, estab­ lishing criteria that take into account all the possible needs of patients receiving detoxifica­ tion and treatment services is an extraordi­ narily complex task. Addiction medicine has sought to develop an efficient system of care that matches patients' clinical needs with the appropriate care setting in the least restric­ tive and most cost-effective manner. Patient placement criteria, such as those published

by the American Society of Addiction Medicine (ASAM) in the *Patient Placement Criteria, Second Edition, Revised,* represent an effort to define how care settings may be matched to patient needs and special charac­ teristics. These criteria-the five **"Adult** Detoxification" placement levels-define the most broadly accepted standard of care for detoxification services. The five levels of care are

1. Level 1-D: Ambulatory Detoxification Without Extended Onsite Monitoring
2. Level 11-D: Ambulatory Detoxification With Extended Onsite Monitoring
3. Level 11.2-D: Clinically Managed Residential Detoxification
4. Level 111.7-D: Medically Monitored Inpatient Detoxification
5. Level IV-D: Medically Managed Intensive Inpatient Detoxification

ASAM criteria are being adopted extensively on the basis of their face validity, though their outcome validity has yet to be clinically proven. The ASAM guidelines are to be regarded as a work in progress, as their authors readily admit. They are an important set of guidelines that are of great help to clini­

cians. For administrators, the standards pub­ lished by such groups as the Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities pro­ vide guidance for overall program operations.

Placement will depend in part on the sub­ stance of abuse. The consensus panel suggests that for alcohol, sedative-hypnotic, and opi­ oid withdrawal syndromes, hospitalization (or some form of 24-hour medical care) is often the preferred setting for detoxification, based on principles of safety and humanitarian con­ cerns. When hospitalization cannot be pro­ vided, then a setting that provides a high level of nursing and medical backup 24 hours a day, 7 days a week is desirable.

A further challenge for detoxification pro­ grams is to provide effective linkages to sub­ stance abuse treatment services. Patients often leave detoxification without followup to the treatment needed to achieve long-term abstinence. Each year at least 300,000 patients with substance use disorders or acute intoxication obtain inpatient detoxification in general hospitals, while additional numbers obtain detoxification in other settings. Only 20 percent of people discharged from acute care hospitals receive substance abuse treat­ ment during that hospitalization. Only 15 percent of people who are admitted to a detoxification program through an emergency room and then discharged go on to receive treatment.

The consensus panel recognizes that medical­ ly assisted withdrawal is not always necessary or desirable. A nonmedical approach can be highly cost-effective and provide inexpensive

**xvi Executive Summary**

access to treatment for individuals seeking aid. Young individuals in good health, with no history of previous withdrawal reactions, may be well served by management of withdrawal without medication. However, personnel supervising in this setting should be trained to identify life-threatening symptoms and solicit help through the emergency medical system as needed.

The consensus panel also agreed on several guidelines for nonmedical detoxification pro­ grams. Such programs should follow local gov­ ernmental regulations regarding their licensing and inspection. In addition, it is desirable that all such programs have an alcohol and drug­ free environment as well as personnel who are familiar with the features of substance use withdrawal syndromes, have training in basic life support, and have access to an emergency medical system that can transport patients to emergency departments and other sites for clin­ ical care.

A major clinical question for detoxification is the appropriateness of the use of medication in the management of an individual in with­ drawal. This can be a difficult matter because protocols have not been firmly established through scientific studies or evidence-based methods. Furthermore, the course of with­ drawal is unpredictable and currently avail­ able techniques of screening and assessment do not predict who will experience life-threat­ ening complications.

Although it is the philosophy of some treat­ ment facilities to discontinue all medications, this course of action is not always in the best interest of the patient. Abrupt cessation of psychotherapeutic medications may cause severe withdrawal symptoms or the re-emer­ gence of a psychiatric disorder. As a general rule, therapeutic doses of medication should be continued through any withdrawal if the patient has been taking the medication as pre­ scribed. Decisions about discontinuing the medication should be deferred until after the individual has completed detoxification. If, however, the patient has been abusing the

medication or the psychiatric condition was clearly caused by substance use, then the rationale for discontinuing the medication is strengthened. Finally, practitioners should consider withholding medication that lowers the seizure threshold (e.g., bupropion, con­ ventional antipsychotics) during the acute alcohol withdrawal period or at least pre­ scribing a loading dose or scheduled taper of benzodiazepine.

Further studies are needed to confirm the clinical experience that psychiatric symptoms (including anxiety, depression, and personali­ ty disorders) respond to specific treatment of the addiction. For example, cognitive-behav­ ioral techniques employed in the 12-Step treatment approach have been effective in the management of anxiety and depression associ­ ated with addiction. Although challenging, treatment of both addiction and co-occurring psychiatric conditions has proven cost-effec­ tive in some studies.

This TIP also provides medical information on detoxification protocols for specific sub­ stances as well as considerations for individu­ als with co-occurring medical conditions including mental disorders. While the TIP is not intended to take the place of medical texts, it provides the practitioner with an overview of common medical complications seen in individuals who use substances.

Disorders of several systems are discussed in some detail: gastrointestinal (including the gastrointestinal tract, liver, and pancreas), cardiovascular system, hematologic (blood) abnormalities, pulmonary (lung) diseases, dis­ eases of the central and peripheral nervous system, infectious diseases, and special mis­ cellaneous disorders. The TIP presents a cur­ sory overview of special conditions, modifica­ tions in protocols, and the use of detoxifica­ tion medications in patients with co-occurring medical conditions or mental disorders.

Overall treatment of specific conditions is not addressed unless modification of such treat­ ment is needed.

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The setting in which detoxification occurs is also influenced by the existence of co-occur­ ring medical disorders. It is highly desirable that individuals undergoing detoxification be assessed by primary care practitioners (i.e., physicians, physician assistants, nurse practi­ tioners) with some experience in substance abuse treatment. Such an assessment should determine whether the patient is currently intoxicated and the degree of intoxication; the type and severity of the withdrawal syn­ drome; information regarding past with­ drawals; and the presence of co-occurring psychiatric, medical, and surgical conditions that might require specialized care.

Particular attention should be paid to those individuals who have undergone multiple withdrawals in the past and for whom each withdrawal appears worse than previous ones. Subjects with a history of severe with­ drawals, multiple withdrawals, delirium tremens (a potentially fatal syndrome associ­ ated with alcohol withdrawal), or seizures are not good candidates for detoxification pro­ grams in nonmedical settings.

The setting in which detoxification is carried out should be appropriate for the medical and psychological conditions present and should be adequate to provide the degree of monitoring needed to ensure safety (e.g., oximetry [a measurement of the amount of oxygen present in the blood], greater fre­ quency of taking **vital** signs, etc.). Acute, life­ threatening conditions need to be addressed concurrently with the withdrawal process and

intensive care unit monitoring may be indicat­ ed. Detoxification staff providing support should be familiar with the signs and symp­ toms of common co-occurring medical disor­ ders. Likewise, personnel at medical facilities (e.g., emergency rooms, physicians' offices) should be aware of the signs of withdrawal and how it affects the treatment of the pre­ senting medical conditions.

This TIP will also bring clinicians and admin­ istrators up to date on administrative issues related to detoxification, including how the services themselves can be paid for. It is

unusual in a clinical treatment improvement protocol to discuss issues related to how clini­ cal services are reimbursed. In the field of substance abuse and detoxification services, however, reimbursement issues have become so intertwined with the delivery of services that the consensus panel deemed it necessary to address the conflicts and misunderstand­ ings that sometimes arise between the care systems and the reimbursement systems.

Third-party payors sometimes prefer to man­ age payment for detoxification separately from other phases of substance abuse treat­ ment, thus treating detoxification as if it occurred in isolation from that treatment.

This "unbundling" of services can result in the separation of services into scattered seg­ ments. In other instances, reimbursement and utilization policies dictate that only detoxifi­ cation can be authorized. This detoxification often does not cover the nonmedical counsel­ ing that is an integral part of substance abuse treatment.

Finally, identifying and maintaining funding sources is a major issue in detoxification.

Substance abuse treatment in the United States is financed through a diverse mix of public and private sources, with substantially more being spent by the public sector. The existence of diverse funding streams in sub­ stance abuse treatment funding presents both management challenges and opportunities for program independence and stability.

However, a program with only one major funding source is financially and clinically vulnerable to changes in its major source's budget and priorities. This situation should be avoided. The TIP suggests ways to diversi­ fy funding sources to create a steady stream of resources that can withstand the loss of one particular funding source.

This **TIP** also makes recommendations for fostering relationships with reimbursement organizations, such as managed care organi­ zations (MCOs). These positive working rela­ tionships are vital to successfully link the patient to the needed services. For example,

the MCO may use a wide variety of specific criteria and protocols to determine whether or not services may be authorized for sub­ stance abuse, typically including the ASAM patient placement criteria and other level of care or diagnosis-based criteria sets.

Successfully addressing the needs of the staff at MCOs that are responsible for authorizing the care provided to patients is a critical ele­ ment in maintaining a relationship with an MCO and the program's clinical and financial viability. To do so, staff should understand what MCO staff do, be well trained in con­ ducting professional relationships over the telephone, be familiar with the criteria and protocols used by the MCOs with which the program has contracts, and have easy access to the abundance of clinical and service infor­ mation required by an MCO in order to help them complete a review and authorize ser­ vices. Maintaining thorough, clear, and accu­ rate records is essential to this process.

Detoxification staff also should be familiar

with each MCO's appeal or exceptions process for those occasions when the outcome of a first-level review is unsatisfactory.

Regardless of their role in providing detoxifi­ cation services, all personnel should keep in mind that patients undergoing detoxification are in the midst of a personal and medical crisis. For many patients, this crisis repre­ sents a window of opportunity to acknowledge their substance abuse problem and become willing to seek treatment. Physicians, nurses, substance abuse counselors, and administra­ tors are in a unique position, not only to ensure a safe and humane withdrawal from substances of dependency, **but** also to foster the path for the patient's entry into substance abuse treatment. This TIP suggests ways for clinicians and programs to prepare the patient for treatment while addressing the complex psychosocial and medical variables involved in detoxification.

# 1 Overview, Essential Concepts, and Definitions in Detoxification

**In This Chapter...**

Purpose of the TIP Audience

Scope

History of Detoxification Services

Definitions Guiding Principles in

Detoxification and

Substance Abuse Treatment

Challenges to Providing Effective Detoxification

Chapter 1 provides a brief historical overview of changes in the percep­ tions and provision of detoxification services. It also introduces the core concepts of the detoxification field, discusses the primary goals of detoxifi­ cation services, clarifies the distinction between detoxification and treat­ ment, and highlights some of the broader issues involved with providing detoxification within systems of care.

#### Purpose of the TIP

This TIP is a revision of TIP 19, *Detoxification From Alcohol and Other Drugs* (Center for Substance Abuse Treatment [CSAT] 1995d). Significant changes in the area of detoxification services since the publi­ cation of TIP 19 include

* Refinement of patient placement procedures
* Increased knowledge of the physiology of withdrawal
* Pharmacological advances in the management of withdrawal
* Changes in the role of detoxification in the continuum of services for patients with substance use disorders, and new issues in the management of detoxification services within comprehensive systems of care
* Emerging issues regarding specific populations (e.g., women, cultural minorities, adolescents)

This TIP provides clinicians with up-to-date information in these areas. It also expands on the administrative, legal, and ethical issues commonly encountered in the delivery of detoxification services and suggests perfor­ mance measures for detoxification programs. Like its predecessor, this **TIP** was created by a panel of experts with diverse experience in detoxification services-physicians, psycholo­ gists, counselors, nurses, and social workers, all with particular expertise to share.

#### Audience

The primary audiences for this TIP include substance abuse treatment counselors; adminis­ trators of detoxification programs; Single State Agency directors; psychiatrists and other physicians working in the field; primary care providers such as physicians, nurse practition­ ers, physician assistants, nurses, psychologists, and other clinical staff members; staff of man­ aged care and insurance carriers; policymak­ ers; and others involved in planning, evaluat­ ing, and delivering services for detoxifying patients from substances of abuse. Secondary audiences include public safety/police and criminal justice personnel, educational institu­ tions, those involved with assisting workers (e.g., Employee Assistance Programs), shel­ ters/feeding programs, and managed care orga­ nizations. The TIP also should prove useful to providers of other services in comprehensive systems of care (vocational counseling, occupa­ tional therapy, and public housing/assisted liv­ ing), administrators, and payors (public, pri­ vate, and managed care).

#### Scope

Among other issues covered in this TIP is the importance of detoxification as one compo­ nent in the continuum of healthcare services for substance-related disorders. The TIP reinforces the urgent need for nontraditional settings-such as emergency rooms, medical and surgical wards in hospitals, acute care clinics, and others that do not traditionally

provide detoxification services-to be pre­ pared to participate in the process of getting the patient who is in need of detoxification into a program as quickly as possible to potentially avoid the myriad possible negative consequences associated with substance abuse (e.g., physiological and psychological distur­ bances/disorders, criminal involvement, unemployment, etc.). Furthermore, it pro­ motes the latest strategies for retaining indi­ viduals in detoxification while also encourag­ ing the development of the therapeutic alliance to promote the patient's entrance into substance abuse treatment. This includes sug­ gestions on addressing psychosocial issues that may affect detoxification services.

This TIP provides medical information on detoxification protocols for specific sub­ stances, as well as considerations for individ­ uals with co-occurring medical conditions including mental disorders. While the TIP is not intended to take the place of medical texts, it provides the practitioner with an overview of medical considerations.

This TIP will also bring clinicians and adminis­ trators up-to-date on important aspects of detoxification, including how the services are to be paid for. It is unusual in a clinical treatment in1provement protocol to discuss issues related to how clinical services are reimbursed.

However, in the field of substance abuse and detoxification services, reimbursement issues have become so intertwined with the delivery of services that the consensus panel deemed it necessary to address the conflicts and misun­ derstandings that sometimes arise between the care systems and the reimbursement systems.

#### History of Detoxification Services

Prior to the 1970s, public intoxication was treated as a criminal offense. People arrested for it were held in the "drunk tanks" of local jails where they underwent withdrawal with little or no medical intervention (Abbott et al.

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1995; Sadd and Young 1987). Shifts in the medical field, in perceptions of addiction, and in social policy changed the way that people with dependency on drugs, including alcohol, were viewed and treated. Two notable events were particularly instrumental in changing attitudes. In 1958, the American Medical Association (AMA) took the official position that alcoholism is a disease. This declaration suggested that alcoholism was a medical prob­ lem requiring medical intervention. In 1971, the National Conference of Commissioners on Uniform State Laws adopted the Uniform Alcoholism and Intoxication Treatment Act, which recommended that "alcoholics not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society" (Keller and Rosenberg 1973, p. 2). While this recommendation did not carry the weight of law, it made a major change in the legal impli­ cations of addiction. With these changes came more humane treatment of people with addic­ tions.

Several methods of detoxification have evolved that reflect a more humanitarian view of people with substance use disorders. In the "medical model," detoxification is characterized by the use of physician and nursing staff and the administration of medication to assist people through withdrawal safely (Sadd and Young 1987). The "social model" rejects the use of medication and the need for routine medical care, relying instead on a supportive nonhospi­ tal environment to ease the passage through withdrawal (Sadd and Young 1987). Today, it is rare to find a "pure" detoxification model. For example, some social model programs use medi­ cation to ease withdrawal but generally employ nonmedical staff to monitor withdrawal and conduct triage (i.e., sorting patients according to the severity of their disorders). Likewise, medical programs generally have some compo­ nents to address social/personal aspects of addiction.

Just as the treatment and the conceptualiza­ tion of addiction have changed, so too have the patterns of substance use and the accom­ panying detoxification needs. The popularity of cocaine, heroin, and other substances has led to the need for different kinds of detoxifi­ cation services. At

the same time, public health officials have increased invest- ments in detoxifica­ tion services and substance abuse treatment, especially after 1985, as a means to inhibit the spread of HIV infec­ tion and AIDS

TheAMA's position is that sub­ stance dependence is a disease, and it encourages physi­

cians and other clinicians, health organizations, and policymakers to base all their activi- ties on this premise.

among people who inject drugs. More recently, people with substance use disor­ ders are more likely to abuse more than one drug simultane­ ously (i.e., polydrug abuse) (Office of Applied Studies 2005).

The AMA continues to maintain its posi­ tion that substance dependence is a dis- ease, and it encour-

ages physicians and other clinicians, health organizations, and policymakers to base all their activities on this premise (AMA 2002). As treatment regimens have become more sophisticated and polydrug abuse more com­ mon, detoxification has evolved into a com- passionate science.

#### Definitions

Few clear definitions of detoxification and related concepts are in general use at this time. Criminal justice, health care, substance abuse, mental health, and many other sys-

**Overview, Essential Concepts, and Definitions in Detoxification** 3

terns all define detoxification differently. This TIP offers a clear and uniform set of defini­ tions for the various components of detoxifi­ cation and substance abuse treatment that may prove useful to the field of detoxifica­ tion.

###### Detoxification

Detoxification is a set of interventions aimed at managing acute intoxication and withdraw­ al. It denotes a clearing of toxins from the body of the patient who is acutely intoxicated and/or dependent on substances of abuse.

Detoxification seeks to minimize the physical harm caused by the abuse of substances. The acute medical management of life-threatening intoxication and related medical problems generally is not included within the term *detoxification* and is not covered in detail in this TIP.

The Washington Circle Group (WCG), a body of experts organized to improve the quality and effectiveness of substance abuse preven­ tion and treatment, defines detoxification as "a medical intervention that manages an indi­ vidual safely through the process of acute withdrawal" (McCorry et al. 2000a, p. 9).

The WCG makes an important distinction, however, in noting that "a detoxification pro­ gram is not designed to resolve the long­ standing psychological, social, and behavioral problems associated with alcohol and drug abuse" (McCorry et al. *2000a,* p. 9). The con­ sensus panel supports this statement and has

taken special care to note that *detoxification is not substance abuse treatment and rel1abil­ itation.* For further explanation, see the text box below.

The consensus panel built on existing defini­ tions of detoxification as a broad process with three essential components that may take place concurrently or as a series of steps:

* *Evaluation* entails testing for the presence of substances of abuse in the bloodstream, measuring their concentration, and screen­ ing for co-occurring mental and physical conditions. Evaluation also includes a com­ prehensive assessment of the patient's medi­ cal and psychological conditions and social situation to help determine the appropriate level of treatment following detoxification. Essentially, the evaluation serves as the basis for the initial substance abuse treat­ ment plan once the patient has been with­ drawn successfully.
* *Stabilization* includes the medical and psy­ chosocial processes of assisting the patient through acute intoxication and withdrawal to the attainment of a medically stable, fully supported, substance-free state. This often is done with the assistance of medications, though in some approaches to detoxification no medication is used. Stabilization

includes familiarizing patients with what to expect in the treatment milieu and their role in treatment and recovery. During this time practitioners also seek the involvement of the patient's family, employers, and

***Detoxification as Distinct From Substance Abuse Treatment***

*Detoxification* is a set of interventions aimed at managing acute intoxication and withdrawal. Supervised detoxification may prevent potentially life-threatening complications that might appear if the patient were left untreated. At the same time, detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence as a result of hospitalization or legal involvement. Finally, for some patients it represents a point of first con­ tact with the treatment system and the first step to recovery. *Treatment/rehabilitation,* on the other hand, involves a constellation of ongoing therapeutic services ultimately intended to promote recovery for substance abuse patients.

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other significant people when appropriate and with release of confidentiality.

* *Fostering the patient's entry into treatment* involves preparing the patient for entry into substance abuse treatment by stressing the importance of following through with the complete substance abuse treatment contin­ uum of care. For patients who have demon­ strated a pattern of completing detoxifica­ tion services and then failing to engage in substance abuse treatment, a written treat­ ment contract may encourage entrance into a continuum of substance abuse treatment and care. This contract, which is not legally binding, is voluntarily signed by patients when they are stable enough to do so at the beginning of treatment. In it, the patient agrees to participate in a continuing care plan, with details and contacts established prior to the completion of detoxification.

All three components (evaluation, stabiliza­ tion, and fostering a patient's entry into treatment) involve treating the patient with compassion and understanding. Patients undergoing detoxification need to know that someone cares about them, respects them as individuals, and has hope for their future. Actions taken during detoxification will demonstrate to the patient that the provider's recommendations can be trusted and fol­ lowed.

###### Other Relevant Terms

As defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4tl1 edition, Text Revision* (DSM-IV-TR) (American Psychiatric Association [APA] 2000), a *sub­ stance-related disorder* is a "disorder related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure" (APA 2000, p. 191). The term substance "can refer to a drug of abuse, a medication, or a toxin" (APA 2000,

p. 191). In this TIP, the term *substance* refers to alcohol as well as other drugs of abuse.

Substance-related disorders are divided into two groups: substance use disorders and sub-

stance-induced disorders. According to the DSM-IV-TR, *substance use disorders* include both "substance dependence" and "substance abuse." *Substance dependence* refers to "a cluster of cognitive, behavioral, and physio­ logical symptoms indicating that the individu­ al continues use of the substance despite sig­ nificant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and com­ pulsive drug-taking behavior" (APA 2000, p. 192). *Substance abuse* refers to "a maladap­ tive pattern of substance use manifested by recurrent and significant adverse conse­ quences related to the repeated use of sub­ stances" (APA 2000, p. 198). It should be noted that for purposes of this TIP, the term "substance abuse" is sometimes used to denote both *substance abuse* and *substance dependence* as they are defined by the DSM­ IV-TR.

This TIP also uses the DSM-IV-TR definitions for *substance intoxication* and *substance withdrawal. Substance intoxication* is "the development of a reversible substance-specific syndrome due to the recent ingestion of (or exposure to) a substance" whereas *substance withdrawal* is "the development of a sub­ stance-specific maladaptive behavioral change, with physiological and cognitive con­ comitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use" (APA 2000, pp. 199, 201). Figure 1-1

(p. 6) defines these and other relevant terms.

*Treatment/rehabilitation* includes an ongoing, continual assessment of the patient's physical, psychological, and social status, as well as an analysis of environmental risk factors that may be contributing to substance use and the identification of immediate relapse triggers as well as prevention strategies for coping with them. It also includes the delivery of primary medical care and psychiatric care, if neces­ sary, to help the patient abstain from sub­ stance use and minimize the physical harm caused by it. Ultimately, the goal of treat­ ment/rehabilitation is to attain a higher level of social functioning by reducing risk factors,

**Overview, Essential Concepts, and Definitions in Detoxification s**

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| --- |
| ***Figure 1-1 DSM-IV-TR Definitions of Terms*** |
| **Tern1** | **Definition** |
| Substance | A drug of abuse, a medication, or a toxin. |
| Substance-related disorders | Disorders related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin expo­ sure. |
| Substance abuse (in this **TIP,** also sometimes used to denote "substance dependence") | A maladaptive (i.e., harmful to a person's life) pattern of sub­ stance use marked by recurrent and significant negative conse­ quences related to the repeated use of substances. |
| Substance dependence (in this **TIP,** "substance abuse" is sometimes used to include "dependence") | A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual is continuing use of the substance despite significant substance-related problems. A person experi­ encing substance dependence shows a pattern of repeated self­ administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior. |
| Substance intoxication | The development of a reversible substance-specific syndrome as the result of the recent ingestion of (or exposure to) a substance. |
| Substance withdrawal | The development of a substance-specific maladaptive behavioral change, usually with uncomfortable physiological and cognitive consequences, that is the result of a cessation of, or reduction in, heavy and prolonged substance use. |
| *Source:* APA 2000. |

enhancing protective factors, and thus decreasing the possibility of relapse.

*Maintenance* includes the continuation of counseling and support specified in the treat­ ment plan, refinement and strengthening of strategies to avoid relapse, and engagement in ongoing relapse prevention, aftercare, and/or domiciliary care (Lehman et al. 2000).

As a final note, in this **TIP** persons in need of detoxification services and subsequent sub­ stance abuse treatment are referred to as

patients to emphasize that these persons are coming into contact with physicians, nurses, physician assistants, and medical social work­ ers in a medical setting in which the patient often is physically **ill** from the effects of with­ drawal from specific substances. In some social setting detoxification programs, the terms "client" or "consumer" may be used in place of "patient."

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#### Guiding Principles in Detoxification and Substance Abuse Treatment

The consensus panel recognizes that the suc­ cessful delivery of detoxification services is dependent on standards that are to some extent

empirically measurable and agreed upon by all parties. The consensus panel developed guide­ lines (listed in Figure 1-2) that serve as the foundation for the TIP.

***Figure 1-2 Guiding Principles Recognized by the Consensus Panel***

1. Detoxification does not constitute substance abuse treatment but is one part of a continuum of care for substance-related disorders.
2. The detoxification process consists of the following three sequential and essential components:
	* Evaluation
	* Stabilization
	* Fostering patient readiness for and entry into treatment

A detoxification process that does not incorporate all three critical components is considered incomplete and inadequate by the consensus panel.

1. Detoxification can take place in a wide variety of settings and at a number of levels of intensity within these settings. Placement should be appropriate to the patient's needs.
2. Persons seeking detoxification should have access to the components of the detoxification process described above, no matter what the setting or the level of treatment intensity.
3. All persons requiring treatment for substance use disorders should receive treatment of the same quality and appropriate thoroughness and should be put into contact with a substance abuse treat­ ment program after detoxification, if they are not going to be engaged in a treatment service provided by the same program that provided them with detoxification services. There can be "no wrong door to treatment" for substance use disorders (CSAT 2000a).
4. Ultimately, insurance coverage for the full range of detoxification services is cost-effective. If reim­ bursement systems do not provide payment for the complete detoxification process, patients may be released prematurely, leading to medically or socially unattended withdrawal. Ensuing medical com­ plications ultimately drive up the overall cost of health care.
5. Patients seeking detoxification services have diverse cultural and ethnic backgrounds as well as unique health needs and life situations. Organizations that provide detoxification services need to ensure that they have standard practices in place to address cultural diversity. It also is essential that care providers possess the special clinical skills necessary to provide culturally competent compre­ hensive assessments. Detoxification program administrators have a duty to ensure that appropriate training is available to staff. (For more information on cultural competency training and specific competencies that clinicians need to be "culturally competent" see the forthcoming TIP *Improving Cultural Competence in Substance Ahuse Treatment* [SAMHSA in development *a]).*
6. A successful detoxification process can be measured, in part, by whether an individual who is sub­ stance dependent enters, remains in, and is compliant with the treatment protocol of a substance abuse treatment/rehabilitation program after detoxification.

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#### Challenges to Providing Effective Detoxification

It is an important challenge for detoxification service providers to find the most effective way to foster a patient's recovery. Effective detoxification includes not only the medical stabilization of the patient and the safe and humane withdrawal from drugs, including alcohol, but also entry into treatment.

Successfully linking detoxification with sub­ stance abuse treatment reduces the "revolving door" phenomenon of repeated withdrawals, saves money in the medium and long run, and delivers the sound and humane level of care patients need (Kertesz et al. 2003). Studies show that detoxification and its linkage to the appropriate levels of treatment lead to increased recovery and decreased use of detoxification and treatment services in the future. In addition, recovery leads to reduc­ tions in crime, general healthcare costs, and expensive acute medical and surgical treat­ ments consequent to untreated substance abuse (Abbot et al. 1998; Aszalos et al. 1999). While detoxification is not treatment per se, its effectiveness can be measured, in part, by the patient's continued abstinence.

Another challenge to providing effective detoxification occurs when programs try to develop linkages to treatment services. A study (Mark et al. 2002) conducted for the Substance Abuse and Mental Health Services Administration highlights the pitfalls of the service delivery system. According to the authors, each year at least 300,000 patients with substance use disorders or acute intoxi­ cation obtain inpatient detoxification in gen­ eral hospitals while additional numbers obtain detoxification in other settings. Only about one-fifth of people discharged from acute care hospitals for detoxification receive substance abuse treatment during that hospi­ talization. Moreover, only 15 percent of peo­ ple who are admitted through an emergency room for detoxification and then discharged receive any substance abuse treatment.

Finally the average length of stay for people undergoing detoxification and treatment in 1997 was only 7. 7 days (Mark et al. 2002). Given that "research has shown that patients who receive continuing care have better out­ comes in terms of drug abstinence and read­ mission rates than those who do not receive continuing care," the report authors conclude that there is a pronounced need for better linkage between detoxification services and the treatment services that are essential for full recovery (Mark et al. 2002, p. 3).

Reimbursement systems can present another challenge to providing effective detoxification services (Galanter et al. 2000). Third-party payors sometimes prefer to manage payment for detoxification separately from other phas­ es of addiction treatment, thus treating detox­ ification as if it occurred in isolation from addiction treatment. This "unbundling" of services has promoted the separation of all services into somewhat scattered segments (Kasser et al. 2000). In other instances, some reimbursement and utilization policies dictate that only "detoxification" currently can be authorized, and "detoxification" for that poli­ cy or insurer does not cover the nonmedical counseling that is an integral part of sub­ stance abuse treatment. Many treatment pro­ grams have found substance abuse counselors to be of special help with resistant patients, especially for patients with severe underlying shame over the fact that their substance use is out of control. Yet some payors will not reim­ burse for nonmedical services such as those provided by these counselors, and therefore the use of such staff by a detoxification or treatment service may be impossible, in spite of the fact that they are widely perceived as useful for patients.

Payors are gradually beginning to understand that detoxification is only one component of a comprehensive treatment strategy. Patient placement criteria, such as those published by the American Society of Addiction Medicine (ASAM) in the *Patient Placement Criteria, Second Edition, Revised* (ASAM 2001), have come to the fore as clinicians and

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insurers try to reach agreements on the level of treatment required by a given patient, as well as the medically appropriate setting in which the treatment services are to be deliv­ ered. Accordingly, the TIP offers suggestions

for resolving conflicts as well as clearly defin­ ing terms used in patient placement and treat­ ment settings as a step toward clearer under­ standing among interested parties.

## 2 Settings, Levels of Care, and Patient Placement

**In This Chapter...**

Role of Various Settings in the Delivery of Services

Other Concerns Regarding Levels of Care and Placement

Establishing criteria that take into account all the possible needs of patients receiving detoxification and treatment services is an extraordi­ narily complex task. This chapter discusses the criteria for placing patients in the appropriate treatment settings and offering the required intensity of services (i.e., level of care).

#### Role of Various Settings in the Delivery of Services

Addiction medicine has sought to develop an efficient system of care that matches patients' clinical needs with the appropriate care setting in the least restrictive and most cost-effective manner. (For an explanation of least restrictive care, see the text box, p. 12.) Challenges to effective placement matching for clients arise from a number of factors:

* Deficits in the full range of care settings and levels of care
* Limitations imposed by third-party payors (e.g., strict adherence to standardized admission criteria)
* Clinicians' lack of authority (and sometimes sufficient knowledge) to determine the most appropriate care setting and level of care
* Insurance that does not have a substance use disorder benefit available as part of its patient coverage
* Absence of any health insurance at all (Gastfriend et al. 2000) No clear solution or formula to meet these challenges has emerged.

***Least Restrictive Care***

*Least restrictive* refers to patients' civil rights and their right to choice of care. There are four spe­ cific themes of historical and clinical importance:

1. Patients should be treated in those settings that least interfere with their civil rights and freedom to participate in society.
2. Patients should be able to disagree with clinician recommendations for care. While this includes the right to refuse any care at all, it also includes the right to obtain care in a setting of their choice (as long as considerations of dangerousness and mental competency are satisfied). It implies a patient's right to seek a higher or different level of care than that which the clinician has planned.
3. Patients should be informed participants in defining their care plan. Such planning should be done in collaboration with their healthcare providers.
4. Careful consideration of State laws and agency policies is required for patients who are unable to act in their own self-interests. Because the legal complexities of this issue will vary from State to State the TIP cannot provide definitive guidance here, but providers need to consider whether or not the person is "gravely" incapacitated, suicidal, or homicidal; likely to commit grave bodily injury; or, in some States, likely to cause injury to property. In such cases, State law and/or case law may hold providers responsible if they do not commit the patient to care, but in other cases programs may be open to lawsuits for forcibly holding a patient.

In spite of the impediments, some progress has been made in developing comprehensive patient placement criteria. Because the choice of a treatment setting and intensity of treat­ ment (level of care) are so important, the American Society of Addiction Medicine (ASAM) created the *Patient Placement Criteria, Second Edition, Revised* (PPC-2R) a consensus-based clinical tool for matching patients to the appropriate setting and level of care. The ASAM PPC-2R represents an effort to define how care settings may be matched to

patient needs and special characteristics. These criteria currently define the most broadly accepted standard of care for the treatment of substance use disorders. ASAM criteria are intended to provide flexible clinical guidelines; these criteria may not be appropriate for par­ ticular patients or specific care settings.

The PPC-2R identifies six "assessment dimen­ sions to be evaluated in making placement decisions" (ASAM 2001, p. 4). They are as follows:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery/Living Environment

The ASAM PPC-2R describes both the settings in which services may take place and the inten­ sity of services (i.e., level of care) that patients may receive in particular settings. It is impor­ tant to reiterate, however, that the ASAM

PPC-2R criteria do not characterize all the details that may be essential to the success of treatment (Gastfriend et al. 2000). Moreover, traditional assumptions that certain treatment can be delivered only in a particular setting may not be applicable or valuable to patients. Clinical judgn1ent and consideration of the patient's particular situation are required for appropriate detoxification and treatment.

In addition to the general placement criteria for treatment for substance-related disorders, ASAM also has developed a second set of place-

ment criteria, which are more important for the purposes of this TIP-the five "'Adult Detoxification" placement levels of care within Dimension **1** (ASAM 2001). These "Adult Detoxification" levels of care are

* 1. *Level* ***I-D:*** *Ambulatory Detoxification Without Extended Onsite Monitoring* (e.g., physician's office, home health care agen­ cy). This level of care is an organized out­ patient service monitored at predeter­ mined intervals.
	2. *Level II-D: Ambulatory Detoxification With Extended Onsite Monitoring* (e.g., day hospital service). This level of care is monitored by appropriately credentialed and licensed nurses.
	3. *Level III.2-D: Clinically Managed Residential Detoxification* (e.g., nonmedi­ cal or social detoxification setting). This level emphasizes peer and social support and is intended for patients whose intoxi­ cation and/or withdrawal is sufficient to warrant 24-hour support.
	4. *Level III.7-D: Medically Monitored Inpatient Detoxification* (e.g., freestanding detoxification center). Unlike Level 111.2.D, this level provides 24-hour medi­ cally supervised detoxification services.
	5. *Level IV-D: Medically Managed Intensive Inpatient Detoxification* (e.g., psychiatric hospital inpatient center). This level pro­ vides 24-hour care in an acute care inpa­ tient settings.

As described by the ASAM PPC-2R, the domain of detoxification refers not only to the reduction of the physiological and psychologi­ cal features of withdrawal syndromes, hut also to the process of interrupting the momen­ tum of compulsive use in persons diagnosed with substance dependence (ASAM 2001).

Because of the force of this momentum and the inherent difficulties in overcoming it even when there is no clear withdrawal syndrome, this phase of treatment frequently requires a greater intensity of services initially to estab­ lish participation in treatment activities and patient role induction. That is, this phase

should increase the patient's readiness for and commitment to substance abuse treat­ ment and foster a solid therapeutic alliance between the patient and care provider.

It is important to note that ASAM PPC-2R criteria are only guidelines, and that there are no uniform protocols for determining which patients are placed in which level of care. For further information on patient placement, readers are advised to consult TIP 13, *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders* (Center for Substance Abuse Treatment [CSAT] 1995h).

Because this TIP is geared to audiences that may or may not be familiar with the ASAM PPC-2R levels of care, this section discusses the services and staffing specific to the care settings that are familiar to a broad audience.

**Physician's Office**

It has been estimated that nearly one half of the patients who visit a primary care provider have some type of problem related to sub­ stance use (Miller and Gold 1998). Indeed, because the physician may be the first point of contact for these people, initiation of treat­ ment often begins in the family physician's office (Prater et al. 1999). Physicians should use prudence in determining which patients may undergo detoxification safely on an out­ patient basis. As a general rule, outpatient treatment is just as effective as inpatient treatment for patients with mild to moderate withdrawal symptoms (Hayashida 1998).

For physicians treating patients with sub­ stance use disorders, preparing the patient to enter treatment and developing a therapeutic alliance between patient and clinician should begin as soon as possible. This includes pro­ viding the patient and his family with infor­ mation on the detoxification process and sub­ sequent substance abuse treatment, in addi­ tion to providing medical care or referrals if necessary. Staffing should include certified interpreters for the deaf and other language

interpreters if the program is serving patients in need of those services. Physicians should be able to accommodate frequent followup visits during the management of acute with­ drawal. Medications should be dispensed in limited amounts.

***Level of care***

##### *Ambulatory detoxification without* extended onsite monitoring

This level of detoxification (ASAM's Level I­ D) is an organized outpatient service, which may be delivered in an office setting, health­ care or addiction treatment facility, or in a patient's home by trained clinicians who pro­ vide medically supervised evaluation, detoxi­ fication, and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions.

These services should be delivered under a defined set of policies and procedures or med­ ical protocols (ASAM 2001). Ambulatory detoxification is considered appropriate only when a positive and **helpful** social support network is available to the patient. In this level of care, outpatient detoxification ser­ vices should be designed to treat the patient's level of clinical severity, to achieve safe and comfortable withdrawal from mood-altering drugs, and to effectively facilitate the patient's transition into treatment and recov­ ery.

##### *Ambulatory detoxification with* extended onsite monitoring

Essential to this level of care-and distin­ guishing **it** from Ambulatory Detoxification Without Extended Onsite Monitoring-is the availability of appropriately credentialed and licensed nurses (such as registered nurses **[RN**s] or licensed practical nurses **[LPNs])** who monitor patients over a period of several hours each day of service (ASAM 2001).

Otherwise, this level of detoxification (ASAM's Level 11-D) also is an organized out­ patient service. Like Level 1-D, in this level of care detoxification services are provided in regularly scheduled sessions and delivered

under a defined set of policies and procedures or medical protocols. Outpatient services are designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs, includ­ ing alcohol, and to effectively facilitate the patient's entry into ongoing treatment and recovery (ASAM 2001).

*Staffing*

Although they need not be present in the treatment setting at all times, physicians and nurses are essential to office-based detoxifica­ tion. In States where physician assistants, nurse practitioners, or advance practice clini­ cal nurse specialists are licensed as physician extenders, they may perform the duties ordi­ narily carried out by a physician (ASAM 2001).

Because detoxification is conducted on an outpatient basis in these settings, it is impor­ tant for medical and nursing personnel to be readily available to evaluate and confirm that detoxification in the less supervised setting is safe. All clinicians who assess and treat patients should be able to obtain and inter­ pret information regarding the needs of these persons, and all should be knowledgeable about the biomedical and psychosocial dimen­ sions of alcohol and illicit drug dependence.

Requisite skills and knowledge base include the following:

* Understanding how to interpret the signs and symptoms of alcohol and other drug intoxica­ tion and withdrawal
* Understanding the appropriate treatment and monitoring of these conditions
* The ability to facilitate the individual's entry into treatment

It is essential that medical consultation is readily available in emergencies. It is desir­ able that medical staff link patients to treat­ ment services, although this may be an unrea­ sonable expectation that cannot be met in a busy office setting. Linkage to treatment ser­ vices may be provided by the physician or by

designated counselors, psychologists, social workers, and acupuncturists who are avail­ able either onsite or through the healthcare system (ASAM 2001).

###### Freestanding Urgent Care Center or Emergency Department

There are several distinctions between urgent care facilities and emergency rooms (ERs).

Urgent care often is used by patients who cannot or do not want to wait until they see their doctor in his or her office, whereas emergency rooms are utilized more often by patients who perceive themselves to be in a crisis situation. Unlike emergency depart­ ments, which are required to operate 24 hours a day, freestanding urgent care centers usually have specific hours of operation.

Staffing for urgent care centers generally is more limited than for an ER. Standard staffing includes only a physician, an RN, a technician, and a secretary. Despite these dis­ tinctions, in actual practice there is consider­ able overlap between the two-the ERwill see medical problems that could be handled by visits to offices, and urgent care facilities will handle some cases of emergency medicine.

A freestanding urgent care center or emergen­ cy department reasonably can be expected to provide assessment and acute biomedical (including psychiatric) care. However, these settings often are unable to provide satisfacto­ ry psychosocial stabilization or complete biomedical stabilization (which includes both the initiation and taper of medications used in the treatment of substance withdrawal syn­ dromes). Appropriate triage and successful linkage to ongoing detoxification services is essential. The ongoing detoxification services may be provided in an inpatient, residential, or outpatient setting. Patients with more than moderate biomedical or psychosocial compli­ cations are more likely to require treatment in an inpatient setting. Care in these settings can be quite costly and should be accessed

only when there are serious concerns about a patient's safety.

A timely and accurate assessment in an emer­ gency department is of the highest impor­ tance. This will permit the rapid transfer of the patient to a setting where complete care can be provided.

Ideally, personnel in the emergency department will have at least a small amount of experi­ ence **and** expertise **in** identifying critically ill substance-using patients who may be about to experience or are already expe­ riencing withdrawal symptoms. Three essential rules apply to emergency depart­ ments and their han­ dling of intoxicated patients and patients who have begun to experience with­ drawal:

Although they need not be present in the treatment setting at all times, physicians and nurses are essential to office-based detoxification.

* Emergency depart­ ments and their clinicians should never simply

administer medications to intoxicated persons and then send them home.

* No intoxicated patient should ever be allowed to leave a hospital setting. **All** such persons should be referred to the appropriate detoxi­ fication setting if possillle, although there are legal restrictions that **forbid** holding persons against their will under certain conditions (Armenian et al. 1999).
* A clear distinction must be made between acute intoxication on the one hand and with­ drawal on the other. Acute intoxication, it must be remembered, creates special issues and challenges that need to be addressed. The risk of suicidality in patients who pre­ sent in a state of intoxication needs to be

carefully assessed. Because of their volatility and often risky behavior, patients who are intoxicated, as well as those patients who have begun to experience withdrawal, merit special attention. For more on treating intox­ icated patients, see chapter 3.

*Level of care*

Inpatient detoxification provides 24-hour supervision, observation, and support for patients who are intoxicated or exper1encmg withdrawal.

Care is provided to patients whose with­ drawal signs and symptoms are suffi­ ciently severe to require primary medical and nursing care services. The services are deliv­ ered under a defined set of physi­ cian-managed pro­ cedures or medical protocols. Both set­ tings provide medi­ cally directed assess­ ment and acute care that includes the ini­ tiation of detoxifica­ tion for substance use withdrawal.

Neither setting is likely to offer satis­ factory biomedical stabilization or 24-

hour observation. Generally speaking, triage to inpatient care can easily be facilitated from either setting.

Freestanding urgent care centers and emer­ gency departments are outpatient settings that are uniquely designed to address the needs of patients in biomedical crisis. For patients with substance use disorders, care in these settings is not complete **until** successful linkage is made to treatment that is focused specifically on the substance use disorder. To accomplish this, a comprehensive assessment, taking into account psychosocial as well as

biomedical issues, is recommended wherever possible.

Appreciation of the value of multidimensional patient assessment is central to the clinician's ability to decide which triage (linkage) options are least restrictive and most cost-effective

for a given patient.

*Staffing*

Both emergency departments and freestanding urgent care units are staffed by physicians.

The same rules regarding who may provide care apply here as they did in the discussion of staffing of office-based detoxification (ASAM 2001). An RN or other licensed and creden­ tialed nurse is available for priniary nursing care and observation. Psychologists, social workers, addiction counselors, and acupunc­ turists usually are not available in these set­ tings. The physician or attending nurse usually facilitates linkage to substance abuse treat­ ment.

###### Freestanding Substance Abuse Treatment or Mental Health Facility

Freestanding substance abuse treatment facili­ ties may or may not be equipped to provide adequate assessment and treatment of co­ occurring psychiatric conditions and biopsy­ chosocial problems, as the range of services varies considerably from one facility to anoth­ er. Inpatient mental health facilities, on the other hand, are able generally to provide treat­ **ment** for substance use disorders **and** co-occur­ ring psychiatric conditions. Nonetheless, like substance abuse treatment facilities, the range of available services varies from one mental health facility to another.

General guidelines for considering patient placement in either of these settings are pro­ vided below; however, it should be empha­ sized that a clear understanding of the specif­ ic services that a given setting provides is

indispensable to identifying the least restric­ tive and most cost-effective treatment option that may be available. Concern for safety is of primary importance, and the final decision regarding placement always rests with the treating physician.

*Level of care*

*Medically Monitored Inpatient* Detoxification

Inpatient detoxification provides 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. Since this level of care is relatively more restrictive and more costly than a resi­ dential treatment option, the treatment mission in this setting should be clearly focused and limited in scope. Primary emphasis should be placed on ensuring that the patient is medically stable (including the initiation and tapering of medications used for the treatment of sub­ stance use withdrawal); assessing for adequate biopsychosocial stability, quickly intervening to establish this adequately; and facilitating effec­ tive linkage to and engagement in other appro­ priate inpatient and outpatient services.

Inpatient settings provide medically managed intensive inpatient detoxification. At this level of care, physicians are available 24 hours per day by telephone. A physician should be available to assess the patient within 24 hours of admission (or sooner, if medically neces­ sary) and should be available to provide onsite monitoring of care and further evalua­ tion on a daily basis. An RN or other quali­ fied nursing specialist should be present to administer an initial assessment. A nurse will be responsible for overseeing the monitoring of the patient's progress and medication administration on an hourly basis, if needed. Appropriately licensed and credentialed staff should be available to administer medications in accordance with physician orders.

*Clinically Managed Residential* Detoxification

Residential settings vary greatly in the level of care that they provide. Those with intensive medical supervision involving physicians, nurse practitioners, physician assistants, and nurses can handle all but the most demanding compli­ cations of intoxication and withdrawal. On the other hand, some residential settings have min­ imally intensive medical oversight. Residential detoxification in settings with linrited medical oversight often is referred to as "social detoxifi­ cation." (Though the "social detoxification" model is not linrited to residential facilities.) Facilities with lower levels of care should have clear procedures in place for implementing and pursuing appropriate medical referral and linkage, especially in the case of emergencies.

For example, a patient who is in danger of seizures or delirium tremens needs to be referred to the appropriate medical facility for acute care of presenting symptoms, possibly medicated, and then returned to a social detox­ ification setting for continuing monitoring and observation. The establishment of this kind of collaborative relationship between institutions provides a good example of a cost-effective way to provide adequate care to patients.

Residential detoxification programs provide 24-hour supervision, observation, and sup­ port for patients who are intoxicated or expe­ riencing withdrawal. They are characterized by an emphasis on peer and social support (ASAM 2001). Standards published by such groups as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) provide further information on quali­ ty measures for residential detoxification.

*Staffing*

Inpatient detoxification programs employ licensed, certified, or registered clinicians who provide a planned regimen of 24-hour, profes­ sionally directed evaluation, care, and treat­ ment services for patients and their families. An interdisciplinary team of appropriately trained clinicians (such as physicians, RNs and LPNs, counselors, social workers, and psychol­ ogists) should be available to assess and treat the patient and to obtain and interpret infor­ mation regarding the patient's needs. The num­ ber and disciplines of team members should be appropriate to the range and severity of the patient's problems (ASAM 2001).

Residential detoxification programs are staffed by appropriately credentialed person­ nel who are trained and competent to imple­ ment physician-approved protocols for patient observation and supervision. These persons also are responsible for determining the appropriate level of care and facilitating the patient's transition to ongoing care.

Medical evaluation and consultation should be available 24 hours a day, in accordance with treatment/transfer practice guidelines. All clinicians who assess and treat patients should be able to obtain and interpret infor­ mation regarding the needs of these persons and should be knowledgeable about the biomedical and psychosocial dimensions of alcohol and other drug dependence. Such knowledge includes awareness of the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate the individual's entry into ongoing care. Staff should ensure that patients are taking medi­ cations according to their physician's orders and legal requirements (ASAM 2001).

Some residential detoxification programs are staffed to supervise self-administered medica­ tions for the management of withdrawal. All such programs should rely on established clinical protocols to identify patients who

have biomedical needs that exceed the capaci­ ty of the facility and to identify which pro­ grams will likely have a need for transferring such patients to more appropriate treatment settings.

###### Intensive Outpatient and Partial Hospitalization Programs

An intensive outpatient program (IOP) or par­ tial hospitalization program (PHP) is appropri­ ate for patients with mild to moderate with­ drawal symptoms. Thorough psychosocial assessment and intervention should be avail­ able in addition to biomedical assessment and stabilization. Many of these programs have close clinical and/or administrative ties to hos­ pital centers. When needed, triage to a higher level of care should be easy to accomplish.

Outpatient treatment should be delivered in conjunction with all components of detoxifica­ tion.

*Level of care*

This level of detoxification is an organized out­ patient service that requires patients to be pre­ sent onsite for several hours a day. It is thus similar to a physician's office in that ambulato­ ry detoxification with extended onsite monitor­ ing is provided. Unlike the physician's office, in the IOP and PHP it is standard practice to have a multidisciplinary team available to pro­ vide or facilitate linkage to a range of medically supervised evaluation, detoxification, and referral services.

Detoxification services also are provided in regularly scheduled sessions and delivered under a defined set of policies and procedures or medical protocols. These outpatient ser­ vices are designed to treat the patient's level of clinical severity, to achieve safe and com­ fortable withdrawal from mood-altering drugs (including alcohol), and to effectively facili-

tate the patient's engagement in ongoing treat­ ment and recovery (ASAM 2001).

A partial hospitalization program may occupy the same setting (i.e., physical space) as an acute care inpatient treatment program.

Although occupying the same space, the levels of care provided by these two programs are distinct yet complementary. Acute care inpa­ tient programs provide detoxification services to patients in danger of severe withdrawal and who therefore need the highest level of medically managed intensive care, including access to life support equipment and 24-hour

medical support. In contrast, partial hospital­ ization programs provide services to patients with mild to moderate symptoms of withdraw­ al that are not likely to be severe or life­ threatening and that do not require 24-hour medical support. The transition from an acute care inpatient program to either a par­ tial hospitalization or intensive outpatient program sometimes is referred to as a "step­ down." Typically, whether these programs share space and staff with an acute care inpa­ tient program or are physically distinct from a hospital structure, they have close clinical and/or administrative ties to hospital centers. Collaborative working relationships are indis­ pensable in pursuing the goal of providing patients with the most appropriate level of care in the most cost-effective setting.

*Staffing*

IOPs and PHPs should be staffed by physi­ cians who are available daily as active mem­ bers of an interdisciplinary team of appropri­ ately trained professionals and who medically manage the care of the patient. An RN or other licensed and credentialed nurse should be available for primary nursing care and observation during the treatment day.

Addiction counselors or licensed or registered addiction clinicians should be available to administer planned interventions according to the assessed needs of the patient. The multi­ disciplinary professionals (such as physicians, nurses, counselors, social workers, psycholo­ gists, and acupuncturists) should be available

as an interdisciplinary team to assess and care for the patient with a substance-related disorder, as well as patients with both a sub­ stance use disorder and a co-occurring biomedical, emotional, or behavioral condi­ tion. Successful linkage to treatment for the substance use disorder (in addition to biomedical stabilization) is central to the mis­ sion of an intensive

outpatient or partial hospitalization pro- gram (ASAM 2001).

Successful linkage to treatment for the substance use disorder (in addition to biomedical stabilization) is central to the mission of an intensive out- patient or partial hospitalization program.

For more informa­ tion, see the TIP *Substance Abuse:*

*Clinical Issues in Intensive Outpatient Treatment* [SAMHSA in development d].

###### Acute Care Inpatient Settings

There are several types of acute care inpatient settings. They include

* Acute care general hospitals
* Acute care addic­ tion treatment units in acute care gener­ al hospitals
* Acute care psychi­ atric hospitals
* Other appropriately licensed chemical dependency special­ ty hospitals

These settings share the ready availability of acute care medical and nursing staff, life sup­ port equipment, and ready access to the **full** resources of an acute care general hospital or its psychiatric **unit.** This level of care provides medically managed intensive inpatient detoxifi­ cation (ASAM 2001).

**Settings, Levels of Care, and Patient Placement 19**

*Level of care*

Acute inpatient care is an organized service that provides medically monitored inpatient detoxification that is delivered by medical and nursing professionals. Medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds is pro­ vided for patients whose withdrawal signs and symptoms are sufficiently severe tore1JUire 24- hour inpatient care. Services should be deliv­ ered under a set of policies and procedures or clinical protocols designated and approved by a qualified physician (ASAM 2001).

*Staffing*

Acute care inpatient detoxification programs typically are staffed by physicians who are available 24 hours a day as active members of an interdisciplinary team of appropriately trained professionals and who medically man­ age the care of the patient. In some States, these duties may be performed by an RN or physician assistant. An RN or LPN, as usual, is available for primary nursing care and obser­ vation 24 hours a day. Facility-approved addic­ tion counselors or licensed orregistered addic­ tion clinicians should be available 8 hours a day to administer planned interventions according to the assessed needs of the patient. An interdisciplinary team of appropriately trained clinicians (such as physicians, nurses, counselors, social workers, and psychologists) should be available to assess and treat the patient **with** a substance-related disorder, or a patient with co-occurring substance use, biomedical, psychological, or behavioral condi­ tions (ASAM 2001).

#### Other Concerns Regarding Levels of Care and Placement

In part because of the need to keep costs to a minimum and in part as the result of research

in the field, outpatient detoxification is becom­ ing the standard for treatment of symptoms of withdrawal from substance dependence in many locales. Most alcohol treatment programs have found that more than 90 percent of patients with withdrawal symptoms can be treated as outpatients (Abbott et al. 1995).

Careful screening of these patients is essential to reserve for inpatient treatment those clients with possibly complicated withdrawal; for example, patients with subacute medical or psychiatric conditions (that in and of them­ selves would not require hospitalization) and those in danger of seizures or delirium tremens should receive inpatient care. Inpatient addic­ tion treatment programs will vary in the level of acute medical or psychiatric care that can be provided. Figure 2-1 presents an overview of issues to consider in deciding between inpatient and outpatient detoxification.

ASAM criteria are being adopted extensively on the basis of their "face validity," though their outcome validity has yet to be clinically proven. Early studies of more versus less restrictive and intensive treatment settings on randomized samples generally have failed to show group differences, and studies continue to show this pattern (Gastfriend et al. 2000). Whether patients undergoing detoxification will have better results as outpatients rather

than as inpatients remains to be established (Hayashida 1998).

Another consideration is that ASAM place­ ment guidelines are not always the best guide to placing a patient in the proper setting at the proper level. For example, what is the clinician to do with the patient who qualifies for outpatient treatment according to the ASAM guidelines but is homeless in sub-zero temperatures? No provision is made for such cases. The ASAM guidelines are to beregard­ ed as a "work in progress," as their authors readily admit (ASAM 2001, p. 19).

Nevertheless, they are an important set of guidelines that are of great help to clinicians. For administrators, the standards published

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| ***Figure 2-1 Issues* To *Consider in Determining Whether Inpatient or Outpatient******Detoxification Is Preferred*** |
| **Considerations** | **Indications** |
| Allility to arrive at clinic on a daily basis | Necessary if outpatient detoxification is to be car­ ried out |
| History of previous delirium tremens or withdraw­ al seizures | Contraindication to outpatient detoxification: recurrence likely; specific situation may suggest that an attempt at outpatient detoxification is pos­ sible |
| No capacity for informed consent | Protective environment (inpatient) indicated |
| Suicidal/homicidal/psychotic condition | Protective environment (inpatient) indicated |
| Allie/willing to follow treatment recommendations | Protective environment (inpatient) indicated if unable to follow recommendations |
| Co-occurring medical conditions | Unstable medical conditions such as diabetes, hypertension, or pregnancy: all relatively strong contraindications to outpatient detoxification |
| Supportive person to assist | Not essential but advisable for outpatient detoxifi­ cation |
| *Source:* Consensus Panelist Sylvia Dennison, **M.D.** |

by such groups as JCAHO and CARF offer guidance for overall program operations.

It has become clear that detoxification involves much more than simply medically withdrawing a patient from alcohol or other drugs. Detoxification, whether done on an inpatient, residential, or outpatient basis, fre­ quently is the initial therapeutic encounter between patient and clinician. Irrespective of the substance involved, a detoxification

episode should provide an opportunity for biomedical (including psychiatric) assess­ ment, referral for appropriate services, and linkage to treatment services. Chapter 3 pro­ vides an overview of the psychosocial and biomedical issues relevant to detoxification, strategies to engage the patient, and an overview of providing adequate linkage to fol­ low up treatment and services.

## 3 An Overview of Psychosocial and Biomedical Issues During Detoxification

**In This Chapter...**

Evaluating and Addressing Psychosocial and Biomedical Issues

Strategies for Engaging and Retaining Patients in Detoxification

Referrals and Linkages

Regardless of setting or level of care, the goals of detoxification are to provide safe and humane withdrawal from substances and to foster the patient's entry into long-term treatment and recovery.

Detoxification presents a unique opportunity to intervene during a period of crisis and move a client to make changes in the direction of health and recovery. Hence, a primary goal of the detoxification staff should be to build the therapeutic alliance and motivate the patient to enter treatment. This process should begin even as the patient is being medically stabilized (Onken et al. 1997).

Psychological dependence, co-occurring psychiatric and medical con­ ditions, social supports, and environmental conditions critically influ­ ence the probability of successful and sustained abstinence from sub­ stances. Research indicates that addressing psychosocial issues during detoxification significantly increases the likelihood that the patient will experience a safe detoxification and go on to participate in sub­ stance abuse treatment. Staff members' ability to respond to patients' needs in a compassionate manner can make the difference between a return to substance abuse and the beginning of a new (and more posi­ tive) way of life.

This chapter addresses the psychosocial and biomedical issues that may affect detoxification and ensuing treatment. It highlights evaluation pro­ cedures for patients undergoing detoxification, discusses strategies for engaging and retaining patients in detoxification and preparing them for treatment, and presents an overview for providing linkages to other services.

***Overarching Principles for Care During Detoxification Services***

* Detoxification services do not offer a "cure" for substance use disorders. They often are a first step toward recovery and the "first door" through which patients pass to treatment.
* Substance use disorders are treatable, and there is hope for recovery.
* Substance use disorders are brain disorders and not evidence of moral weaknesses.
* Patients are treated with respect and dignity at all times.
* Patients are treated in a nonjudgmental and supportive manner.
* Services planning is completed in partnership with the patient and his or her social support network, including such persons as family, significant others, or employers.
* All health professionals involved in the care of the patient will maximize opportunities to promote rehabili­ tation and maintenance activities and to link her or him to appropriate substance abuse treatment imme­ diately after the detoxification phase.
* Active involvement of the family and other support systems while respecting the patient's rights to privacy and confidentiality is encouraged.
* Patients are treated with due consideration for individual background, culture, preferences, sexual orien­ tation, disability status, vulnerabilities, and strengths.

#### Evaluating and Addressing Psychosocial and Biomedical Issues

Patients entering detoxification are undergoing profound personal and medical crisis.

Withdrawal itself can cause or exacerbate cur­ rent emotional, psychological, or mental prob­ lems. The detoxification staff needs to be equipped to identify and address potential problems.

###### Considerations for Conducting the Initial Evaluation

An initial evaluation will help detoxification staff foresee any variables that might compli­ cate a safe and effective withdrawal. Figure 3-1 lists the biomedical and psychosocial domains that can affect the stabilization of the patient.

The following sections include some general guidelines and important considerations to follow when providing detoxification services.

###### General Guidelines for Addressing Immediate Medical Concerns

Because substance abuse affects all systems of the body and is associated with lack of self­ care, it is not unusual for detoxification to be complicated by medical problems. Health pro­ fessionals should screen for medical problems that may put the client at risk for a medical cri­ sis or expose other clients or staff to contagious diseases. This section outlines important con­ siderations for both nonmedical and medical staff. Chapter 5 provides a clinical overview of co-occurring medical conditions and is geared primarily toward medical personnel.

*Co-occurring medical* conditions

The initial consultation should include an eval­ uation of the expected signs, symptoms, and severity of the withdrawal. Detoxification is not an exact science, but any significant deviation from the expected course of withdrawal should be observed closely. Figure 3-2 (p. 26) provides

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| ***Figure 3-1 Initial Biomedical and Psychosocial Evaluation Domains*** |
| **Biomedical Domains** |
| * *General lwalth* l1istory-What is the patient's medical and surgical history? Are there any psychi­ atric or medical conditions? Are there known medication allergies? Is there a history of seizures?
* *Mental status-Is* the patient oriented, alert, cooperative? Are thoughts coherent? Are there signs of psychosis or destructive thoughts?
* *General physical assessment with neurological* exam-This will ascertain the patient's general health and identify any medical or psychiatric disorders of immediate concern.
* *Temperature, pulse, blood pressure--These* are important indicators and should be monitored throughout detoxification.
* *Patterns of substance* abuse--When did the patient last use? What were the substances of abuse? How much of these substances was used and how frequently?
* *Urine toxicology screen for commonly abused substances.*
* *Past substance abuse treatments or detoxification-This* should include the course and number of previous withdrawals, as well as any complications that may have occurred.
 |
| **Psychosocial Domains** |
| * *Demographic* features-Gather information on gender, age, ethnicity, culture, language, and educa­ tional level.
* *Living conditions-Is* the patient homeless or living **in** a shelter? What is the living situation? Are sig­ nificant others in the home (and, if so, can they safely supervise)?
* *Violence, suicide risl(-ls* thepatient aggressive, depressed, or hopeless? Is there a history of vio­ lence?
* *Transportation-Does* the patient have adequate means to get to appointments? Do other arrange­ ments need to be made?
* *Financial situation-ls* the patient able to purchase medications and food? Does the patient have adequate employment and income?
* *Dependent children-ls* the patient able to care for children, provide adequate child care, and ensure the safety of children?
* *Legal status--Is* the patient a legal resident? Are there pending legal matters? Is treatment court ordered?
* *Physical, sensory, or cognitive disabilities-Does* the client have disabilities that require considera­ tion?
 |

a list of signs and symptoms of conditions that require immediate medical attention. All staff members who work with patients should be aware of these and seek medical consultation for the patients as necessary.

Seizures are of special concern. Practitioners should interview the patient and family about seizure disorders and seizure history. In addi­ tion, nonmedical staff should be aware of signs of impending seizures such as tremors,

* Change in mental status
* Increasing anxiety and panic
* Hallucinations
* Seizures
* Temperature greater than 100.4° F (these patients should be considered potentially infectious)
* Significant increases and/or decreases in blood pressure and heart rate
* Insomnia
* Abdominal pain
* Upper and lower gastrointestinal bleeding
* Changes in responsiveness of pupils
* Heightened deep tendon reflexes and ankle clonus, a reflex beating of the foot when pressed rostrally (i.e., toward the mouth of the patient), indicating profound central nervous system irritability and the potential for seizures

***Figure 3-2 Symptoms and Signs of Conditions That Require Immediate***

***Medical Attention***

increased blood pressure, overactive reflexes, and high temperature and pulse. **It** is essential that nonmedical staff be trained in protocols to prevent injury in the event of a seizure.

Competence in carrying out these protocols should be evaluated by a physician or nurse clinician. For more information on seizures, see chapter 4.

All staff working with patients should be familiar with medical disorders that are asso­ ciated with various addictive substances or routes of administration. Alcoholism has mul­ tiple organ effects involving the liver, pan­ creas, central nervous system, cardiovascular system, and endocrine system. Cocaine pro­ duces many of its medical complications through vasoconstriction (i.e., narrowing of the blood vessels), including myocardial infarction (heart attack), stroke, renal dis­ ease, spontaneous abortion, and even bowel infarction (death of tissue). Cocaine also can cause seizures and cardiac arrhythmia (irreg­ ular heartbeat). A heroin overdose can lead to a fatal respiratory depression. Intravenous drug use is particularly likely to increase the risk of infectious complications, including

HIV, viral hepatitis, abscesses, and sepsis (the spreading of infection from its original site in the body). Intrapulmonary (within the lungs) administration can cause lung disorders (Dackis and Gold 1991). Nonmedical detoxifi­ cation staff also should be aware of the medi­ cations used in detoxification, medications for common medical and psychiatric disorders, and signs of common medication reactions and interactions.

*Infectious disease*

Standard precautions should be used with all patients to protect the staff and patients against the transmission of infectious diseases, includ­ ing HIV and hepatitis A, B, and C. All open wounds should be cultured and treated to pre­ vent the spread ofinfections. Providers should use HIV/blood and respiratory infection pre­ cautions until HIV and respiratory infectious status are known. Patients with respiratory infections should be carefully evaluated. The panel suggests that tuberculin testing be per­ formed or recent test results obtained on all patients to screen for active tuberculosis. A chest x-ray is recommended if indicated by the

patient's history and physical assessments. Nonmedical detoxification staff should be trained to watch for the signs of common infec­ tious diseases passed through casual contact, including infestation with scabies and lice.

###### General Guidelines for Addressing Immediate Mental Health Needs

The following section provides general guide­ lines for treating patients who have immediate mental health needs. For more detailed infor­ mation on the treatment of patients with co­ occurring psychiatric conditions see TIP 42, *Substance Ahuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT] 2005c).

*Suicide*

Those who are users of multiple illicit sub­ stance are more likely to experience psychiatric disorders, and the risk is highest among those who use both opiates and benzodiazepines and/or alcohol (Marsden et al. 2000).

Depression is more common among those who abuse a combination of these substances, and women are at higher risk than men. Among those patients who are positive for depression, the risk of suicide is high. Marsden and col­ leagues' 2000 study of 1,075 clients entering treatment showed that 29 percent reported sui­ cidal ideation in the past 3 months.

During acute intoxication and withdrawal, **it** is important to provide an environment that minimizes the opportunities for suicide attempts. As a precaution, locations not clearly visible to staff should be free of items that might be used for suicide attempts.

Frequent safety checks should be implement­ ed; the frequency of these checks should be increased when signs of depression, shame, guilt, helplessness, worthlessness, and hope­ lessness are present. When feasible, patients at risk for suicide should be placed in areas that are easily monitored by staff. Most

important, when interacting with patients at risk for suicide, staff should avoid harsh con­ frontation and judgment and instead focus on the treatable nature of substance use disor­ ders and the rehabilitation options available. These interactions offer an opportunity to start a dialog with the patient regarding the impact of substance use on mental illness and vice versa.

*Anger and aggression*

Alcohol, cocaine, amphetamine, and hallu­ cinogen intoxication may be associated with increased risk of violence. Symptoms associ­ ated with this increased risk for violence include hallucinations, paranoia, anxiety, and depression. As a precaution, all patients who are intoxicated should be considered poten­ tially violent (Miller et al. 1994). Programs should have in place well-developed plans to promote staff and patient safety, including protocols for response by local law enforce­ ment agencies or security contractors. Staff working in detoxification programs should be trained in techniques to de-escalate anger and aggression. In many cases, aggressive behav­ iors can be defused through verbal and envi­ ronmental means (Reilly and Shopshire 2002). For the protection of the staff and the patient, physical restraint should be used as a last resort and programs should be aware of local laws and regulations pertaining to physi­ cal restraint. Figure 3-3 (p. 28) lists some use­ ful ways of managing patients who are angry and aggressive. Readers may refer to the standards published by such groups as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) for further guidance. The Substance Abuse and Mental Health Services Administration (SAMHSA) also has published guidelines on the use of seclusion and restraint, which call for the reduction and possible elimination of their use (SAMHSA 2002).

* Speak in a soft voice.
* Isolate the individual from loud noises or distractions.
* Provide reassurance and avoid confrontation, judgments, or angry tones.
* Enlist the assistance of family members or others who have a relationship of trust.
* Offer medication when appropriate.
* Separate the individual from others who may encourage or support the aggressive behaviors.
* Enlist additional staff members to serve as visible backup if the situation escalates.
* Have a clearly developed plan to enlist the support of law enforcement or security staff if necessary.
* Establish clear admission protocols in order to help screen for potentially aggressive/violent patients.
* Determine one's own level of comfort during interaction with the patient and respect personal limits.
* Ensure that neither the clinician's nor the patient's exit from the examination room is blocked.

***Figure 3-3 Strategies for De-escalating Aggressive Behaviors***

*Co-occurring mental* disorders

With the patient's consent, a review of the patient's mental health history with the patient and family is useful in identifying co-occurring psychiatric conditions. Mental health profes­ sionals caring for the client should be consult­ ed. If a pharmacy profile on the patient is available, it should be copied for review (within the confines of State and Federal confidentiali­ ty laws).

Diagnosis of co-occurring substance-related disorders and mental conditions is difficult during acute intoxication and withdrawal because **it** often is impossible to be precise until the clinical picture allows for the full assess­ ment of both the effects of substance use and of the symptoms of mental disorders. As the indi­ vidual moves from severe to moderate with­ drawal symptoms, attention to differential diagnosis of substance use disorders and other psychiatric disorders becomes a priority (First et al. 2002). The American Psychiatric Association (APA) and the American Society of Addiction Medicine (ASAM) guidelines recom­ mend a period of 2 to 4 weeks of abstinence before attempting to diagnose a psychiatric dis­ order (APA 2000; ASAM 2001).

###### General Guidelines for Addressing Nutritional Concerns

Malnutrition is a major concern for patients entering detoxification because the nutrient deficiencies associated with substance abuse can interfere with or even prolong the detoxifi­ cation process (Nazrul Islam et al. 2001).

Longstanding irregular eating habits and poor dietary intake only exacerbate the problem (Pelican et al. 1994). The detoxification process itself is stressful to the body and may result in increased nutrient requirements. Proper nutri­ tion during recovery improves to a significant extent the adverse effects of the substance abuse (Nazrul Islam et al. 2001).

*Nutritional evaluation*

An evaluation of nutritional status should be a core component of detoxification. It should be noted, however, that for patients who abuse alcohol, the administration of fluids to address dehydration should be the first step, with nutritional evaluation occurring after the patient is adequately hydrated.

The nutritional evaluation should consist of laboratory and anthropometric indices, a detailed nutritional history, and nutrition counseling (Simko et al. 1995). The interven­ tion begins in the initial acute phase of with­ drawal and continues through detoxification and subsequent substance abuse treatment. If the patient consents, family members or signifi­ cant others may be included in the nutritional evaluation and counseling.

Weight is an important consideration in deter­ mining the nutritional status of the person with a substance use disorder. Substance abuse may result in a reduction in food intake and disrup­ tion in the patient's metabolism that mayin turn have caused an eating disorder, weight loss, and malnutrition. Conversely, weight gain may be related to inactivity and an excessive intake of highly refined carbohydrates (Zador et al. 1996). Patients should be asked whether there have been any recent changes in their weight. While a patient may appear to be ade­ quately nourished, a skinfold caliper (an instrument that measures the thickness of a fold of skin with its underlying layer of fat) can determine body density (the relationship of the body's mass to its volume), though the body mass index may be a better indicator of nutri­ tional status (Simko et al. 1995).

Other questions to ask during the initial evalu­ ation concern appetite, eating patterns, food preferences, snacking habits, food allergies, food intolerance, special diets, and foods to be avoided because of cultural or religious beliefs. A food frequency questionnaire, food diary, or 24-hour food recall may be of use.

Many drug addictions are associated with abnormal glucose (sugar) metabolism. This abnormality means that the body is unable to maintain a stable concentration of glucose in the blood. Abnormally high or low blood sugar levels easily can be confused with the signs and symptoms of alcohol intoxication or withdraw­ al; consequently, a check of blood glucose level is particularly important in patients with a his­ tory of blood sugar abnormalities. Hypogly­ cemia (low levels of blood sugar) in the person

with a substance use disorder may lead to dras­ tic mood changes. When blood glucose levels drop below a certain threshold, these patients usually feel depressed, anxious, or moody and may experience cravings for their drug of choice.

*Nutritional deficits* associated with specific substances

As noted, the abuse of drugs can interfere with nutrient utilization and storage. Detoxification personnel should be fa1niliar with the nutrition­ al deficits associated with specific substances.

Opioids are known to decrease calcium absorp­ tion and to increase cholesterol and body potassium levels. Magnesium deficiency often is seen in chronic alcohol dependence. Other nutrient deficiencies seen in alcohol abuse include protein, fat, zinc, calcium, iron, vita­ mins A and E, and the water-soluble vitamins pyridoxine, thiamine, folate, and vitamin Bl2 (Nazrul Islam et al. 2001). Alcohol also con­ tains calories (7 kcal/gn1) that when consumed in excessive amounts may displace nutrient­ dense foods. Cocaine is an appetite suppressant and may interfere with the absorption of calci­ um and vitainin D. Laboratory tests for pro­ tein, vitamins, and iron and the other elec­ trolytes are recommended to determine the extent of liver function as well as supplementa­ tion (Fontaine et al. 2001). Caution should be exercised when using supplements because of their potential interactions with other drugs and treatments.

*Addressing nutritional* deficits

Detoxification should include efforts to address nutritional deficits and to begin the patient on a course of improved eating habits. It is crucial to switch the paradigm from ingesting sub­ stances harmful to the body to taking in foods that heal the body (Nebelkopf 1981, 1987, 1988). The regularity of meal times, taste, and presentation are important considerations.

Attractively arranged, pleasant-tasting food may inspire the patient to consume vital nutri­ ents and adequate calories. It is important that during the detoxification process, the patient avoid substituting one addiction for another.

Consuming excessive amounts of caffeine or sugar can compromise the process and lead to relapse. Patients should be offered only decaf­ feinated beverages and healthful snacks instead of refined carbohydrates such as sugar-based sweets like candy, cookies, or donuts. Fresh fruits, vegetables, and other whole foods can contribute to the individual's health and well­ ness.

Gastrointestinal disturbances (i.e., nausea, vomiting, and diarrhea) may accompany the first phase of detoxification. Such distur­ bances can worsen dehydration and may dis­ turb blood chemistry balance, which in turn can lead to mental status changes, neurologi­ cal or heart problems, and other potentially dangerous medical conditions. Patients with gastrointestinal disturbances may only be able to tolerate clear liquids. When solid foods are tolerated, balanced meals consisting of low-fat foods, with an increased intake of

protein (meat, dairy products, legumes), com­ plex carbohydrates (whole grain bread and cereals), and dietary fiber are recommended (Duyff 1996). Patients undergoing detoxifica­ tion may also experience constipation.

Increasing the fiber content of the diet will help to alleviate this discomfort.

*Considerations for patients* with special dietary requirements

Patients with special dietary requirements need additional nutrition therapy. A person with diabetes, for example, should follow the dietary guidelines of the American Diabetes Association, which emphasizes individualized meal planning (American Diabetes Association 2004). A patient who is a vegetarian may have additional nutritional deficiencies, especially if she or he is a vegan (i.e., a person who avoids eating all foods derived from animals, including

milk products and eggs). If a vegan enters detoxification with marginal or low nutrient stores, his or her diet should be augmented with legumes, meat analogs, textured vegetable protein, nuts, and seeds. Many other medical conditions (e.g., ulcers, heart disease, food allergies, etc.) may require special diets. At intake, any special dietary considerations should be noted.

###### Considerations for Intoxication and Withdrawal in Adolescents

Generally, detoxification is the same for adoles­ cents as it is for adult clients. However, there are a few in1portant and unique considerations for adolescent patients. For one, adolescents are more likely than adults to drink large quantities of alcohol in a short period of time, making it is especially in1portant that detoxifi­ cation providers be alert to escalating blood alcohol levels in these patients. Moreover, ado­ lescents are more likely than adults to use drugs they cannot identify, to combine multiple substances with alcohol, to ingest unidentified substances, and to be unwilling to disclose drug use (Westermeyer 1997). As a result, the con­ sensus panel recommends routinely screening adolescent patients for illicit drug intoxication. It also is important for staff to be trained in how to assess for the use of PCP, which can present with psychosis-like symptoms. Staff should ask the adolescent directly whether he has used PCP within the 12-hour period before entering the clinic or treatment center.

Adolescents should be placed in a secure, clean environment with observation and sup­ portive care. If alcohol, heroin, or other drugs associated with vomiting are suspected, protecting the individual's airway and posi­ tioning the patient on his or her side to avoid aspiration (inhaling) of stomach contents are critical. In severe cases of ingestion of respi­ ratory depressants, respiratory support may be needed. If the individual is severely com­ bative or belligerent, physical restraint may be needed as a last resort when allowed and

appropriate. In milder cases, observation in a quiet, secure room with compassionate reas­ surance may be sufficient. Additionally, ado­ lescents served in adult settings should be separated from the adult population and observed closely to ensure that they are not victimized (i.e., verbally, physically, or sexu­ ally) by adult clients. Finally, adolescents in detoxification settings should always be screened carefully for suicide potential and

co-occurring psychiatric problems.

It sometimes is challenging to establish rap­ port with adolescents, as their experience with adults may be marked by adverse conse­ quences. Asking open-ended questions and using street terminology for drugs and other expressions commonly used by teenagers can be helpful both in establishing rapport and in obtaining an accurate substance use history. For more information on working with ado­ lescents, see **TIP** 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999d), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 19991).

###### Considerations for Patients Who Are Parents With Dependent Children

For parents-especially women-entering detoxification programs, the safety of children often is a concern and one of the biggest barri­ ers to retention. Even if women do not have custody of their children they often are the ones who continue to care for them. Some chil­ dren may show extreme need for their mother while separated from her, and their demands could trigger unauthorized leave from detoxifi­ cation. Thus, ensuring that children have a safe place to stay while their mothers are in detoxification is of vital in1portance. Working with women and men to identify supportive family or friends may identify temporary child­ care resources. A consult or referral to the treatment facility's social services while the patient is being detoxified is indicated when the care of children is uncertain.

###### Considerations for Victims of Domestic Violence

While both men and women are victims of domestic abuse, women's substance use is asso­ ciated with increased risk of intiniate partner violence (Cunradi et al. 2002). Staff should know the signs of domestic violence and be pre­ pared to follow proce-

dures to ensure the safety of the patient.

Ensuring that children have a safe place to stay while their mothers are in detoxificaton is of vital importance.

If a patient discloses a history of domestic violence, trained staff can help the victim create a long­ term safety plan or make a proper refer­ ral. If a safety plan is made or phone numbers for domes­ tic violence help are provided, related information should be labeled carefully so as not to disclose its purpose (e.g., list­ ed as women's health resources) since the abuser may go through all personal belongings. All print-

ed information about domestic violence also should be disguised and none should be kept by the patient when she leaves the safe facili­ ty. If the victim needs to press charges or obtain a restraining order, this should be done from a safe setting (e.g., inpatient detox­ ification). If at all possible, the victim should be escorted to a safety shelter. It may be important that the abused person, whether male or female, not be allowed to talk to the abuser while in detoxification. Parents who are victims of domestic violence may need help with parenting skills and securing coun­ seling and childcare. Therefore, it is impor­ tant for detoxification providers to be famil­ iar with local childcare resources. For more

information see TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997b).

###### Considerations for Culturally Diverse Patients

In providing psychosocial supports for cultur­ ally diverse patients, cultural sensitivity is of tremendous importance. Clients' expectations

of detoxification, their feelings about the healthcare system generally, and their social and community support structures vary according to their cultural backgrounds. In working with any specific population, the prac­ titioner should avoid defining the patient in terms of his culture, since over- or underem­ phasizing the patient's race or ethnicity can be detrimental (Clark et al. 1998). Figure 3-4 pro-

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| ***Figure 3-4 Questions* To *Guide Practitioners* To *Better Understand the Patient's******Cultural Framework*** |
| * What language do you prefer we use?
* Therapists and clients sometimes have different ideas about diseases, can you tell me more about your idea of why you are in detoxification now?
* Do you require assistance for daily living activities (such as personal hygiene, shopping, paying bills, etc.)?
* What do you call your present condition/situation (as it relates to substance use)? How does your family view your present condition/situation (as it relates to substance use)?
* What is the role of alcohol or drugs in your family?
* How does your community view your present condition/situation (as it relates to substance use)? Or what is the role of alcohol or drugs in your community?
* How has your present condition/situation (as it relates to substance use) altered your status in the community?
* What experiences have you had with the healthcare system?
* Do you think your substance use is a problem for you?
* What do you think caused your present condition/situation (as it relates to substance use)?
* Why do you think it started?
* What is going on in your body?
* How has your present condition/situation (as it relates to substance use) altered your life?
* How have you tried to solve the problem(s) associated with substance use in the past? Was it helpful? What worked/didn't work?
* Why are you coming now?
* Are you on any herbal medications or special foods for this problem?
* What concerns or fears do you have about your present condition/situation (as it relates to substance use)?
* What concerns or fears do you have about this treatment?
 |
| *Source:* Adapted from Tang and Bigby 1996; Thurman et al. 1995. |

vides clinicians with some helpful questions to guide their discussions.

###### Considerations for Chronic Relapsers

A patient who recently relapsed after a period of extended abstinence may feel especially hopeless and vulnerable (an abstinence viola­ tion effect). In this situation, clinicians can acknowledge progress that had been made prior to relapse and reassure the patient that the internal gains from past recovery work have not all been lost (despite the feeling at the moment that they have), perhaps reframing the severity of emotional pain as an indicator of how important recovery is to the patient.

#### Strategies for Engaging and Retaining Patients in Detoxification

It is essential to keep patients who enter detoxi­ fication from "falling through the cracks" (Kertesz et al. 2003). Successful providers acknowledge and show respect for the patient's pain, needs, and joys, and validate the patient's fears, ambivalence, expectation of recovery, and positive life changes. It is essen­ tial that all clinicians who have contact with patients in withdrawal continually offer hope and the expectation of recovery. An atmo­ sphere that conveys comfort, relaxation, clean­ liness, availability of medical attention, and security is beneficial to patients experiencing the discomforts of the withdrawal process.

Throughout the detoxification experience, detoxification staff should be unified in their message that detoxification is only the begin­ ning of the substance abuse treatment process and that rehabilitation and maintenance activi­ ties are critical to sustained recovery.

###### Educate the Patient on the Withdrawal Process

During intoxication and withdrawal, it is useful to provide information on the typical with­ drawal process based on the particular drug of abuse. Usually withdrawal includes symptoms that are the opposite of the effects of the partic­ ular drug. This rebound effect can cause anxi­ ety and concern for patients. Providing infor­ mation about the common withdrawal symp­ toms of the specific drugs of abuse may reduce discomfort and the likelihood that the individu­ al will leave detoxification services prematurely (for a list of withdrawal symptoms, see chapter 4). Settings that routinely encounter individu­ als in withdrawal should have written materials available on drug effects and withdrawal from specific drugs, and have staff who are well versed in the signs and symptoms of withdraw­ al. An additional consideration is providing such information to non-English-speaking patients and their families.

Interventions that assist the client in identify­ ing and managing urges to use also may be helpful in retaining the client in detoxification and ensuring initiation of rehabilitation.

These interventions may include cognitive­ behavioral approaches that help the individu­ al identify thoughts or urges to use, the devel­ opment of an individualized plan to resist these urges, and use of medications such as naltrexone to reduce craving (Anton 1999; Miller and Gold 1994).

###### Use Support Systems

The use of client advocates to intervene with clients wishing to leave early often can be an effective strategy for promoting retention in detoxification. Visitors should be instructed about the importance of supporting the individ­ ual in both detoxification and substance abuse treatment. If available, and if the patient is sta­ ble, he or she can attend onsite 12-Step or other support group meetings while receiving detoxification services. These activities rein­ force the need for substance abuse treatment

and maintenance activities and may provide a critical recovery-oriented support system once detoxification services are completed.

###### Maintain a Drug-Free Environment

Maintaining a safe and drug-free environment is essential to retaining clients in detoxifica­ tion. Providers should be alert to drug-seek­ ing behaviors, including bringing alcohol or other drugs into the facility. Visiting areas should be easy for the staff to monitor closely, and staff may want to search visiting areas and other public areas periodically to reduce the opportunities for acquiring substances. It is important to note, however, that personnel should be respectful in their efforts to main­ tain a drug-free environment. It is important to explain to patients (prior to treatment) and visitors why substances are not allowed in the facility.

###### Consider Alternative Approaches

Alternative approaches such as acupuncture are safe, inexpensive, and increasingly popular in both detoxification and substance abuse treatment. Although the effectiveness of alter­ native treatments in detoxification and treat­ ment has not been validated in well-controlled clinical trials, if an alternative therapy brings patients into detoxification and keeps them there, **it** may have utility beyond whatever spe­ cific therapeutic value it may have (Trachtenberg 2000). Other treatments that reside outside the Western biomedical system, typically grouped together under the heading of Complementary or Alternative Medicine, also may be useful for retaining patients. Indeed, given the great cultural diversity in the United States, other culturally appropriate practices should be considered.

###### Enhancing Motivation

Motivational enhancements are particularly well-suited to accomplishing the detoxification

services goal of promoting initiation in reha­ bilitation and maintenance activities. Use of these techniques in the detoxification setting increases the likelihood that patients will seek treatment by helping them understand the adverse consequences of continued substance use. It also establishes a supportive and non­ judgmental relationship between the sub­ stance abuse counselor and the patient-this therapeutic alliance is an important factor in the patient's choice to seek treatment services (Miller and Rollnick 2002). TIP 35, *Enhancing Motivation for Clrnnge in Substance Abuse Treatment* (CSAT 1999c), covers specific interventions and techniques to increase motivation to change substance­ related behaviors. TIP 35 also includes some basic principles common to motivational interventions (CSAT 1999c, p. xvii):

* Focus on the patient's strengths.
* Show respect for a patient's decisions and autonomy; respect should be maintained at all times, even when the patient is intoxicated.
* Avoid confrontation.
* Individualize treatment.
* Do not use labels that depersonalize the patient, such as "addict" or "alcoholic."
* Empathize with the patient, making an attempt to understand the patient's perspec­ tive and accept his or her feelings.
* Accept treatment goals that involve small steps toward ultimate goals.
* Assist the patient in developing an awareness of discrepancies between her or his goals or values and current behavior.
* Listen reflectively to the patient's immediate concerns and ask open-ended questions.

In addition, the detoxification team can lever­ age the relationship the patient has with sig­ nificant others. Using interventions such as Community Reinforcement and Family Training (CRAFT) (Miller et al. 1999), the detoxification team can help significant others in the patient's life capitalize on moments when the patient is ready for change and

assist the patient in preparing for change in a nonthreatening, nonconfrontational manner. The consensus panel does not recommend that clinicians use direct confrontation in helping a person with a substance use disor­ der begin the process of detoxification and subsequent substance abuse treatment.

Techniques that involve purposefully con­ fronting patients about their substance use behavior, such as the Johnson Intervention, where significant others are taught to con­ front the individuals using substances (Liepman 1993), have been shown to be high­ ly effective when significant others implement them. However, subsequent studies of clini­ cians, groups, and programs that rely on con­ frontational techniques have yielded poor outcomes (Miller et al. 1995). Moreover, the vast majority of significant others do not wish to use these techniques, and for that reason these techniques are not recommended (Miller et al. 1999).

Care should be taken to ensure that any sig­ nificant other who is involved in motivating the patient for therapy is appropriate for this task. Only significant others who have been appropriately introduced to the intervention by a clinician should participate. The pres­ ence of a trained facilitator is recommended, either for coaching or for facilitating the intervention. It also is important to have the recommended treatment option readily avail­ able so if the patient agrees, admission can be swift and seamless. Those individuals selected to intervene should support the patient's abstinence from substances of abuse.

Furthermore, if the patient places consider­ able value on her or his relationships with these significant others, success is more likely (Longabaugh et al. 1993).

###### Tailoring Motivational Intervention to Stage of Change

Perhaps the most well-known and empirically validated model of "readiness to change" that has been applied to substance abuse is the

*transtheoretical model,* also known as the *stages of clrnnge model* (DiClemente and Prochaska 1998). The interventions to increase patient motivation for substance abuse treatment described in TIP 35, *Enhancing Motivation for Change in Substance Abuse*

*Treatment* (CSAT 1999c) are based on this model.

Clinicians, groups, and programs that rely on confrontational techniques have yielded poor outcomes.

According to the model, a client is considered to be at one of five stages of readiness to change his substance-abus­ ing behavior, each stage being progres­ sively closer to sus­ tained recovery.

Those stages are *pre­ contemplation, con­ templation, prepara­ tion, action,* and *maintenance.* The model assumes that individuals may move back and forth between different stages over time. A corollary to this assumption is that an

individual's level of motivation is definitely *not* a permanent characteristic. Rather, moti­ vation to change can be influenced by others, including detoxification treatment staff.

In general, the basic concept is to try to move patients to the next stage of change. The clini­ cian needs to identify any potential obstacles that might hinder the patient's progress through the stages of change. The transtheo­ retical model is illustrated in Figure 3-5

**(p.** 36) and the details of each stage are described in the text below.

***Figure 3-5 The Transtheoretical Model (Stages of Change)***

*Source:* DiClemente and Prochaska 1998.

In the *precontemplation* stage, the individual is not considering any change in substance­ using behavior in the foreseeable future.

Typically, a patient in this stage either is unaware that his substance use is a problem or is unwilling or too discouraged to make a change. Often, a person in the precontempla­ tion stage has not experienced serious conse­ quences from substance use. During the pre­ contemplation stage, the clinician should be attentive for and seize upon any ambivalence

expressed by the patient toward substance­ related behaviors. Such ambivalence may be more likely to emerge during initial detoxifi­ cation, before the patient has returned to a relative zone of comfort and greater denial. For patients who are determined to remain in the precontemplation stage, the main goal is to get the patient to begin to consider chang­ ing. To accomplish this, the clinician might express concern, listen to the patient's per-

spective, and keep the door open for further communication regarding treatment options.

In the *contemplation* stage, the individual has some awareness that substance use presents a problem. In this stage, the patient may express a desire or willingness to change, but has no definite plans to do so in the near future, which generally is considered to be the next 2 to 6 months. Whether **it** is explicit­ ly stated or not, it is thought that most indi­ viduals in this stage are ambivalent about changing. That is, side-by-side with any desire to change is a desire to continue the current behavior. For patients in the contem­ plation stage, clinicians are advised to use "decisional balancing strategies" to help the patient move to the action stage (Carey et al. 1999). In this approach, the clinician helps the patient to consider the positive and nega­ tive aspects of her substance abuse and has the patient weigh them against each other with the expectation that the scale of balance tips in favor of adopting new behavior.

Psychoeducation on the interaction of sub­

stance abuse with other problems, including health, legal, employment, parenting, and mental illness, can be part of this procedure. Helping the patient understand that ambiva­ lent feelings about changing substance use behaviors are normal and expected can be particularly useful at this stage.

In the *preparation* stage, the patient is aware that his substance use presents a significant problem and desires change. Moreover, the patient has made a conscious decision to com­ mit himself to a behavior change. This stage is defined as one in which the individual pre­ pares for the upcoming change in specific ways, such as deciding whether a formal treatment program is needed and, if so, which one. This stage is characterized by goal set­ ting and making commitments to stop using, such as informing coworkers, friends, and family of treatment plans. For patients in the preparation stage, clinicians should elicit the patient's goals and strategies for change and be on the alert for signs that the patient is ready to move into the action stage. It is criti-

cal that the clinician respond quickly to any requests for treatment to capitalize on this motivation before it wanes. One of the most critically important roles the clinician can play in this stage is to assist the patient in developing a plan of action or a behavioral contract, taking into account the individual needs of the patient. As part of this process the clinician should help the patient enlist social support. Exploring the patient's expec­ tations regarding treatment and her role in it is important. Finally, because of the common­ ly experienced difficulty in accessing treat­ ment, the clinician should discuss with the patient ways of maintaining motivation for change during a possible wait for entry into a treatment program, should the patient be placed, for example, on a waiting list.

In the *action* stage, the patient is taking active steps to change substance use behav­ iors. This includes making modifications to his habits and environment, such as not spending time in places or with people associ­ ated with drug taking behavior. These changes may even continue to be made 3 to 6 months after substance abuse has ceased.

In the *maintenance* stage, the patient is work­ ing to maintain the changes initiated in the action phase.

###### Fostering a Therapeutic Alliance

The therapeutic alliance refers to the quality of the relationship between a patient and his care providers and is the "nonspecific factor" that predicts successful therapy outcomes across a variety of different therapies (Horvath and Luborsky 1993). A therapeutic alliance should be developed in the context of an ability to form an alliance to a group of helping individu­ als-such as a healthy support network or therapeutic community. A clinically appropri­ ate relationship between the clinician and patient that is supportive, empathic, and non­ judgmental is the hallmark of a strong thera­ peutic alliance.

Readiness to change predicts a positive thera­ peutic alliance (Connors et al. 2000). Strong alliances, in **turn,** have been associated with positive outcomes in patients who are depen­ dent on alcohol (Connors et al. 1997), as well as patients involved in methadone mainte­ nance, on such measures as illicit drug use, employment status, and psychological func­ tioning. In addition, the practitioner's exper­ tise and competence instill confidence in the treatment and strengthen the therapeutic alliance. Emphasis also should be given to the alliance with a social support network, which can be a powerful predictor of whether the patient stays in treatment (Luborsky 2000).

Given the importance of the therapeutic alliance and the fact that detoxification often is the entry point for patients into substance abuse treatment services, work on establish­ ing a therapeutic alliance ideally will begin upon admission. Many of the guidelines listed above for enhancing motivation apply to establishing this rapport. Newman (1997) makes some additional recommendations for developing the therapeutic alliance, such as discussing the issue of confidentiality with patients and acknowledging that the road to

recovery is difficult. He also advises being consistent, dependable, trustworthy, and available, even when the patient is not. The clinician should remain calm and cool even if the patient becomes noticeably upset.

Practitioners should be confident yet humble and should set limits in a respectful manner without engaging in a power struggle. See Figure 3-6 for a list of characteristics most valuable to a clinician in strengthening the therapeutic alliance.

#### Referrals and Linkages

Once an individual passes through the most severe of the withdrawal symptoms and is safe and medically stable, the focus of the psychoso­ cial interventions shifts toward actively prepar­ ing her for substance abuse treatment and maintenance activities. These interventions include **(1)** assessment of the patient's charac­ teristics, strengths, and vulnerabilities that will influence recommendations for substance abuse treatment; (2) preparing the patient to participate in treatment; and (3) successfully linking the patient to treatment as well as other needed services and resources.

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| ***Figure 3-6 Clinician's Characteristics Most Important* to *the Therapeutic Alliance*** |
| * Is supportive, empathic, and nonjudgmental
* Knows which patients can be engaged and which should be referred to another treatment provider
* Can establish rapport with any client
* Remembers to discuss confidentiality issues
* Acknowledges challenges on the road to recovery
* Is consistent, trustworthy, and reliable
* Remains calm and cool even when a client is upset
* Is confident but humble
* Sets limits without engaging in a power struggle
* Recognizes the client's progress toward a goal
* Encourages self-expression on the part of the client
 |

Ensuring that patients with substance use dis­ orders enter substance abuse treatment fol­ lowing detoxification often is difficult. Many patients believe that once they have eliminat­ ed the substance or substances of abuse from their bodies, they have achieved abstinence. Moreover, some insurance policies may not cover treatment, or only offer partial cover­ age. The patient may have to go through cum­ bersome channels to determine if treatment is covered, and if so, how much.

Preparation should focus on eliminating administrative barriers to entering substance abuse treatment prior to discussing treatment options with the patient. Discussions with the patient should be consistent with the patient's improving ability to process and assess infor­ mation in such a way that the patient appears to be acting with his or her own interests in mind.

###### Evaluation of the Patient's RehabiIitation Needs

To make appropriate recommendations for ongoing treatment and recovery activities, detoxification staff need to determine the individual characteristics of clients and their environments that are likely to influence the level of care, setting, and specialized services needed for recovery. ASAM's *Patient Placement Criteria, Second Edition, Revised* (PPC-2R) (ASAM 2001) provides one widely used model for determining the level of ser­ vices needed to address substance-related dis­ orders. The levels of treatment services range from community-based early intervention groups to medically managed intensive inpa­ tient services. As noted in chapter 2, providers need to make a placement decision based on six dimensions:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions or Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery/Living Environment

Due to the limited time patients stay in detoxifi­ cation settings, **it** is challenging for programs to conduct a complete assessment of the rehabili­ tation needs of the individual. With this in mind, detoxification programs should focus on those areas that are essential to make an appropriate linkage to substance abuse treat­ ment services. The assessment of the psychoso­ cial needs affecting the rehabilitation process itself may have to be left to the professionals providing substance abuse treatment. Other assessment considerations include

* Special needs, such as co-occurring psychi­ atric and medical conditions **that** may com­ plicate treatment or limit access to available rehabilitation services
* Pregnancy, physical limitations, and cogni­ tive impairments that limit the settings suit­ able for the individual
* Support system issues such as family sup­ port, domestic violence, and isolation that influence recommendations about residen­ tial versus outpatient settings
* The needs of dependent children
* The need for gender-specific treatment (for more information see the forthcoming TIPs *Substance Abuse Treatment: Addressing tl1e Specific Needs of Women* [SAMHSA in development *e]* and *Substance Abuse Treatment: Men's Issues* [SAMHSA in development g]).

Figure 3-7 (p. 40) outlines the areas the consen­ sus panel recommends for assessment to deter­ mine the most appropriate rehabilitation plan.

Appendix C lists a variety of instruments use­ ful in characterizing the addiction and related disorders (for example, the Addiction Severity Index [ASI]), measuring motivation­ al willingness to change (Stages of Change Readiness and Treatment Eagerness Scale [SOCRATES] and University of Rhode Island Change Assessment [URICA]), and evaluating co-occurring psychiatric conditions and social

**An Overview of Psychosocial and Biomedical Issues During Detoxification 39**

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| ***Figure 3-7 Recommended Areas for Assessment* To *Determine Appropriate******Rehabilitation Plans*** |
| **Domain** | **Description** |
| Medical Conditions and Complications | Infectious illnesses, chronic illnesses requiring intensive or specialized treat­ ment, pregnancy, and chronic pain |
| Motivation/Readiness to Change | Degree to which the client acknowledges that substance use behaviors are a problem and is willing to confront them honestly |
| Physical, Sensory, or Mobility Limitations | Physical conditions that may require specially designed facilities or staffing |
| Relapse History and Potential | Historical relapse patterns, periods of abstinence, and predictors of absti­ nence; client awareness of relapse triggers and craving |
| Substance Abuse/Dependence | Frequency, amount, and duration of use; chronicity of problems; indicators of abuse or dependence |
| Developmental and Cognitive Issues | Ability to participate in confrontational treatment settings, and benefit from cognitive interventions and group therapy |
| Family and Social Support | Degree of support from family and significant others, substance-free friends, involvement in support groups |
| Co-Occurring Psychiatric Disorders | Other psychiatric symptoms that are likely to complicate the treatment of the substance use disorder and require treatment themselves, concerns about safety in certain settings (note that assessment for co-occurring disorders should include a determination of any psychiatric medications that the patient may be taking for the condition) |
| Dependent Children | Custody of dependent children or caring for noncustodial children and options for care of these children during rehabilitation |
| Trauma and Violence | Current domestic violence that affects the safety of the living environment, co­ occurring posttraumatic stress disorder or trauma history that might compli­ cate rehabilitation |
| Treatment History | Prior successful and unsuccessful rehabilitation experiences that might influ­ ence decision about type of setting indicated |
| Cultural Background | Cultural identity, issues, and strengths that might influence the decision to seek culturally specific rehabilitation programs, culturally driven strengths or obstacles that might dictate level of care or setting |
| Strengths and Resources | Unique strengths and resources of the client and his or her environment |
| Language | Language or speech issues that make it difficult to communicate or require an interpreter familiar with substance abuse |



**40 Chapter 3**

and family factors. Administering these instruments requires varying degrees of sophistication on the part of the clinician. All instruments should be considered for their cultural, linguistic, level of cognitive compre­ hension, and developmental appropriateness for each patient. For further information on patient placement see TIP 13, *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders* (CSAT 1995h).

###### Settings for Treatment

Just as with settings for detoxification, set­ tings where substance abuse treatment is pro­ vided often are confused with the level of intensity of the services. It is increasingly clear that although level of intensity of ser­ vices and setting are both critical to success­ ful recovery, they are two separate dimen­ sions to be considered when linking clients to treatment. This process has been called "de­ linking" or "unbundling" and generally involves determining the need for social ser­ vices independently from the clinical intensity (Gastfriend and McLellan 1997; McGee and Mee-Lee 1997).

Treatment and maintenance activities are offered in a variety of settings. These include settings specifically designed to deliver sub­ stance abuse treatment, such as freestanding substance abuse treatment centers, as well as settings operating for other purposes, includ­ ing mental health centers, jails and prisons, and community corrections facilities.

Descriptions of these settings appear below:

* *Inpatient programs* for treatment of sub­ stance abuse generally are delivered in hos­ pitals and freestanding clinics and provide 24-hour nursing care in addition to inten­ sive treatment for substance-related prob­ lems.
* *Residential treatment programs* normally provide 24-hour supervision by nonmedical staff and the availability of medical staff may be limited. These programs deliver

highly intensive substance abuse counseling and clients may participate in the upkeep of facilities. Peer support is critical to the treatment delivered. As a general rule, patients will stay at a residential treatment facility for 7 to 30 days.

* *Therapeutic communities* (TCs) usually have 24-hour supervision by nonmedical staff or clients who have sustained recov­ ery. They tend to provide highly intensive counseling services and rely on peer sup­ **port** and confrontation to shape behaviors of clients. The TC is based on concepts of self-help. Residence **in** a TC is longer than a patient's stay in a residential program­ patients usually stay for a period of at least 30 days and often 6 months to a year. In some special situations, such as a criminal justice setting, TC residence can last 2

years or n10re.

* *Transitional residential programs and halfway houses* ordinarily have 24-hour supervision from nonmedical staff or clients who have sustained recovery. Patients in these programs often are working and par­ ticipate in counseling and peer support dur­ ing the evening and weekend hours.
* *Partial lwspitalization and day treatment programs* use a combination of medical and nonmedical staff to deliver a high intensity of counseling services during daytime hours. Patients return home in the evenings.
* *Intensive outpatient programs* usually are delivered by nonmedical staff in a clinic location. Patients receive 6 to 9 hours of counseling services each week in two or three contacts.
* *Traditional outpatient services* typically are delivered by counselors in a clinic or office setting and provide fewer hours of services than the "intensive outpatient" programs.
* *Recovery maintenance activities* are not treatment but are highly valuable for ongo­ ing sobriety maintenance. They include 12- Step and other support groups aimed at maintaining the gains accomplished in treat-

ment settings. Oxford House establishments and other "clean and sober" living environ­ ments are among the resources that clini­ cians should explore and perhaps incorpo­ rate in maintenance activities.

###### Provide Linkage to Treatment and Maintenance Activities

Approximately half of those making an appointment for treatment do not appear for their first appointment and another 20 per­ cent or more fail to appear for the second appointment (Gottheil et al. 1997; Parker 2002). As patients near completion of detoxi­ fication, whether they take the next step and enter treatment is dependent on a number of variables. Patients who are employed, are motivated beyond the precontemplation stage, and have family and social support, as well as those with co-occurring psychiatric condi­ tions, are more likely to initiate treatment.

Conversely, those who have severe drug dependence and those who are older are less likely to follow through and enter treatment (Kirchner et al. 2000; Weisner et al. 2001). Women are more likely to initiate treatment after detoxification than men, and individuals who have health insurance that features a

behavioral health carve-out and lower cost­ sharing requirements are more likely to enter treatment than those who do not (Mark et al. 2003h). Kleinman and associates (2002) fol­ lowed 279 opioid- and cocaine-dependent patients who had been in detoxification pro­ grams to determine how many had entered substance abuse treatment 30 days after leav­ ing the detoxification program. They found that those who were on parole, homeless, or who had been using drugs for less than 20 years were more likely than others to have entered treatment.

Research indicates that patients are more likely to initiate and remain in rehabilitation if they believe the services will help them with specific life problems (Fiorentine et al. 1999). Figure 3-8 suggests strategies that detoxifica­ tion personnel can use with their patients to promote the initiation of treatment and main­ tenance activities.

###### Provide Access to Wraparound Services

Patients are more likely to engage in treatment if they believe the full array of their problems

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| --- |
| ***Figure 3-8 Strategies* To *Promote Initiation of Treatment and******Maintenance Activities*** |
| * Perform assessment of urgency for treatment.
* Reduce time between initial call and appointment.
* Call to reschedule missed appointments.
* Provide information about what to expect at the first session.
* Provide information about confidentiality.
* Offer tangible incentives.
* Engage the support of family members.
* Introduce the client to the counselor who will deliver rehabilitation services.
* Offer services that address basic needs, such as housing, employment, and childcare.
 |
| *Source:* Carroll 1997; Fehr et al. 1991. |

will be addressed, including those needs typi­ cally addressed by wraparound services (e.g., housing, vocational assistance, childcare, transportation) (Fiorentine et al. 1999).

Moreover, patients receiving needed wraparound services remain in substance abuse treatment longer and improve more than people who do not receive such services (Hser et al. 1999).

As the individual passes through acute intoxi­ cation and withdrawal, it is important to ensure that the basic needs of the patient are met after discharge. These needs include access to a safe, stable, and drug-free living environment if possible; physical safety; food and clothing; ongoing health and prenatal care; financial assistance; and childcare.

Ensuring access to these basic needs may be problematic, and staff must be flexible and creative in finding the means to meet the basic needs of the patient.

Clearly, services planning should extend beyond the issues of substance dependence to other areas that may affect compliance with rehabilitation. Detoxification providers should be familiar with available resources for legal assistance, dental care, support groups, interpreters, housing assistance, trauma treatment, recovery-sensitive parent­ ing groups, spiritual and cultural support, employment assistance, and other assistance programs for basic needs. Family and other support systems also can be helpful to the patient in accessing services and should take part in the services planning as often as possi­ ble, always with the patient's consent.

To address the needs of homeless and indigent patients, detoxification providers should be familiar with emergency shelters, cash assis­ tance, and food programs in their communi­ ties and should have established referral rela­ tionships. Assessing women, teenagers, older adults, and other vulnerable individuals for victimization by another member of the household also is important. Patients should be linked with prenatal and primary health care for domestic violence. Ideally, linkage to

these programs includes more than a phone number; detoxification staff should assist patients in scheduling initial appointments and arranging for transportation.

Linkage to primary health and prenatal care as well as to community resources is essential for individuals with substance use disorders. Linkages can be an effective mechanism to assist the patient in accessing these services if they are not available as a part of the detoxi­ fication program. Formalized referral arrangements through contracts or memoran­ da of understanding can be useful to specify organizational obligations (D'Aunno 1997).

###### Minimize Access Barriers

An integral part of the process of linking an individual with rehabilitation and treatment resources is to address access barriers.

Transportation, child care during treatment, the potential for relapse between detoxification discharge and treatment admission, housing needs, and safety issues such as possible domestic violence should be addressed through an individualized plan prior to discharge.

The problem of a patient's placement on a waiting list presents a special barrier to treat­ ment. The solution lies in developing strate­ gies to maintain motivation for treatment dur­ ing the waiting period.

For pregnant women and patients with depen­ dent children, the threat of Child Protective Services removing their children for abuse and neglect due to drug use can be a barrier to entering a treatment program.

Additionally, interacting with hostile or unfriendly practitioners and encountering resistance from family, partners, or friends can be barriers to treatment entry.

Detoxification staff should be knowledgeable about State laws regarding drug use during pregnancy and definitions of child abuse and neglect in order to be able to reassure and encourage women to enter treatment.

People who identify as having a physical or cognitive disability also face special barriers to treatment. The reader is referred to TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998g) and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000d), for more information on these topics.

For racial/ethnic minorities, access barriers can be compounded by language, cultural, and financial factors. The ability of programs to develop culturally specific interventions, train staff and interpreters to respond to the specific needs of these individuals, and be aware of cultural differences in the manifesta­ tion of symptoms is critical to improving access to care. Supervision of staff and train­ ing in cross-cultural issues is equally impor­ tant to all programs serving diverse patient populations. The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (SAMHSA in development *a)* con­ tains more information on this topic.

###### Use Case Management

Case management presents an opportunity to tailor services to individual client needs and to minimize barriers to these services (Gastfriend and McLellan 1997). Case man­ agement is a set of services managed to assist the client in accessing needed resources. It is a useful strategy to ensure that access to wraparound services such as employment, housing, health care, and basic needs are met along with minimizing barriers to accessing substance abuse treatment. As outlined in

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998a), the common functions of case management

are defined as assessment, planning, linkage, monitoring, and advocacy. Case managers can facilitate the critical linkage between detoxification services and rehabilitation by providing transportation to the rehabilitation facility, arranging for childcare, or assisting with housing needs. Additionally, case man­ agement is a widely used strategy to integrate

mental health and substance abuse treatment for those with co-occurring conditions (Drake and Mueser 2000).

###### Linkage to Ongoing Psychiatric Services

Although it is important to make referrals for ongoing psychiatric attention, the presence of psychological symptoms should not prevent detoxification staff from referring patients to substance abuse treatment. Individuals with co-occurring psychiatric conditions appear to be able to initiate and benefit from substance abuse treatment like individuals without psy­ chiatric conditions (Joe et al. 1995).

Since some psychiatric illnesses may affect drug cravings in patients who are substance dependent, it is important to ensure that both the psychiatric condition and the substance use disorder are addressed in rehabilitation (Anton 1999). Individuals who are taking psy­ chotropic medications should be counseled about the importance of continuing on these medications. Whenever possible, discharge from the detoxification services should be coordinated with the patient's mental health provider in the community, and the patient should have an appointment scheduled at the time of discharge from the detoxification facility. Detoxification providers should request that the patient sign appropriate releases of information to provide assessment and other material to the mental health provider to promote continuity of care. This should only occur when the patient is medi­ cally stabilized and is in such a state of mind that he or she can make coherent decisions in this regard (e.g., while intoxicated, patients should not be permitted to sign releases).

For individuals with serious co-occurring psy­ chiatric conditions, integrated treatment for substance use disorders and mental illness is recommended. Case management services as described above may be especially important for individuals with severe mental illness impeding their ability to access services on their own. Increasingly, substance abuse and

mental health providers are implementing models using clinicians trained to deliver both substance abuse and mental health treatment concurrently (Drake and Mueser 2000). For more information, see TIP 42, *Substance Abuse Treatment for Persons With Co­ Occurring Disorders* (CSAT 2005c).

###### Linkage to Followup Medical Care

The patient's consent should be sought to involve her or his primary healthcare provider in the coordination of care. Patients with chronic medical conditions and those in need of followup care should have an appointment made for followup medical care before leaving the detoxification setting (Luborsky et al.

1997).

###### Considerations for Individuals With Chronic Substance Dependence

For individuals with substance abuse prob­ lems who detoxify regularly but have limited periods of abstinence, traditional treatment

approaches may not be effective. In some cases, addressing other needs may provide an avenue to engage the individual with chronic substance dependence in treatment. Case management approaches can be successful at addressing the need for housing, health care, and basic needs even though the individual is not yet willing to confront the issue of drink­ ing or other drug use (Cox et al. 1998). TIP 27, *Compreliensive Case Management for Substance Abuse Treatment* (CSAT 1998a), provides additional information about deliv­ ery of case management services to homeless individuals with substance use disorders and those with other complex problems.

Documentation of repetitive inappropriate use of voluntary detoxification services may help pave the way for civil commitment to involuntary treatment where this is an option, and, where detoxification resources are limit­ ed, treatment systems need to be creative in designing care plans for patients seeking fre­ quent detoxification without evidence of any therapeutic benefit.