Detoxification and Substance Abuse Treatment (Updated) Part 1

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1 Overview, Essential Concepts, and Definitions in Detoxification

In This Chapter...

Chapter 1 provides a brief historical overview of changes in the perceptions and provision of detoxification services. It also introduces the core concepts of the detoxification field, discusses the primary goals of detoxification services, clarifies the distinction between detoxification and treatment, 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] 1995*d*). Significant changes in the area of detoxification services since the publication 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 performance measures for detoxification programs. Like its predecessor, this TIP was created by a panel of experts with diverse experience in detoxification services—physicians, psychologists, counselors, nurses, and social workers, all with particular expertise to share.

Audience

The primary audiences for this TIP include substance abuse treatment counselors; administrators of detoxification programs; Single State Agency directors; psychiatrists and other physicians working in the field; primary care providers such as physicians, nurse practitioners, physician assistants, nurses, psychologists, and other clinical staff members; staff of managed care and insurance carriers; policymakers; and others involved in planning, evaluating, and delivering services for detoxifying patients from substances of abuse. Secondary audiences include public safety/police and criminal justice personnel, educational institutions, those involved with assisting workers (e.g., Employee Assistance Programs), shelters/feeding programs, and managed care organizations. The TIP also should prove useful to providers of other services in comprehensive systems of care (vocational counseling, occupational therapy, and public housing/assisted living), administrators, and payors (public, private, and managed care).

Scope

Among other issues covered in this TIP is the importance of detoxification as one component 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 prepared 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 disturbances/disorders, criminal involvement, unemployment, etc.). Furthermore, it promotes the latest strategies for retaining individuals in detoxification while also encouraging the development of the therapeutic alliance to promote the patient's entrance into substance abuse treatment. This includes suggestions on addressing psychosocial issues that may affect detoxification services.

This TIP provides medical information on detoxification protocols for specific substances, as well as considerations for individuals 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 administrators up-to-date on important aspects of detoxification, including how the services are to be paid for. It is unusual in a clinical treatment improvement 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 misunderstandings 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.

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 problem 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 implications of addiction. With these changes came more humane treatment of people with addictions.

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 nonhospital 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 medication 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 components to address social/personal aspects of addiction.

Just as the treatment and the conceptualization of addiction have changed, so too have the patterns of substance use and the accompanying detoxification needs. The popularity of cocaine, heroin, and other substances has led to the need for different kinds of detoxification services. At the same time, public health officials have increased investments in detoxification services and substance abuse treatment, especially after 1985, as a means to inhibit the spread of HIV infection and AIDS among people who inject drugs. More recently, people with substance use disorders are more likely to abuse more than one drug simultaneously (i.e., polydrug abuse) (Office of Applied Studies 2005).

The AMA's position is that substance dependence is a disease, and it encourages physicians and other clinicians, health organizations, and policymakers to base all their activities on this premise.

The AMA continues to maintain its position that substance dependence is a disease, and it encourages 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 common, detoxification has evolved into a compassionate 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-

tems all define detoxification differently. This TIP offers a clear and uniform set of definitions for the various components of detoxification and substance abuse treatment that may prove useful to the field of detoxification.

Detoxification

Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. 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 prevention and treatment, defines detoxification as "a medical intervention that manages an individual safely through the process of acute withdrawal" (McCorry et al. 2000*a*, p. 9). The WCG makes an important distinction, however, in noting that "a detoxification program is not designed to resolve the long-standing psychological, social, and behavioral problems associated with alcohol and drug abuse" (McCorry et al. 2000*a*, p. 9). The consensus panel supports this statement and has taken special care to note that *detoxification is not substance abuse treatment and rehabilitation*. For further explanation, see the text box below.

The consensus panel built on existing definitions 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 screening for co-occurring mental and physical conditions. Evaluation also includes a comprehensive assessment of the patient's medical 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 treatment plan once the patient has been withdrawn successfully.
- *Stabilization* includes the medical and psychosocial 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 contact 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.

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 continuum of care. For patients who have demonstrated a pattern of completing detoxification services and then failing to engage in substance abuse treatment, a written treatment 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, stabilization, 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 followed.

Other Relevant Terms

As defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM-IV-TR) (American Psychiatric Association [APA] 2000), a *substance-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 substance-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 physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior" (APA 2000, p. 192). *Substance abuse* refers to "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (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 substance-specific maladaptive behavioral change, with physiological and cognitive concomitants, 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 necessary, to help the patient abstain from substance use and minimize the physical harm caused by it. Ultimately, the goal of treatment/rehabilitation is to attain a higher level of social functioning by reducing risk factors,

Figure 1-1
DSM-IV-TR Definitions of Terms

Term	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 exposure.
Substance abuse (in this TIP, also sometimes used to denote "substance dependence")	A maladaptive (i.e., harmful to a person's life) pattern of substance use marked by recurrent and significant negative consequences 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 experiencing 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 treatment 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 substance abuse treatment are referred to as patients to emphasize that these persons are coming into contact with physicians, nurses, physician assistants, and medical social workers in a medical setting in which the patient often is physically ill from the effects of withdrawal from specific substances. In some social setting detoxification programs, the terms "client" or "consumer" may be used in place of "patient."

Guiding Principles in Detoxification and Substance Abuse Treatment

The consensus panel recognizes that the successful 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 guidelines (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.
3. 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.
4. 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.
5. 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 treatment 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 2000*a*).
6. Ultimately, insurance coverage for the full range of detoxification services is cost-effective. If reimbursement systems do not provide payment for the complete detoxification process, patients may be released prematurely, leading to medically or socially unattended withdrawal. Ensuing medical complications ultimately drive up the overall cost of health care.
7. 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 comprehensive 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 Abuse Treatment* [SAMHSA in development *a*]).
8. A successful detoxification process can be measured, in part, by whether an individual who is substance dependent enters, remains in, and is compliant with the treatment protocol of a substance abuse treatment/rehabilitation program after detoxification.

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 substance 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 reductions in crime, general healthcare costs, and expensive acute medical and surgical treatments 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 intoxication obtain inpatient detoxification in general 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 hospitalization. Moreover, only 15 percent of people 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 outcomes in terms of drug abstinence and readmission 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 phases of addiction treatment, thus treating detoxification 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 policy or insurer does not cover the nonmedical counseling that is an integral part of substance abuse treatment. Many treatment programs 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 reimburse 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

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 delivered. Accordingly, the TIP offers suggestions for resolving conflicts as well as clearly defining terms used in patient placement and treatment settings as a step toward clearer understanding among interested parties.

2 Settings, Levels of Care, and Patient Placement

In This Chapter...

Establishing criteria that take into account all the possible needs of patients receiving detoxification and treatment services is an extraordinarily 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 specific 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 treatment (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 particular patients or specific care settings.

The PPC-2R identifies six "assessment dimensions 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 intensity of services (i.e., level of care) that patients may receive in particular settings. It is important 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 judgment 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 agency). This level of care is an organized outpatient service monitored at predetermined 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., nonmedical or social detoxification setting). This level emphasizes peer and social support and is intended for patients whose intoxication 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 III.2.D, this level provides 24-hour medically supervised detoxification services.
5. *Level IV-D: Medically Managed Intensive Inpatient Detoxification* (e.g., psychiatric hospital inpatient center). This level provides 24-hour care in an acute care inpatient settings.

As described by the ASAM PPC-2R, the domain of detoxification refers not only to the reduction of the physiological and psychological features of withdrawal syndromes, but also to the process of interrupting the momentum 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 establish participation in treatment activities and patient role induction. That is, this phase should increase the patient's readiness for and commitment to substance abuse treatment 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] 1995*h*).

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 substance use (Miller and Gold 1998). Indeed, because the physician may be the first point of contact for these people, initiation of treatment 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 outpatient 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 substance 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 providing the patient and his family with information on the detoxification process and subsequent substance abuse treatment, in addition 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 withdrawal. 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, healthcare or addiction treatment facility, or in a patient's home by trained clinicians who provide medically supervised evaluation, detoxification, 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 medical 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 services 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 recovery.

Ambulatory detoxification with extended onsite monitoring

Essential to this level of care—and distinguishing it from Ambulatory Detoxification Without Extended Onsite Monitoring—is the availability of appropriately credentialed and licensed nurses (such as registered nurses [RNs] 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 II-D) also is an organized outpatient service. Like Level I-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, including 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 detoxification. In States where physician assistants, nurse practitioners, or advance practice clinical nurse specialists are licensed as physician extenders, they may perform the duties ordinarily carried out by a physician (ASAM 2001).

Because detoxification is conducted on an outpatient basis in these settings, it is important 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 interpret information regarding the needs of these persons, and all should be knowledgeable about the biomedical and psychosocial dimensions 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 intoxication 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 desirable that medical staff link patients to treatment services, although this may be an unreasonable expectation that cannot be met in a busy office setting. Linkage to treatment services may be provided by the physician or by

designated counselors, psychologists, social workers, and acupuncturists who are available 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 departments, 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 distinctions, in actual practice there is considerable overlap between the two—the ER will 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 emergency department reasonably can be expected to provide assessment and acute biomedical (including psychiatric) care. However, these settings often are unable to provide satisfactory psychosocial stabilization or complete biomedical stabilization (which includes both the initiation and taper of medications used in the treatment of substance withdrawal syndromes). 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 complications 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 emergency department is of the highest importance. 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 experience and expertise in identifying critically ill substance-using patients who may be about to experience or are already experiencing withdrawal symptoms. Three essential rules apply to emergency departments and their handling of intoxicated patients and patients who have begun to experience withdrawal:

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

- Emergency departments 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 detoxification setting if possible, 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 withdrawal 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 present 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 intoxicated patients, see chapter 3.

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

Level of care

Care is provided to patients whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. The services are delivered under a defined set of physician-managed procedures or medical protocols. Both settings provide medically directed assessment and acute care that includes the initiation of detoxification for substance use withdrawal. Neither setting is likely to offer satisfactory biomedical stabilization or 24-hour observation. Generally speaking, triage to inpatient care can easily be facilitated from either setting.

Freestanding urgent care centers and emergency 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 credentialed nurse is available for primary nursing care and observation. Psychologists, social workers, addiction counselors, and acupuncturists usually are not available in these settings. The physician or attending nurse usually facilitates linkage to substance abuse treatment.

Freestanding Substance Abuse Treatment or Mental Health Facility

Freestanding substance abuse treatment facilities may or may not be equipped to provide adequate assessment and treatment of co-occurring psychiatric conditions and biopsychosocial problems, as the range of services varies considerably from one facility to another. Inpatient mental health facilities, on the other hand, are able generally to provide treatment for substance use disorders and co-occurring 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 provided below; however, it should be emphasized that a clear understanding of the specific services that a given setting provides is

indispensable to identifying the least restrictive 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 residential 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 substance use withdrawal); assessing for adequate biopsychosocial stability, quickly intervening to establish this adequately; and facilitating effective linkage to and engagement in other appropriate 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 necessary) and should be available to provide onsite monitoring of care and further evaluation on a daily basis. An RN or other qualified 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 complications of intoxication and withdrawal. On the other hand, some residential settings have minimally intensive medical oversight. Residential detoxification in settings with limited medical oversight often is referred to as "social detoxification." (Though the "social detoxification" model is not limited 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 detoxification 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 support for patients who are intoxicated or experiencing 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 quality measures for residential detoxification.

Staffing

Inpatient detoxification programs employ licensed, certified, or registered clinicians who provide a planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for patients and their families. An interdisciplinary team of appropriately trained clinicians (such as physicians, RNs and LPNs, counselors, social workers, and psychologists) should be available to assess and treat the patient and to obtain and interpret information regarding the patient's needs. The number 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 personnel who are trained and competent to implement 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 information 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 medications according to their physician's orders and legal requirements (ASAM 2001).

Some residential detoxification programs are staffed to supervise self-administered medications for the management of withdrawal. All such programs should rely on established clinical protocols to identify patients who have biomedical needs that exceed the capacity of the facility and to identify which programs 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 partial hospitalization program (PHP) is appropriate for patients with mild to moderate withdrawal symptoms. Thorough psychosocial assessment and intervention should be available in addition to biomedical assessment and stabilization. Many of these programs have close clinical and/or administrative ties to hospital 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 detoxification.

Level of care

This level of detoxification is an organized outpatient service that requires patients to be present onsite for several hours a day. It is thus similar to a physician's office in that ambulatory detoxification with extended onsite monitoring is provided. Unlike the physician's office, in the IOP and PHP it is standard practice to have a multidisciplinary team available to provide 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 services are designed to treat the patient's level of clinical severity, to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol), and to effectively facili-

tate the patient's engagement in ongoing treatment 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 inpatient 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 hospitalization programs provide services to patients with mild to moderate symptoms of withdrawal 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 partial 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 inpatient program or are physically distinct from a hospital structure, they have close clinical and/or administrative ties to hospital centers. Collaborative working relationships are indispensable 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 physicians who are available daily as active members of an interdisciplinary team of appropriately 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 multidisciplinary professionals (such as physicians, nurses, counselors, social workers, psychologists, 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 substance use disorder and a co-occurring biomedical, emotional, or behavioral condition. Successful linkage to treatment for the substance use disorder (in addition to biomedical stabilization) is central to the mission of an intensive outpatient or partial hospitalization program (ASAM 2001). For more information, see the TIP *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* [SAMHSA in development *d*].

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

Acute Care Inpatient Settings

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

- Acute care general hospitals
- Acute care addiction treatment units in acute care general hospitals
- Acute care psychiatric hospitals
- Other appropriately licensed chemical dependency specialty hospitals

These settings share the ready availability of acute care medical and nursing staff, life support 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 detoxification (ASAM 2001).

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 provided for patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. Services should be delivered 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 manage 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 observation 24 hours a day. Facility-approved addiction counselors or licensed or registered addiction 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 conditions (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 becoming 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 themselves would not require hospitalization) and those in danger of seizures or delirium tremens should receive inpatient care. Inpatient addiction 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 placement 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 be regarded 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

Figure 2-1
Issues To Consider in Determining Whether Inpatient or Outpatient Detoxification Is Preferred

Considerations	Indications
Ability to arrive at clinic on a daily basis	Necessary if outpatient detoxification is to be carried out
History of previous delirium tremens or withdrawal seizures	Contraindication to outpatient detoxification: recurrence likely; specific situation may suggest that an attempt at outpatient detoxification is possible
No capacity for informed consent	Protective environment (inpatient) indicated
Suicidal/homicidal/psychotic condition	Protective environment (inpatient) indicated
Able/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 detoxification

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, frequently 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) assessment, referral for appropriate services, and linkage to treatment services. Chapter 3 provides an overview of the psychosocial and biomedical issues relevant to detoxification, strategies to engage the patient, and an overview of providing adequate linkage to follow 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 conditions, social supports, and environmental conditions critically influence the probability of successful and sustained abstinence from substances. 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 substance 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 positive) way of life.

This chapter addresses the psychosocial and biomedical issues that may affect detoxification and ensuing treatment. It highlights evaluation procedures 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 rehabilitation and maintenance activities and to link her or him to appropriate substance abuse treatment immediately 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 orientation, 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 current emotional, psychological, or mental problems. 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 complicate 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 professionals should screen for medical problems that may put the client at risk for a medical crisis or expose other clients or staff to contagious diseases. This section outlines important considerations 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 evaluation 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

Figure 3-1
Initial Biomedical and Psychosocial Evaluation Domains

Biomedical Domains

- *General health history*—What is the patient's medical and surgical history? Are there any psychiatric 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 educational level.
- *Living conditions*—Is the patient homeless or living in a shelter? What is the living situation? Are significant others in the home (and, if so, can they safely supervise)?
- *Violence, suicide risk*—Is the patient aggressive, depressed, or hopeless? Is there a history of violence?
- *Transportation*—Does the patient have adequate means to get to appointments? Do other arrangements need to be made?
- *Financial situation*—Is the patient able to purchase medications and food? Does the patient have adequate employment and income?
- *Dependent children*—Is 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 consideration?

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 addition, nonmedical staff should be aware of signs of impending seizures such as tremors,

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

- 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

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 associated with various addictive substances or routes of administration. Alcoholism has multiple organ effects involving the liver, pancreas, central nervous system, cardiovascular system, and endocrine system. Cocaine produces many of its medical complications through vasoconstriction (i.e., narrowing of the blood vessels), including myocardial infarction (heart attack), stroke, renal disease, spontaneous abortion, and even bowel infarction (death of tissue). Cocaine also can cause seizures and cardiac arrhythmia (irregular 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 detoxification staff also should be aware of the medications 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, including HIV and hepatitis A, B, and C. All open wounds should be cultured and treated to prevent the spread of infections. Providers should use HIV/blood and respiratory infection precautions until HIV and respiratory infectious status are known. Patients with respiratory infections should be carefully evaluated. The panel suggests that tuberculin testing be performed 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 infectious diseases passed through casual contact, including infestation with scabies and lice.

General Guidelines for Addressing Immediate Mental Health Needs

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

Suicide

Those who are users of multiple illicit substance 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 colleagues' 2000 study of 1,075 clients entering treatment showed that 29 percent reported suicidal 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 implemented; the frequency of these checks should be increased when signs of depression, shame, guilt, helplessness, worthlessness, and hopelessness 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 confrontation and judgment and instead focus on the treatable nature of substance use disorders 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 hallucinogen intoxication may be associated with increased risk of violence. Symptoms associated with this increased risk for violence include hallucinations, paranoia, anxiety, and depression. As a precaution, all patients who are intoxicated should be considered potentially 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 enforcement agencies or security contractors. Staff working in detoxification programs should be trained in techniques to de-escalate anger and aggression. In many cases, aggressive behaviors can be defused through verbal and environmental 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 physical restraint. Figure 3-3 (p. 28) lists some useful 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).

Figure 3-3
Strategies for De-escalating Aggressive Behaviors

- 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.

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 professionals caring for the client should be consulted. If a pharmacy profile on the patient is available, it should be copied for review (within the confines of State and Federal confidentiality 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 assessment of both the effects of substance use and of the symptoms of mental disorders. As the individual moves from severe to moderate withdrawal 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 recommend a period of 2 to 4 weeks of abstinence before attempting to diagnose a psychiatric disorder (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 detoxification 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 nutrition 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 intervention begins in the initial acute phase of withdrawal and continues through detoxification and subsequent substance abuse treatment. If the patient consents, family members or significant others may be included in the nutritional evaluation and counseling.

Weight is an important consideration in determining the nutritional status of the person with a substance use disorder. Substance abuse may result in a reduction in food intake and disruption in the patient's metabolism that may in 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 adequately 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 nutritional status (Simko et al. 1995).

Other questions to ask during the initial evaluation 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 withdrawal; consequently, a check of blood glucose level is particularly important in patients with a history of blood sugar abnormalities. Hypoglycemia (low levels of blood sugar) in the person with a substance use disorder may lead to drastic 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 familiar with the nutritional deficits associated with specific substances. Opioids are known to decrease calcium absorption 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, vitamins A and E, and the water-soluble vitamins pyridoxine, thiamine, folate, and vitamin B12 (Nazrul Islam et al. 2001). Alcohol also contains calories (7 kcal/gm) that when consumed in excessive amounts may displace nutrient-dense foods. Cocaine is an appetite suppressant and may interfere with the absorption of calcium and vitamin D. Laboratory tests for protein, vitamins, and iron and the other electrolytes are recommended to determine the extent of liver function as well as supplementation (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 substances 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 nutrients 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 decaffeinated 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 wellness.

Gastrointestinal disturbances (i.e., nausea, vomiting, and diarrhea) may accompany the first phase of detoxification. Such disturbances can worsen dehydration and may disturb blood chemistry balance, which in turn can lead to mental status changes, neurological 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), complex carbohydrates (whole grain bread and cereals), and dietary fiber are recommended (Duyff 1996). Patients undergoing detoxification 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 adolescents as it is for adult clients. However, there are a few important 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 important that detoxification providers be alert to escalating blood alcohol levels in these patients. Moreover, adolescents 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 consensus 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 supportive care. If alcohol, heroin, or other drugs associated with vomiting are suspected, protecting the individual's airway and positioning the patient on his or her side to avoid aspiration (inhaling) of stomach contents are critical. In severe cases of ingestion of respiratory depressants, respiratory support may be needed. If the individual is severely combative 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 reassurance may be sufficient. Additionally, adolescents 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 sexually) 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 rapport with adolescents, as their experience with adults may be marked by adverse consequences. 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 adolescents, see TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*d*), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*f*).

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 barriers to retention. Even if women do not have custody of their children they often are the ones who continue to care for them. Some children may show extreme need for their mother while separated from her, and their demands could trigger unauthorized leave from detoxification. Thus, ensuring that children have a safe place to stay while their mothers are in detoxification is of vital importance. Working with women and men to identify supportive family or friends may identify temporary childcare 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 associated with increased risk of intimate partner violence (Cunradi et al. 2002). Staff should know the signs of domestic violence and be prepared to follow procedures 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 referral. If a safety plan is made or phone numbers for domestic violence help are provided, related information should be labeled carefully so as not to disclose its purpose (e.g., listed as women's health resources) since the abuser may go through all personal belongings. All printed information about domestic violence also should be disguised and none should be kept by the patient when she leaves the safe facility. If the victim needs to press charges or obtain a restraining order, this should be done from a safe setting (e.g., inpatient detoxification). 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 counseling and childcare. Therefore, it is important for detoxification providers to be familiar with local childcare resources. For more

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

Considerations for Culturally Diverse Patients

In providing psychosocial supports for culturally 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 practitioner should avoid defining the patient in terms of his culture, since over- or underemphasizing the patient's race or ethnicity can be detrimental (Clark et al. 1998). Figure 3-4 pro-

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 violation 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 detoxification 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 essential that all clinicians who have contact with patients in withdrawal continually offer hope and the expectation of recovery. An atmosphere that conveys comfort, relaxation, cleanliness, 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 beginning of the substance abuse treatment process and that rehabilitation and maintenance activities 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 withdrawal process based on the particular drug of abuse. Usually withdrawal includes symptoms that are the opposite of the effects of the particular drug. This rebound effect can cause anxiety and concern for patients. Providing information about the common withdrawal symptoms of the specific drugs of abuse may reduce discomfort and the likelihood that the individual will leave detoxification services prematurely (for a list of withdrawal symptoms, see chapter 4). Settings that routinely encounter individuals 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 withdrawal. An additional consideration is providing such information to non–English-speaking patients and their families.

Interventions that assist the client in identifying 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 individual identify thoughts or urges to use, the development 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 individual in both detoxification and substance abuse treatment. If available, and if the patient is stable, he or she can attend onsite 12-Step or other support group meetings while receiving detoxification services. These activities reinforce 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 detoxification. Providers should be alert to drug-seeking 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 maintain 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 alternative treatments in detoxification and treatment 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 specific 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 rehabilitation 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 nonjudgmental relationship between the substance 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 Change in Substance Abuse Treatment* (CSAT 1999*c*), 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 1999*c*, 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 perspective 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 leverage the relationship the patient has with significant 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 disorder begin the process of detoxification and subsequent substance abuse treatment. Techniques that involve purposefully confronting patients about their substance use behavior, such as the Johnson Intervention, where significant others are taught to confront the individuals using substances (Liepman 1993), have been shown to be highly effective when significant others implement them. However, subsequent studies of clinicians, groups, and programs that rely on confrontational 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 significant 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 presence 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 available 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 considerable 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

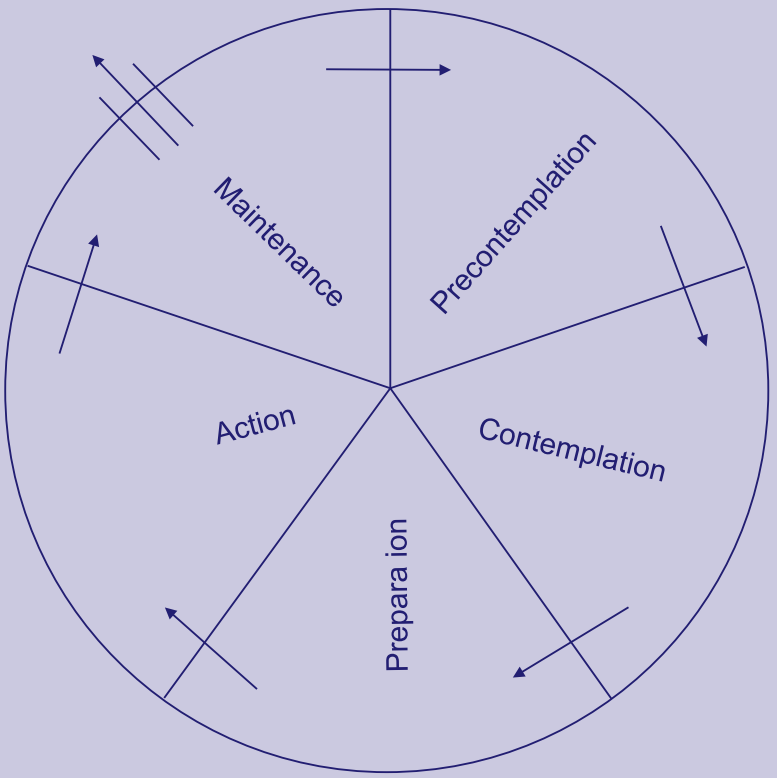
Perhaps the most well-known and empirically validated model of "readiness to change" that has been applied to substance abuse is the *transtheoretical model,* also known as the *stages of change model* (DiClemente and Prochaska 1998). The interventions to increase patient motivation for substance abuse treatment described in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*) are based on this model.

According to the model, a client is considered to be at one of five stages of readiness to change his substance-abusing behavior, each stage being progressively closer to sustained recovery. Those stages are *precontemplation, contemplation, preparation, 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, motivation to change can be influenced by others, including detoxification treatment staff.

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

In general, the basic concept is to try to move patients to the next stage of change. The clinician needs to identify any potential obstacles that might hinder the patient's progress through the stages of change. The transtheoretical 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 precontemplation stage has not experienced serious consequences from substance use. During the precontemplation 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 detoxification, 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 changing. 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 explicitly stated or not, it is thought that most individuals 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 contemplation 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 negative 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 substance abuse with other problems, including health, legal, employment, parenting, and mental illness, can be part of this procedure. Helping the patient understand that ambivalent 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 commit himself to a behavior change. This stage is defined as one in which the individual prepares 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 setting 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 critical 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 expectations regarding treatment and her role in it is important. Finally, because of the commonly experienced difficulty in accessing treatment, 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 behaviors. This includes making modifications to his habits and environment, such as not spending time in places or with people associated 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 working 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 individuals—such as a healthy support network or therapeutic community. A clinically appropriate relationship between the clinician and patient that is supportive, empathic, and nonjudgmental is the hallmark of a strong therapeutic alliance.

Readiness to change predicts a positive therapeutic alliance (Connors et al. 2000). Strong alliances, in turn, have been associated with positive outcomes in patients who are dependent on alcohol (Connors et al. 1997), as well as patients involved in methadone maintenance, on such measures as illicit drug use, employment status, and psychological functioning. In addition, the practitioner's expertise 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 establishing 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 psychosocial interventions shifts toward actively preparing her for substance abuse treatment and maintenance activities. These interventions include (1) assessment of the patient's characteristics, 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.

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 disorders enter substance abuse treatment following detoxification often is difficult. Many patients believe that once they have eliminated 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 coverage. The patient may have to go through cumbersome 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 information in such a way that the patient appears to be acting with his or her own interests in mind.

Evaluation of the Patient's Rehabilitation 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 services needed to address substance-related disorders. The levels of treatment services range from community-based early intervention groups to medically managed intensive inpatient 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 detoxification settings, it is challenging for programs to conduct a complete assessment of the rehabilitation 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 treatment services. The assessment of the psychosocial 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 psychiatric and medical conditions that may complicate treatment or limit access to available rehabilitation services
- Pregnancy, physical limitations, and cognitive impairments that limit the settings suitable for the individual
- Support system issues such as family support, domestic violence, and isolation that influence recommendations about residential 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 the 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 consensus panel recommends for assessment to determine the most appropriate rehabilitation plan.

Appendix C lists a variety of instruments useful in characterizing the addiction and related disorders (for example, the Addiction Severity Index [ASI]), measuring motivational 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

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 treatment, 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 abstinence; 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 complicate rehabilitation
Treatment History	Prior successful and unsuccessful rehabilitation experiences that might influence 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

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 comprehension, 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 1995*h*).

Settings for Treatment

Just as with settings for detoxification, settings where substance abuse treatment is provided often are confused with the level of intensity of the services. It is increasingly clear that although level of intensity of services and setting are both critical to successful recovery, they are two separate dimensions to be considered when linking clients to treatment. This process has been called "delinking" or "unbundling" and generally involves determining the need for social services 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 substance abuse treatment, such as freestanding substance abuse treatment centers, as well as settings operating for other purposes, including mental health centers, jails and prisons, and community corrections facilities. Descriptions of these settings appear below:

- *Inpatient programs* for treatment of substance abuse generally are delivered in hospitals and freestanding clinics and provide 24-hour nursing care in addition to intensive treatment for substance-related problems.
- *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 recovery. They tend to provide highly intensive counseling services and rely on peer support 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 more.
- *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 participate in counseling and peer support during the evening and weekend hours.
- *Partial hospitalization 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 ongoing 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 environments are among the resources that clinicians should explore and perhaps incorporate 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 percent or more fail to appear for the second appointment (Gottheil et al. 1997; Parker 2002). As patients near completion of detoxification, 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 conditions, 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. 2003*b*). Kleinman and associates (2002) followed 279 opioid- and cocaine-dependent patients who had been in detoxification programs to determine how many had entered substance abuse treatment 30 days after leaving 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 detoxification personnel can use with their patients to promote the initiation of treatment and maintenance activities.

Provide Access to Wraparound Services

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

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 typically 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 intoxication 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 parenting 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 possible, always with the patient's consent.

To address the needs of homeless and indigent patients, detoxification providers should be familiar with emergency shelters, cash assistance, and food programs in their communities and should have established referral relationships. 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 detoxification program. Formalized referral arrangements through contracts or memoranda 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 treatment. The solution lies in developing strategies to maintain motivation for treatment during the waiting period.

For pregnant women and patients with dependent 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 1998*g*) and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*d*), 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 manifestation of symptoms is critical to improving access to care. Supervision of staff and training in cross-cultural issues is equally important to all programs serving diverse patient populations. The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (SAMHSA in development *a*) contains 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 management 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 1998*a*), 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 management 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 psychiatric 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 psychotropic 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 medically 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 psychiatric 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 2005*c*).

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 problems 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 drinking or other drug use (Cox et al. 1998). TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*), provides additional information about delivery 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 limited, treatment systems need to be creative in designing care plans for patients seeking frequent detoxification without evidence of any therapeutic benefit.

Center for Substance Abuse Treatment.
Detoxification and Substance Abuse Treatment.
Treatment Improvement Protocol (TIP) Series, No. 45.
HHS Publication No. (SMA) 15-4131.
Rockville, MD: Center for Substance Abuse Treatment, 2015.

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