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Detoxification from Alcohol and Other Drugs

Treatment Improvement Protocol (TIP) Series

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Consensus Panel Chair

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This publication was written under contract number ADM 270-91-0007 from the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA). Sandra Clunies, M.S., served as the CSAT Government project officer. Dorynne Czechowicz, M.D., served as the Government content advisor. Carolyn

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The opinions expressed herein are the views of the consensus panel members and do not reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

DHHS Publication No. (SMA) 95-3046.
Printed 1995.

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What Is a TIP?

C SAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A chair for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high-quality and innovative AOD abuse treatment.

This TIP, *Detoxification From Alcohol and Other Drugs*, describes detoxification care in a number of settings. Detoxification and patient matching are discussed. The TIP provides clinical guidelines for detoxification from specific classes of drugs such as sedative-hypnotics, stimulants, and opiates. Detoxification needs of special populations are addressed. The TIP also includes information helpful to planners and policymakers about costs, quality improvement, outcome criteria, healthcare reform, and linking detoxification—often the gateway to ongoing treatment—to the larger continuum of care in the substance abuse treatment system. Legal and ethical issues of concern to detoxification programs are also examined.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Her contributions as co-chair are appreciated.
Dr. Smith also served as a field reviewer for the document.

Foreword

The Treatment Improvement Protocol (TIP) series fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves."

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

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Chapter 1—Introduction

The subject of this Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) is alcohol and other drug (AOD) detoxification—the process through which a person who is physically dependent on alcohol, illegal drugs, prescription medications, or a combination of these drugs is withdrawn from the drug or drugs of dependence. Since most persons who have a substance use disorder are addicted to a combination of alcohol and/or other drugs (polydrug abuse), detoxification often involves more than one substance.

This TIP was written by a panel composed of AOD specialists in detoxification—physicians specializing in addiction medicine, nurses, counselors, social workers, administrators, and researchers. Their goal was to develop comprehensive guidelines that would be useful to single State agency directors, physicians, nurses, other clinical staff, program administrators, staff of insurance carriers and managed care organizations, policymakers, and other individuals involved in planning, evaluating, and providing AOD detoxification services.

Panel members discussed detoxification settings and service components, and they reviewed patient assessment techniques and current detoxification protocols, as well as experimental treatments. They considered the needs of special populations; discussed issues related to measuring program outcomes, program financing, and healthcare reform; and identified legal and ethical issues of concern to program staff and administrators. This document reflects the panelists' consensus on these issues and incorporates many suggestions and recommendations from field reviewers.

Goals of Detoxification

The term detoxification implies a clearing of toxins (Alling, 1992). For many AOD-dependent people, removal of drugs from their bodies is indeed part of

the detoxification process. In the context of treating patients who are physically dependent on alcohol or other drugs, detoxification also includes the period of time during which the body's physiology is adjusting to the absence of drugs. However, as Gerstein and Harwood (1990) write, "Detoxification . . . is not a treatment for drug-seeking behavior. Rather, it is a family of procedures for alleviating the short-term symptoms of withdrawal from drug dependence." It must also include "a period of psychological readjustment designed to prepare the patient to take the next step in ongoing treatment" (Czechowicz, 1979).

As more and more States implement healthcare reform, third-party payers often manage payment for AOD detoxification services separately from other phases of drug treatment, as though detoxification occurs in isolation from drug treatment. In clinical practice, this separation cannot exist. Detoxification is one component of a comprehensive treatment strategy.

This TIP focuses specifically on detoxification and does not attempt to provide guidance on issues beyond those immediately related to this subject. The panelists who developed the TIP are aware that the discussion of detoxification, apart from the larger context of substance use disorders, is somewhat incomplete. However, the scope of this TIP is determined by the need to cover one issue in depth, complementing but not duplicating information available in other TIPs in the series.

Length of Detoxification

Because detoxification often entails a more intensive level of care than other types of AOD treatment, there is a practical value in defining a period during which a person is "in detoxification." There is no simple way to do this. Usually, the detoxification period is defined as the period during which the patient receives detoxification medications.

Third-party payers often manage payment for AOD detoxification services separately from other phases of drug treatment, as though detoxification occurs in isolation from drug treatment. In clinical practice, this separation cannot exist. Detoxification is one component of a comprehensive treatment strategy.

Another way of defining the detoxification period is by measuring the duration of withdrawal signs or symptoms. However, the duration of these symptoms may be difficult to determine in a correctly medicated patient because symptoms of withdrawal are largely suppressed by the medication. Chapter 3 describes the typical lengths of regimens for withdrawal.

The Role of Detoxification in AOD Abuse Treatment

For many AOD-dependent patients, detoxification is the beginning phase of treatment. It can entail more than a period of physical readjustment. It can also be a time when patients begin to make the psychological readjustments necessary for ongoing treatment. Offering detoxification alone, without followup to an appropriate level of care, is an inadequate use of limited resources. People who have severe problems that predate their AOD dependence or addiction—such as family disintegration, lack of job skills, illiteracy, or psychiatric disorders—may continue to have these problems after detoxification unless specific services are available to help them deal with these factors (Gerstein and Harwood, 1990).

Immediate Goals of Detoxification

- **To provide a safe withdrawal from the drug(s) of dependence and enable the patient to become drug free.** Many risks are associated with withdrawal, some influenced by the setting. For persons who are severely dependent on alcohol, abrupt, unsupervised cessation of drinking may result in delirium tremens or death. Other sedative-hypnotics may produce life-threatening withdrawal syndromes. Withdrawal from opioids produces severe discomfort, but is not generally life-threatening. However, risks to the patient and society are not limited to the severity of the patient's physical disturbance, particularly when the detoxification is conducted in an outpatient setting. Outpatients experiencing withdrawal symptoms may self-medicate with street drugs. The resulting interaction between prescribed medication and street drugs may result in an overdose. Less severe side effects include sedation or a drop in blood pressure.

- **To provide withdrawal that is humane and protects the patient's dignity.** A caring staff, a supportive environment, sensitivity to cultural issues, confidentiality, and the selection of appropriate detoxification medication (if needed) are all important to providing humane withdrawal.
- **To prepare the patient for ongoing treatment of his or her AOD dependence.** During detoxification, patients may form therapeutic relationships with treatment staff or other patients, and may become aware of alternatives to an AOD-abusing lifestyle. Detoxification is an opportunity to offer patients information and to motivate them for longer term treatment.

Repeated Detoxification

Alling discussed detoxification and treatment in a text published in 1992.

Those not familiar with the chronic nature of addictive disorders often characterize detoxification programs as 'revolving doors' through which patients come and go in an endless cycle, and which have little or no impact on the recovery process. Although it is true that many people undergo detoxification more than once—and some do so many times—the assumption that little or no progress has been made is often false.

Alling describes a pattern in individuals who return for several detoxification episodes, observing that young people with a history of AOD dependence of short duration (a year or less) "often are unrealistically optimistic about being able to remain drug free following detoxification." When recently AOD-dependent persons return after several months for repeat detoxification, it is usually with a more realistic expectation about what is needed to remain free from AODs. Individuals who subsequently relapse and return for detoxification a third time may have an even clearer understanding of what is required to sustain recovery (Alling, 1992).

During certain expected and predictable phases of recovery, addicted persons are at increased risk of relapse. However, relapse can occur at any point in recovery. Thus, relapse prevention is a legitimate area for patient education, and the relapsed patient is appropriate for clinical treatment. Treatment services

designed precisely for this stage of the disease may facilitate the individual's return to abstinence.

Issues in Postdetoxification Treatment

Few addicted persons enter detoxification or seek further treatment with the idea of maintaining lifelong abstinence. They may still believe they can control their abuse of AODs. Some persons enter detoxification and other treatment to satisfy the demands of their families, employers, or the courts. They may be motivated to seek treatment because attempts to relieve pressure through other means have proved futile. Clinicians should consider patient motivation when deciding upon appropriate treatment placement.

Families suffer severe consequences from the AOD abuse of their loved ones. The consequences may include obvious problems such as lost income, domestic violence, or divorce. Less obvious consequences may also occur, such as issues concerning trust and children's mirroring maladaptive ways to deal with problems encountered in everyday living. Addiction is a family disease because of the seriousness of its effects on family members and family functioning. Just as the person who abuses AODs needs support, education, and counseling, so too does the family. It is appropriate and important for treatment providers to engage the family in treatment as early as possible, even while the individual is undergoing detoxification.

Effects of AOD Exposure and Withdrawal

Tolerance and Physical Dependence

Continued exposure to AODs induces adaptive changes in an individual's brain cells and neural functioning. The changes vary depending on the drug of abuse and are not completely understood. The term "neuroadaptation" is often used to refer to these changes. One result of neuroadaptation is drug tolerance; that is, increasing the amounts of the drug that are required to produce the same effect. A second consequence of neuroadaptation is physical dependence; the brain cells require the drug in order to function.

Drug Withdrawal

Sudden removal of alcohol or another drug of abuse

from the system of a person who is physically dependent produces either an abstinence or withdrawal syndrome. The abstinence syndrome for each drug follows a predictable time course and has predictable signs and symptoms. Signs are defined by Webster's Medical Dictionary as "objective evidence of disease especially as observed and interpreted by the physician rather than by the patient or lay observer." Symptoms are defined in the same text as "subjective evidence of disease or physical disturbance observed by the patient."

There are three immediate goals of detoxification:

- To provide a safe withdrawal from the drug(s) of dependence and enable the patient to become drug free
- To provide withdrawal that is humane and protects the patient's dignity
- To prepare the patient for ongoing treatment of his or her AOD dependence.

The signs and symptoms of drug withdrawal are usually the reverse of the direct pharmacological effects of the drug. Heroin use commonly produces elevation of mood (euphoria), a decrease in anxiety, insensitivity to pain (analgesia), and a decrease in the activity of the large intestine, often causing constipation. Heroin withdrawal, on the other hand, produces an unpleasant mood (dysphoria), pain, anxiety, and overactivity of the large intestine, often resulting in diarrhea. Alcohol usually reduces anxiety and causes sedation; large quantities may produce sleep, coma, or even death by respiratory depression. In a person who is physically dependent, cessation of alcohol use produces anxiety, insomnia, hallucinations, and seizures.

For short-acting drugs such as alcohol and heroin, the most severe signs and symptoms of withdrawal usually begin within hours of the individual's last use. With a long-acting drug or medication, such as diazepam (Valium), withdrawal symptoms may not begin for several days and usually reach peak intensity after 5 to 10 days. The most severe drug-withdrawal symptoms, during the initial stages of detoxification, constitute the acute abstinence syndrome. The adjective "acute" distinguishes the syndrome from a "chronic" or protracted abstinence syndrome, in which signs and symptoms of withdrawal may continue for weeks to months after cessation of use (Martin and Jasinski, 1969).

Protracted abstinence syndrome is the subject of considerable controversy. Providers often find it difficult to distinguish symptoms caused by drug withdrawal from those caused by a patient's underlying mental disorder, if one is present. The signs and symptoms of protracted withdrawal are not as predictable as those of acute withdrawal. Some patients may be predisposed to a protracted withdrawal. Acute withdrawal syndromes produce measurable signs that researchers can study in animals under controlled laboratory conditions; protracted withdrawal in patients, by contrast, is often confined to distress symptoms that cannot be studied in animals.

The signs and symptoms of drug withdrawal are usually the reverse of the direct pharmacological effects of the drug.

Drug Categories

Addiction specialists and researchers categorize drugs and medications into groups such as *opioids*, *sedative-hypnotics*, and *stimulants*. Drugs in each group are similar pharmacologically and produce a similar withdrawal syndrome. The term *opiate* refers to opium and derivatives of opium, a naturally occurring substance, that have effects similar to those of morphine. Drugs such as heroin and medications such as codeine are examples of opiates. The term *opioid* refers to all substances, both those derived from opium and those synthetically produced, that have effects similar to the effects of morphine. Examples of synthetic opioids include Demerol, Percodan, and methadone. *Sedative-hypnotics* are usually prescribed medications designed to reduce anxiety or facilitate sleep. They include barbiturates such as secobarbital (Seconal) and benzodiazepines such as diazepam (Valium) and alprazolam (Xanax). Alcohol shares many pharmacological characteristics with the sedative-hypnotics. Stimulants produce increased arousal accompanied by a sense of confidence and euphoria. This category of drug includes cocaine and methamphetamine.

All drugs in a given group produce a common withdrawal syndrome; however, the intensity and time span of the withdrawal varies, depending on the specific agent. The signs and symptoms of methadone withdrawal are similar to those of heroin withdrawal; however, the signs of heroin withdrawal begin relatively quickly and peak within 24 to 48 hours after the last dose. Methadone withdrawal symptoms begin

more slowly, are less intense, and last longer.

The severity of withdrawal varies by drug group. Opioid withdrawal is unpleasant and distressing to patients, but it is not medically life threatening to a person who is otherwise physically healthy. On the other hand, withdrawal from alcohol or other sedative-hypnotics can produce grand mal seizures and a life-threatening disruption of physiology, even in a patient without other medical illness. Stimulant withdrawal is characterized by such symptoms as depression, and the primary risk during withdrawal is suicidal behavior.

After detoxification, the physiological functioning of the brain cells gradually returns to its predependent state; however, the cells may not be exactly the same as they were before dependence. Should a person who has undergone detoxification resume use of any drug in the same category as that upon which he or she has been physically dependent, neuroadaptation occurs more rapidly than it did the first time (Cochin and Kornetsky, 1964).

Forces Affecting AOD Detoxification Services

The Case for AOD Detoxification and Treatment

A number of forces are reshaping the delivery of AOD detoxification and treatment services. Some managed care systems and health insurance programs have curtailed substance use disorder treatment services. A challenge for those engaged in healthcare reform is to achieve a balance between high-quality care and cost-effective care. Most health insurance today is provided by employers. Employers and insurers will have more incentives to offer adequate AOD abuse treatment services as a standard benefit if they are educated about the treatable nature of addictive disease and the overall cost-effectiveness of treatment. The AOD abuse treatment system can be instrumental in providing this education. To do so, it will be necessary to substantiate the effectiveness of treatment. Careful research that generates solid data showing the benefits of treatment is the most powerful way to change negative perceptions.

Results were recently published of an important long-term study conducted by the California Department of Alcohol and Drug Programs on the effectiveness of AOD abuse treatment, the costs of treatment, and the economic value of treatment to society (1994). This 2-year study, called the CALDATA study, followed a rigorous probability sample of 1,900 individuals, representing the nearly

150,000 persons who received AOD abuse treatment in California in 1992. The sample included patients who received treatment in therapeutic communities, social model programs, outpatient drug-free programs, and methadone maintenance programs. The cost of treating the approximately 150,000 participants in 1992 was \$209 million, while the benefits accrued during treatment and in the first year afterwards were worth approximately \$1.5 billion. Thus, for every dollar spent on treatment, more than \$7 in future costs were saved, most significantly in the area of crime. For a smaller sample followed through the second year, results indicate that longer range cumulative benefits of treatment will be substantially higher than shorter term benefits.

In a summary of the study, its authors listed the following findings under the heading Treatment Effectiveness:

- **"Crime:** The level of criminal activity declined by two-thirds from before treatment to after treatment. The greater the length of time spent in treatment, the greater the percent reduction in criminal activity.
- **"Alcohol/drug use:** Declines of approximately two-fifths also occurred in the use of alcohol and other drugs from before treatment to after treatment.
- **"Healthcare:** About one-third reductions in hospitalizations were reported from before treatment to after treatment. There were corresponding significant improvements in other health indicators.
- **"Differences by substance:** There has been concern that stimulants, and crack cocaine especially, might be much more resistant to treatment than more familiar drugs such as alcohol or heroin. However, treatment for problems with the major stimulant drugs (crack cocaine, powdered cocaine, and methamphetamine), which were all in widespread use, was found to be just as effective for treatment for alcohol problems, and somewhat more effective than treatment for heroin problems.
- **"No gender, age, or ethnic differences:** For each type of treatment studied, there were slight or no differences in effectiveness between men and women, younger and older participants, or among African Americans, Hispanics, and Whites."

Barriers to Care

Managed care criteria may present barriers to appropriate treatment. Inpatient treatment must be certified as medically necessary. For chemical dependency treatment, insurance providers often

equate medical necessity only with the detoxification phase. Unless the patient has coexisting medical or psychiatric conditions, he or she is often removed from inpatient treatment when detoxification is complete.

Research appears to indicate that, at least in the long term, there are no significant differences between the outcomes for patients who are treated as inpatients and those who are treated as outpatients. Hayashida, et al. (1989) write that "Outpatient medical detoxification should be considered as an effective, safe, and cost-saving treatment alternative for persons with mild-to-moderate symptoms of alcohol withdrawal."

The impact of managed care on patient treatment outcome has not been studied adequately. The panelists were concerned that important clinical decisions affecting patient care were often driven by economic rather than clinical considerations. Skilled clinicians consider many factors other than a diagnosis of substance use disorder when deciding the level of care for a patient. Some examples of these considerations include whether the patient is living in a supportive, drug-free environment; whether there is a high level of family discord; whether the patient has significant psychiatric comorbidity; and whether the patient has access to appropriate transportation to and from the treatment facility.

Many AOD-abusing patients have inadequate treatment coverage and resources. If they relapse to AOD abuse following treatment, they may be fired and lose their health benefits. Because preemployment screening has become common, these individuals frequently are unable to find other jobs and thereby regain health insurance coverage. As a result, many AOD abusers are unemployed and have no health insurance. Their only treatment alternative is the public sector, which in most areas does not have the capacity needed to meet requests for services.

For AOD-dependent individuals, waiting periods and other barriers to treatment are countertherapeutic. An important facet of addiction is the individual's denial of the adverse effects of his or her AOD abuse. Many patients seek detoxification only during times of crisis: a drug-related seizure, an arrest, an illness of a family member, or the death of a friend. Patients who are physically dependent may recognize the need for detoxification, but they may or may not recognize the need for ongoing treatment. For AOD abuse treatment staff, a patient's crisis creates an intervention opportunity. During the crisis and its resolution, patients may be unusually receptive to consideration of lifestyle alternatives, education, and the need for longer term treatment.

Improving Access to Care

Healthcare reform, now on the political agendas of the Nation and the States, offers some avenues for improving access to treatment. Many populations, including the homeless, minority women, and nonregistered immigrants, have little access to treatment. Under some universal health coverage plans, more AOD-dependent persons would have access to treatment, and those with insurance would not be terminated from their policies if they relapsed.

A second area that holds promise for progress in AOD abuse treatment is the developing specialty of addiction medicine. The American Board of Psychiatry and Neurology now offers a subspecialty board certification in addiction medicine for physicians who are already board certified in psychiatry. In addition, the American Society of Addiction Medicine offers a certification of added qualification in addiction medicine for psychiatrists who are already board certified. Certification ensures that physicians who practice addiction medicine share a baseline understanding of the knowledge and skills on which their specialty is based.

Responsibility for AOD abuse treatment does not lie in the hands of physicians alone. It is increasingly shared among nurses, nurse practitioners, physicians' assistants, addiction counselors, social workers, nurses' aides, and other providers, as well as by managed care organizations. For this reason, the movement toward certification and inservice training programs for health providers should be expanded. A multidisciplinary, coordinated approach is essential. To ensure high-quality care, providers will need to establish referral networks and linkages among various treatment modalities.

Finally, unprecedented advances in the basic and behavioral sciences hold promise for the future of substance use disorder treatment. Chief among these are the recent growth in knowledge concerning how AODs affect brain cells and an appreciation of neurocognitive functioning. Some of this knowledge has direct application to AOD abuse treatment, particularly to detoxification.

Contents of This Treatment Improvement Protocol

This document is one in a series of CSAT TIPs. There is some overlap between topics covered in this TIP and others. Detoxification of pregnant women who abuse drugs and detoxification of neonates, although important topics, are not covered in detail in this document because each has been the subject of a

previous TIP (see *Pregnant, Substance-Using Women and Improving Treatment for Drug-Exposed Infants*). Medical, legal, and program considerations regarding infectious diseases (considerations that are important during detoxification) are covered in a TIP entitled *Screening for Infectious Diseases Among Substance Abusers*. These documents are cited in this publication.

Responsibility for AOD abuse treatment does not lie in the hands of physicians alone. A multidisciplinary, coordinated approach is essential. To ensure high-quality care, providers will need to establish referral networks and linkages among various treatment modalities.

This TIP covers the following areas:

Chapter 2—Detoxification Settings and Patient Matching.

This chapter describes the treatment settings in which detoxification occurs and considerations relating to patient matching. In it, the panel proposes a new configuration for detoxification services—the modified medical model. In considering this proposed model, the consensus panel discussed the improvement of quality of care by ensuring that persons are treated in a detoxification setting appropriate to their clinical needs. Patients should have access to all needed treatment services as well, including emergency treatment.

Chapter 3—Clinical Detoxification Protocols.

This chapter describes drug-specific withdrawal syndromes and presents guidelines for their clinical management. Treatment guidelines are outlined in sufficient detail to be of practical use to physicians and nurses. New treatment techniques, such as rapid detoxification protocols and the use of levo-alpha-acetyl-methadol, and experimental treatments such as acupuncture, are reviewed. Also included is information on the medical and legal status of medications such as methadone, which are sometimes used for detoxification.

Chapter 4—Special Populations. This chapter summarizes considerations that must be taken into account when providing detoxification services to individuals who are incarcerated, adolescent, elderly, or human immunodeficiency virus (HIV) positive. The chapter also addresses women's issues in detoxification.

Chapter 5—Improving Quality and Measuring Outcomes of AOD Detoxification Services. This chapter outlines ways in which program staff may

evaluate their services and improve the quality of patient care.

Chapter 6—Costs and Current Payment Mechanisms for AOD Detoxification. This chapter provides a strategy for estimating the costs of detoxification and summarizes information on public and private reimbursement for care.

Appendix A lists articles and other materials used in the development of this TIP as well as recent articles that cover particular aspects of detoxification treatment. Established and readily accessible knowledge in standard texts is not referenced.

Appendix B is a glossary of technical terms used in this TIP.

Appendix C provides information on private and public agencies and associations with resources that

may be useful to staff members of AOD detoxification programs.

Appendix D is a list of acronyms that are commonly used in the AOD abuse treatment field.

Appendix E, written by an attorney, provides an overview of Federal confidentiality requirements and issues relating to recordkeeping and consent to treatment.

Appendix F lists the names of persons who attended the Federal resource panel in the early stages of development of the TIP.

Appendix G lists experts from across the country who participated in the field review of the TIP.

Chapter 2—Detoxification Settings and Patient Matching

Treatment providers should discuss detoxification settings and patient matching within the context of two fundamental principles of high-quality patient care. The first is that the patient's needs should drive the selection of the most appropriate setting. The severity of the patient's withdrawal symptoms and the intensity of care required to ensure appropriate management of these symptoms are of primary importance.

Second, detoxification should be viewed as the gateway to ongoing treatment. As noted in Chapter 1 of this Treatment Improvement Protocol (TIP), providing a safe withdrawal is the first goal of detoxification, and another is to prepare the patient for appropriate followup treatment. Staff members in all detoxification settings, from the least restrictive to the most intensive, must facilitate this goal, as should policies governing reimbursement for services.

Insurance carriers' and managed healthcare organizations' goal of short-term cost savings is having a significant effect on the selection of the treatment settings. Insurance providers have developed and implemented stringent policies concerning reimbursement for alcohol and other drug (AOD) detoxification services. Such policies govern not only the setting in which the services are provided, but also the maximum number and length of detoxification episodes covered.

Insurance carriers' and managed healthcare organizations' goal of short-term cost savings is having a significant effect on the selection of treatment settings.

Insurers are increasingly reluctant to cover inpatient detoxification unless there is clear-cut medical or psychiatric evidence of the patient's need

for this kind of care. They have established medical criteria, such as the severity of AOD dependence and the presence of concurrent medical complications, upon which to base the decision to provide coverage. Insurers may also tie reimbursement of detoxification programs to their structures. For example, services that are offered by social model programs may not be covered if the program has no formal affiliation with a physician.

Current policies concerning reimbursement for services may be problematic from a patient care perspective. They give insufficient weight to the variety of factors that affect the selection of a setting in which the patient has the greatest likelihood of achieving satisfactory detoxification. Some persons in need of detoxification, for example, may not be appropriate candidates for outpatient detoxification because their spouses or others in their household are AOD dependent. These individuals may be more appropriately treated if they undergo detoxification in a residential setting such as a recovery house or other AOD-free residential environment. Detoxification is ultimately cost effective only if it is appropriate to the needs of the individual patient.

Medical Model and Social Model Programs

Considerable variation exists in the levels of care provided by AOD abuse treatment programs. Inpatient programs generally have fairly extensive onsite capabilities for providing medical care to patients or are affiliated with a nearby medical center. Some residential treatment programs are loosely affiliated with a medical center. Intensive outpatient treatment programs may be located within or closely affiliated with a hospital or medical center. Therapeutic communities are residential and have minimal, if any, onsite medical capabilities. They tend to rely on outside sources of medical care.

Detoxification services generally are available under a medical model or a social model.

Medical Model Programs

Medical model programs are directed by a physician and staffed by other healthcare personnel. They range from hospital-based inpatient programs to free-standing medically based residential programs in hospitals or in community facilities that can draw on various medical resources.

Social Model Programs

Social model AOD abuse treatment programs concentrate on providing psychosocial services. Social workers and other clinicians provide services such as individual and family counseling and coordination of care. Patients who need a physician's care may be referred to a nearby emergency department, which is not a cost-effective source of detoxification services. Some programs that provide detoxification services have a physician on call who can prescribe detoxification medications.

Social model programs use a variety of approaches to detoxification, but the emphasis is most often on nonpharmacological management of withdrawal. Usually, counselors do not have prescribing privileges and cannot legally administer medications from stock bottles to patients. In some programs, counselors can assist patients in taking detoxification medications. The patient's medication supply must be in a container that is labeled with the patient's name and that includes instructions for taking the medication. Counselors observe the patient take the medication, and they maintain a log. Counselors can also monitor patients' symptoms and call physicians or nurse practitioners if patients become ill.

Social model programs should not provide detoxification for people who have severe dependence on alcohol or other sedative-hypnotics, as withdrawal can be life threatening in these cases. Patients must be properly medically evaluated when they enter a social model program.

Inpatient and Outpatient Detoxification Settings

Detoxification may occur either in an *inpatient* or an *outpatient* setting. Both types of settings initiate recovery programs that may include referrals for problems such as medical, legal, psychiatric, and family issues.

According to Alling (1992), inpatient detoxification

has the following advantages:

- "The patient is in a protected setting where access to substances of abuse is restricted.
- "The withdrawal process may be safer, especially if the patient is dependent upon high levels of sedative-hypnotic drugs, since the clinician can observe him or her closely for serious withdrawal symptoms, and medications can be adjusted.
- "Detoxification can be accomplished more rapidly than it can in an outpatient setting."

Outpatient detoxification has the following advantages:

- "It is much less expensive than inpatient treatment.
- "The patient's life is not as disrupted as it is during inpatient treatment.
- "The patient does not undergo the abrupt transition from a protected inpatient setting to the everyday home and work settings."

Medical model programs range from hospital-based inpatient programs to free-standing medically based residential programs in hospitals or in community facilities that can draw on various medical resources.

Inpatient Detoxification

Inpatient detoxification is offered in medical hospitals, psychiatric hospitals, and medically managed residential treatment programs.

Acute Care Hospitals

Many acute care hospitals formerly operated subacute-care units, or chemical dependency units, that served as sites for uncomplicated detoxification. These programs, known as Minnesota Model programs, generally involved a 28-day inpatient stay followed by varying lengths of outpatient therapy and participation in self-help groups. Most were based on the Alcoholics Anonymous (12-step) model of personal change and the belief that vulnerability to AOD dependence is permanent but controllable. The goals of these programs were abstinence from all AODs and lifestyle alteration. Because of decreasing insurance reimbursement for stays in such units, many have ceased operation. In an effort to maintain treatment for those who need this type of care, some of the hospitals that house these units have developed other addiction services, such as intensive outpatient treatment programs.

Many acute care hospitals that do not maintain chemical dependency units commonly use a "scatter bed" approach, placing a patient in any clinical area of the hospital in which a bed is available (Alling, 1992).

Psychiatric Hospitals

Psychiatric hospitals occupy an important niche in the spectrum of detoxification settings because they are the preferred settings for patients who are psychotic, suicidal, or homicidal. In areas where medical hospital detoxification programs are not available, patients with no psychiatric comorbid conditions may be admitted to a psychiatric unit for detoxification. The detoxification protocols used in psychiatric hospitals are the same as those used in medical acute and subacute settings.

Medically Managed Residential Treatment Centers

Rather than acute care hospitals, medically managed residential treatment centers are AOD abuse medical care centers, where specialized services are provided by medical staff under the direction of a qualified physician with knowledge of and skills in addiction treatment. Psychosocial and behavioral services are usually provided as necessary components of successful treatment.

Psychiatric hospitals occupy an important niche in the spectrum of detoxification settings because they are the preferred settings for patients who are psychotic, suicidal, or homicidal.

Outpatient Detoxification

Again, outpatient detoxification has three major advantages: it is less expensive; it is less disruptive; and it allows the patient to remain in the same setting where he or she will function when drug free. Outpatient detoxification usually is offered in community mental health centers, AOD abuse treatment clinics, and private clinics.

Emergency Departments. The emergency department (ED) often serves as a gateway to AOD detoxification services. AOD detoxification programs may rely on emergency department staff to assess and initiate treatment for patients with medical conditions or medical complications that occur during detoxification. For social model programs, EDs are often a safety net for patients who need medical treatment. For the AOD abuser who has overdosed or

who is experiencing a medical complication of AOD abuse, the ED may be the initial point of contact with the health services system. It serves as a source of case identification and referral to AOD detoxification programs. Certain illnesses treated in emergency departments may mimic, mask, or resemble symptoms of withdrawal from AODs. Urine and blood toxicology testing may assist ED staff in making the correct diagnosis.

ED staff should refer patients who enter for detoxification to a more appropriate treatment site as soon as they have been assessed and stabilized. The ED of an acute care hospital is neither an appropriate setting for detoxification, nor is it a cost-effective one. However, because of the key role of the ED in the initial management and identification of persons in need of detoxification, ED staff should have both clinical expertise and familiarity with local AOD abuse treatment resources.

Intensive Outpatient Programs. Intensive outpatient programs offer a minimum of 9 hours a week of professionally directed evaluation and treatment in a structured environment. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences. Some programs provide medical detoxification. Many programs have established linkages through which they may refer patients to behavioral and psychosocial treatment. One strength of these programs is the daily contact between patients and staff. Another TIP in this series, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, describes these programs in detail.

Nonintensive Outpatient Programs. In nonintensive outpatient programs, patients attend regularly scheduled sessions that usually total no more than 9 hours of professionally directed evaluation and treatment per week. These programs may provide detoxification services. Treatment approaches and philosophies in staffing of outpatient programs vary considerably. Some offer only assessments; in others, counseling may continue for a year or longer. A majority of programs provide one or two weekly patient visits and may deliver psychiatric or psychological counseling and other services, such as resource referral and management. Many combine counseling with 12-step recovery.

Methadone Maintenance (Maintenance Pharmacotherapy) Clinics. These clinics may provide medically supervised withdrawal for persons abusing heroin who do not want to enter a methadone maintenance program but instead want to use methadone for withdrawal only, as well as for people who want to withdraw from methadone maintenance. The clinics, which must be licensed by the Food and

Drug Administration, the Drug Enforcement Administration, and State regulatory agencies, are the only programs in which methadone maintenance may be conducted for opiate addicts. They may be publicly funded and/or fee-for-service, but the distinction between public and private clinics is not clearcut; for example, many private clinics have contracts with the State or county to provide detoxification services.

A Proposed Modified Medical Model of Detoxification

Social model programs that provide detoxification should have reliable and routine access to medical services to manage medical and psychiatric complications of their patients' withdrawal. The access may be provided by a physician, nurse practitioner, or physician's assistant. The panel suggested calling social model programs that provide medical detoxification services under medical supervision a "modified medical model." The purpose of the new name is to assist such programs in obtaining reimbursement under State healthcare reform and through managed care and third-party payers. The suggested name "modified medical model" caused some controversy among the panelists and field reviewers. Nonmedical panelists noted that the new name could imply a "medical takeover" of social model programs. The panelists with medical backgrounds and orientations pointed out that the current state of the art of detoxification, particularly from alcohol and other sedative-hypnotics and opiates, requires medical assessment and prescription of medications. A closer alliance of the two models would provide better patient care and make some program services reimbursable by healthcare payers.

Advances in AOD abuse treatment over the past decade support this type of program, which may be described as a social model program backed up by all of the medical services needed to meet the physical needs of the patient undergoing detoxification. The essential characteristics of the ideal modified medical model are outlined under the following four headlines.

Program Administration

The "modified medical model" detoxification program is headed by a medical director who has knowledge of and skills in the treatment of addiction and who holds ultimate responsibility for patient care. The clinical responsibilities of the medical director include seeing patients when necessary and remaining on call for

consultations. The director's primary administrative duties are supervising detoxification staff and establishing clinical protocols.

Triage

Triage and ongoing patient evaluation are essential components of the proposed "modified medical model." Staff regularly monitor each patient's vital signs, and the decision to medicate or not to medicate is made by a physician. Such a routine stands in sharp contrast to that of traditional social model programs. Frequently, in these settings, no one is available to monitor patients' vital signs. When crises occur, patients must be transported to a local emergency department. This practice is not cost-effective and does not ensure optimal patient care.

Staffing

A nurse practitioner or a physician's assistant manages day-to-day program operations. If the staff of the modified medical detoxification unit does not include a nurse practitioner or physician's assistant, the medical director's time in the program is expanded.

The nurse's chief responsibilities are to monitor patients' vital signs and to perform other nursing services. When an individual needs medical attention, the nurses call on a member of the medical team, if one is available to the unit, rather than referring the patient to an emergency department. However, if a member of the medical team is not available, the patient should be seen in an emergency department. A registered nurse should remain on call, and nurse's aides (such as rehabilitation technicians or detoxification aides) should be on duty at all times. Appropriate support for the nurse's aides includes, at a minimum, a nurse and a backup physician.

Staff Training, Certification, and Licensure

Ideally, all staff working in the program, including nurses, nurse practitioners, nurse's aides, and physician's assistants, are trained in detoxification and in the treatment of chemical dependency. Taking and interpreting vital signs constitute a minimal standard of care, and some staff members, such as nurse's aides, might be trained to interpret signs relevant to AOD abuse issues, since such training is not provided in many standard curricula. Nurse's aides undoubtedly would also require additional training in AOD abuse issues in order to serve as effective members of the care team in a detoxification unit. Program administrators should establish minimum standards for licensure and accreditation of modified medical programs and staff.

The Role of Patient Matching Criteria

The best detoxification setting for a given patient may be defined as the least restrictive, least expensive setting in which the goals of detoxification can be met. The ability to meet this standard assumes that treatment choices are always based primarily on a patient's clinical needs. The least expensive care may not necessarily be the best care for a given individual. Less expensive but clinically inappropriate care will not be cost effective. It is often difficult to know which patients will be able to reach their detoxification goals in a relatively unrestricted setting, such as an outpatient AOD clinic, and which patients will need closer medical supervision and more comprehensive care. Decisionmakers should rely on clinical experience, close collaboration on the part of the multidisciplinary team, and respect for the patient's wishes to make the appropriate decision.

A comprehensive evaluation of the patient often indicates what therapeutic goals might realistically be achieved during the time allotted for the detoxification process. Alling (1992) suggests that such goals might include "treating current medical problems discovered; helping the person arrange for further drug-free rehabilitation following discharge; and educating the person in the area of drug-related problems, such as relapse prevention, health-related issues, and attention to family, vocational, religious, and legal problems as may be required."

The best detoxification setting for a given patient may be defined as the least restrictive, least expensive setting in which the goals of detoxification can be met. The ability to meet this standard assumes that treatment choices are always based primarily on a patient's clinical needs.

Patient Placement Criteria

For those who seek additional guidance in this area, a number of criteria sets have been developed to guide the process of matching patients to treatment settings. The *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*, developed by the American Society of Addiction Medicine (ASAM) in 1991, are used by many programs. The ASAM criteria, which are intended for use as a clinical tool for matching patients to appropriate levels of care,

reflect a clinical consensus of adult and adolescent treatment specialists and incorporate the results of a field review.

According to the ASAM Patient Placement Criteria, the three goals for management of detoxification are 1) avoidance of potential hazardous consequences of discontinuation of the drug of dependence; 2) facilitation of the patient's completion of detoxification and timely entry into continued treatment; and 3) promotion of patient dignity and easing of discomfort during the withdrawal process.

The ASAM criteria describe levels of treatment that are differentiated by the following three characteristics:

- Degree of direct medical management provided
- Degree of structure, safety, and security provided
- Degree of treatment intensity provided.

The ASAM levels of care range from outpatient treatment to medically managed intensive inpatient care. (The ASAM criteria do not provide for detoxification in social model programs.)

The ASAM criteria offer a variety of options, on the premise that each patient should be placed in a level of care that has the appropriate resources (staff, facilities, and services) to assess and treat the substance use disorder. While the criteria describe four levels of care, variations in staffing and support services may give some programs the capacity for more or less intense monitoring of detoxification than other programs at the same level of care. The levels of care addressed by the ASAM Patient Placement Criteria are matched with the corresponding recommended detoxification settings described in Exhibit 2-1. The TIP entitled *The Role and Current Status of Patient Placement Criteria In the Treatment of Substance Use Disorders* provides a framework to help providers understand the issues surrounding patient placement criteria and offers potential strategies that can be useful in developing criteria. This TIP represents an initial effort to develop criteria that are more consistent with the overall needs of the treatment field.

It provides an analysis of several sets of public and private criteria, including the ASAM criteria and those used by the States of Minnesota, Massachusetts, and Iowa. The TIP provides recommendations for filling in the gaps in existing criteria sets, so uniform criteria can be developed that are acceptable to both treatment providers and payers.

A managed care bibliography that includes information on patient placement criteria is available from CSAT. This Annotated Bibliography of Managed Care Materials can be obtained by contacting CSAT's Division of State Programs at (301) 443-8391.

Advantages and Disadvantages of Placement Criteria

In recent years, some States have begun to develop standards of care on the basis of models such as the ASAM Patient Placement Criteria. The move toward the development of standards of care and their subsequent application across a broad range of detoxification settings has advantages and disadvantages.

Properly developed and executed, such standards have the potential to ensure increased uniformity of treatment and improved appropriateness and cost-effective allocation of resources. A basic consideration is meeting these expectations while at the same time maintaining the focus on the patient's clinical needs as the primary concern. Patient placement criteria can provide a safety net that protects patients from falling

to the lowest level of care as a consequence of economic considerations or a lack of treatment alternatives. A major risk in the use of placement standards, however, is that they may be taken too literally by those not directly involved in patient care. This could result in a patient's receiving an inappropriate level of care that does not meet his or her clinical needs.

Clinicians must exercise judgment in all cases. If a single approach to care is widely adopted and strictly adhered to as the "correct" approach, treatment innovation may be stifled. The chief value of any criteria set is the added power that it gives providers to identify specific patient needs by means of a consistent and detailed assessment process and to choose a level of care that will specifically address those needs.

Exhibit 2-1

ASAM Patient Placement Criteria Applied to Detoxification Settings

ASAM Patient Placement Criteria Level of Care

Level I: Outpatient treatment

Level II: Intensive outpatient or partial hospitalization

Level III: Medically monitored intensive inpatient treatment

Level IV: Medically managed intensive inpatient treatment

Treatment Setting Recommended by Consensus Panel

Outpatient care
Methadone maintenance

Intensive outpatient program

Medical subacute hospital
Chemical dependency recovery program

Psychiatric hospital
Medical acute-care hospital
Emergency room

Chapter 3—Clinical Detoxification Protocols

Some detoxification procedures are specific to particular drugs of dependence; others are based on general principles of treatment and are not drug specific. In this chapter, the general principles are presented first, followed by specific treatment regimens for each category.

Principles of Detoxification

- **Detoxification *alone* is rarely adequate treatment for alcohol and other drug (AOD) dependencies.** The provision of detoxification services without followup to an appropriate level of care is less than optimum use of limited resources. The appropriate level of care following detoxification must be a clinical decision based on the individual needs of the patient.
- **When using medication regimens or other detoxification procedures, only protocols of established safety and efficacy should be used in routine clinical practice.**
- **Providers must advise patients when procedures are used that have not been established as safe and effective.** Such procedures are considered investigatory and should be carried out under an approved research protocol.
- **During detoxification, providers should control patients' access to medication to the greatest extent possible.** Patients who are AOD dependent generally cannot be relied on to take their medication as prescribed. Overdose with either the prescribed medication or other drugs is always a possibility. Because of this, treatment staff should administer as many of the patient's detoxification medications as possible. When it is not possible for the treatment staff to do so, another responsible person should assist the patient in taking the prescribed detoxification medication.
- **Initiation of withdrawal should be individualized.** Many persons come to treatment during times of personal crisis. To initiate withdrawal immediately may intensify their distress. In some cases, treatment staff may prefer to stabilize the patient on medication (for example, a patient using heroin may be stabilized on methadone) to resolve the immediate crisis before initiating withdrawal.
- **Whenever possible, clinicians should substitute a long-acting medication for short-acting drugs of addiction.** For example, when detoxifying a patient from alcohol, clinicians usually prescribe a slowly metabolized benzodiazepine such as diazepam (Valium) or chlordiazepoxide (Librium). This type of medication provides a gradual decline in blood level and a more controlled reversal of neuroadaptation.
- **The intensity of withdrawal cannot always be predicted accurately.** To assign patients to the appropriate level of care, it would be desirable to have empirically validated predictors of withdrawal severity. Unfortunately, no validated objective measures exist that would enable providers to predict with confidence a particular patient's intensity of withdrawal symptoms. Clinical guidelines used to assess probable withdrawal severity include the amount and duration of patients' AOD use, the severity of their prior withdrawals (if any), and the presence of medical or psychiatric comorbidity. Clinicians should take into account the patient's medical history but should also be aware that it cannot be considered totally reliable.
- **Every means possible should be used to ameliorate the patient's signs and symptoms of AOD withdrawal.** Medication should not be the only component of treatment. Psychological support is extremely important in reducing

Principles of detoxification:

- Detoxification *alone* is rarely adequate treatment for AOD dependencies.
- When using medication regimens or other detoxification procedures, clinicians should use only protocols of established safety and efficacy.
- Providers must advise patients when procedures are used that have not been established as safe and effective.
- During detoxification, providers should control patients' access to medication to the greatest extent possible.
- Initiation of withdrawal should be individualized.
- Whenever possible, clinicians should substitute a long-acting medication for short-acting drugs of addiction.
- The intensity of withdrawal cannot always be predicted accurately.
- Every means possible should be used to ameliorate the patient's signs and symptoms of AOD withdrawal.
- Patients should begin participating as soon as possible in followup support therapy such as peer group therapy, family therapy, individual counseling or therapy, 12-step recovery meetings, and AOD recovery educational programs.

patients' distress during detoxification. Also, to the extent that it is medically safe, patients should be physically active.

- **Patients should begin participating as soon as possible in followup support therapy such as peer group therapy, family therapy, individual counseling or therapy, 12-step recovery meetings, and AOD recovery educational programs.** Such services provide much-needed emotional support and provide alternative methods of coping with stresses that trigger AOD abuse. They provide general information about AOD dependence and goals for recovery. Overall health also can be addressed. Counseling on sexual health may include information on sexually transmitted diseases, human immunodeficiency virus (HIV) testing and education, and guidance on safer sexual practices. For injecting drug users, a drug-recovery educational program might include a discussion of the Centers for Disease Control and Prevention recommendations on needle exchange and disinfection.

hospital beds. It is doubtful whether hospitalization (especially beyond a day or two) is necessary in most cases, except for the special problems of addicted neonates, severe sedative-hypnotic dependence, or concurrent medical or severe psychiatric problems. For clients with a documented history of complications or flight from detoxification, residential detoxification may be indicated. Detoxification may . . . be undertaken successfully in most cases on a nonhospital residential, partial day care, or ambulatory basis.

Patients who score higher than 20 on the Clinical Institute Withdrawal Assessment (CIWA-Ar) instrument should be admitted to a hospital. (A detailed description of the CIWA-Ar follows.)

Most patients can be detoxified from alcohol in 3 to 5 days. Providers should consider the withdrawal time frame in terms of when the patient will need the most support; for alcoholics, this occurs the second day after the last ingestion. Other factors that influence the length of the detoxification period include the severity of the dependency and the patient's overall health status. Patients who are medically debilitated should detoxify more slowly.

Alcohol Detoxification

Most alcohol-dependent individuals can be detoxified in a modified medical setting, provided assessment is comprehensive, medical backup is available, and staff know when to obtain a medical consultation. As Gerstein and Harwood (1990) write,

Detoxification episodes are often hospital based and may begin with emergency treatment of an overdose. Much drug detoxification (an estimated 100,000 admissions annually) is now taking place in

Assessing Alcohol Withdrawal Symptoms

The signs and symptoms of acute alcohol abstinence syndrome generally begin 6 to 24 hours after the patient takes his or her last drink. The acute phase of alcohol abstinence syndrome may begin when the

patient still has significant blood alcohol concentrations. Signs and symptoms may include

- Restlessness, irritability, anxiety, agitation
- Anorexia, nausea, vomiting
- Tremor, elevated heart rate, increased blood pressure
- Insomnia, intense dreaming, nightmares
- Impaired concentration, memory, and judgment
- Increased sensitivity to sounds, alteration in tactile sensations
- Delirium (disorientation to time, place, situation)
- Hallucinations (auditory, visual, or tactile)
- Delusions (usually paranoid)
- Grand mal seizures
- Elevated temperature.

Symptoms do not always progress from mild to severe in a predictable fashion. In some patients, a grand mal seizure may be the first manifestation of acute alcohol abstinence syndrome.

Although many programs devise their own methods of monitoring patients' withdrawal signs and symptoms, there is considerable advantage to using a widely accepted validated instrument. The CIWA-Ar is commonly used in clinical and research settings for initial assessment and ongoing monitoring of alcohol withdrawal symptoms. It "takes 2 to 5 minutes to administer, helps make the decision to hospitalize the patient or to treat him or her as an outpatient, and is useful for monitoring and managing the patient during withdrawal" (Fuller and Gordis, 1994). It measures the severity of alcohol withdrawal by rating 10 signs and symptoms: nausea; tremor; autonomic hyperactivity; anxiety; agitation; tactile, visual, and auditory disturbances; headache; and disorientation. The maximum score is 67 (Saitz et al., 1994). The

CIWA-Ar is not copyrighted, and the version in Exhibit 3-1 (Sullivan et al., 1989) may be used freely.

The CIWA-Ar should be repeated at regular intervals (initially every 1 or 2 hours) to monitor patients' progress (Sullivan et al., 1989). Increasing scores on the CIWA-Ar signify the need for additional medication or a higher level of treatment; decreasing scores suggest therapeutic response to medication or treatment milieu. Patients scoring less than 10 on the CIWA-Ar do not usually need additional medication for withdrawal (Saitz et al, 1994.; Sullivan et al., 1989).

Benzodiazepine Treatment of Alcohol Withdrawal

Benzodiazepines, such as chlordiazepoxide (Librium), clonazepam (Klonopin), chlorazepate (Tranxene), and diazepam (Valium), are considered effective tools in ameliorating signs and symptoms of alcohol withdrawal because they decrease the likelihood and number of withdrawal seizures and episodes of delirium tremens. Chlordiazepoxide is "currently the most commonly administered medication for alcohol withdrawal in the United States" (Saitz et al., 1994). Oxazepam (Serax) or lorazepam (Ativan) are sometimes used with patients who have severe liver disease because neither is metabolized by the liver.

There are several acceptable medication regimens for treating alcohol withdrawal:

- **Gradual, tapering doses.** Oral benzodiazepines are administered on a predetermined dosing schedule for several days and gradually discontinued. This regimen is the one most commonly used. Dosing protocols vary widely among treatment facilities. As an example, patients may receive 50 mg of chlordiazepoxide

Signs and symptoms of the acute phase of alcohol abstinence syndrome may include

- Restlessness, irritability, anxiety, agitation
- Anorexia, nausea, vomiting
- Tremor, elevated heart rate, increased blood pressure
- Insomnia, intense dreaming, nightmares
- Impaired concentration, memory, and judgment
- Increased sensitivity to sounds, alteration in tactile sensations
- Delirium (disorientation to time, place, situation)
- Hallucinations (auditory, visual, or tactile)
- Delusions (usually paranoid)
- Grand mal seizures
- Elevated temperature.

Exhibit 3-1

Addiction Research Foundation Clinical Institute Withdrawal Assessment-Alcohol (CIWA-Ar)

This scale is not copyrighted and may be used freely.

Patient: _____

Date: ____/____/____
 y m dTime: ____:____
(24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____

Blood pressure: ____/____

NAUSEA AND VOMITING—Ask "Do you feel sick to your stomach? Have you vomited? Observation.

- 0 no nausea and no vomiting
- 1 mild nausea with no vomiting
- 2
- 3
- 4 intermittent nausea with dry heaves
- 5
- 6
- 7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES—Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

- 0 none
- 1 mild itching, pins and needles, burning or numbness
- 2 mild itching, pins and needles, burning or numbness
- 3 moderate itching, pins and needles, burning or numbness
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

TREMOR—Arms extended and fingers spread apart. Observation.

- 0 no tremor
- 1 not visible, but can be felt fingertip to fingertip
- 2
- 3
- 4 moderate, with patient's arms extended
- 5
- 6
- 7 severe, even with arms not extended

AUDITORY DISTURBANCES—Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

- 0 not present
- 1 very mild harshness or ability to frighten
- 2 mild harshness or ability to frighten
- 3 moderate harshness or ability to frighten
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations.

PAROXYSMAL SWEATS—Observation.

- 0 no sweat visible
- 1 barely perceptible sweating, palms moist
- 2
- 3
- 4 beads of sweat obvious on forehead
- 5
- 6
- 7 drenching sweats

VISUAL DISTURBANCES—Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

- 0 not present
- 1 very mild sensitivity
- 2 mild sensitivity
- 3 moderate sensitivity
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

ANXIETY—Ask "Do you feel nervous?" Observation.

- 0 no anxiety, at ease
- 1 mildly anxious
- 2
- 3
- 4 moderately anxious, or guarded, so anxiety is inferred
- 5
- 6
- 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.

HEADACHE, FULLNESS IN HEAD—Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

- 0 not present
- 1 very mild
- 2 mild
- 3 moderate
- 4 moderately severe
- 5 severe
- 6 very severe
- 7 extremely severe

AGITATION—Observation.

- 0 normal activity
- 1 somewhat more than normal activity
- 2
- 3
- 4 moderately fidgety and restless
- 5
- 6
- 7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM—Ask "What day is this? Where are you? Who am I?"

- 0 oriented and can do serial additions
- 1 cannot do serial additions or is uncertain about date
- 2 disoriented for date by no more than 2 calendar days
- 3 disoriented for date by more than 2 calendar days
- 4 disoriented for place and/or person

Total CIWA-A Score _____
 Rater's Initials _____
 Maximum Possible Score **67**

(or 10 mg of diazepam) every 6 hours during the first day and 25 mg (or 5 mg of diazepam) every 6 hours on the second and third days (Saitz et al., 1994). Doses of withdrawal medication are usually omitted if the patient is sleeping soundly or showing signs of oversedation.

- **Symptom-triggered therapy.** Using the CIWA-Ar, nurses are trained to recognize signs and symptoms of alcohol withdrawal and to give a benzodiazepine to their patients only when signs and symptoms of alcohol withdrawal appear. Studies have demonstrated that appropriate training of nurses in the application of the CIWA-Ar dramatically reduces the number of patients who receive symptom-triggered medication (from 75 percent to 13 percent) (Wartenberg et al., 1990).
- **Loading dose.** Staff administer a slowly metabolized benzodiazepine for only the first day of treatment (Sellers et al., 1983). Patients in moderate-to-severe withdrawal receive 20 mg of diazepam (or 100 mg of chlordiazepoxide) every 1 to 2 hours until they show significant clinical improvement (such as a CIWA-Ar score of 10 or less) or become sedated. A 1985 study by Devenyi indicates that "oral diazepam loading alone may be sufficient to prevent withdrawal seizures in patients who have had them previously and who have no other reason for having seizures." A randomized, double-blind controlled study conducted in an inpatient Veterans Administration hospital and reported in 1994 (Saitz et al.) compared fixed-dose and symptom-triggered therapy and found that patients "treated with symptom-triggered therapy completed their treatment courses sooner and required less medication than patients treated using the standard fixed-schedule approach." Specifically, they received less chlordiazepoxide (median 100 mg versus 425 mg) and received treatment for a shorter period of time (9 hours versus 68 hours). This indicates that symptom-triggered therapy is an approach that could individualize and improve the management of alcohol withdrawal. "Future studies should evaluate the effect of symptom-triggered therapy on the cost and duration of hospitalization for treatment of alcohol withdrawal and should identify the patient populations for whom symptom-triggered therapy is most effective" (Saitz et al., 1994).

Some patients can be withdrawn from alcohol without medication treatment; however, guidelines for identifying patients who can safely be treated without medication have not been validated in controlled clinical trials. Clinically, it is safer to provide

treatment for patients who may not need it than to withhold medication until patients develop severe withdrawal signs and symptoms.

Symptom-triggered therapy is an approach that could individualize and improve the management of alcohol withdrawal.

Other Medications

Carbamazepine (Tegretol)

Carbamazepine, a medication used for treatment of seizures, has been reported as effective in treatment of alcohol withdrawal. A controlled study comparing carbamazepine 800 mg/day to oxazepam 120 mg/day for treatment of alcohol withdrawal found that the two drugs precipitated equivalent scores on the CIWA-Ar. The study's authors concluded that "anticonvulsants with antikindling properties may be superior to traditional benzodiazepines in preventing alcohol withdrawal seizures and in potentially reducing long-term neurologic, behavioral, and psychiatric complications of alcoholism. To our knowledge, no double-blind, controlled studies have directly compared carbamazepine to a benzodiazepine in the treatment of alcohol withdrawal" (Malcolm et al., 1989).

Propranolol (Inderal) and Other Beta-Blockers

Some of the autonomic nervous system hyperactivity of alcohol withdrawal (such as rapid heartbeat, elevation of blood pressure, sweating, and tremors) is ameliorated by medications, such as propranolol (Inderal) and atenolol (Tenormin), that block beta adrenergic receptors. Although effective in decreasing autonomic symptoms, beta-blockers do not prevent hallucinations and confusion or withdrawal seizures. Propranolol may increase the risk of delirium and hallucinations during alcohol withdrawal (Jacob et al., 1983).

Treatment of Delirium and Seizures

Delirium tremens and seizures are two severe physiologic responses to withdrawal from sedative-hypnotics. Patients who develop delirium tremens with auditory, visual, or tactile hallucinations may need antipsychotic medications to ameliorate their hallucinations and to decrease agitation. Haloperidol, known by the trade name of Haldol, generally controls symptoms (0.5 to 2.0 mg every 4 hours by mouth or

by intramuscular injection). Patients who are not vomiting may be given the medication by mouth; those who are severely agitated or vomiting may be administered Haldol intramuscularly. Patients should continue to receive benzodiazepines. Phenothiazines such as chlorpromazine (Thorazine) should not be used because of the increased risk of seizures.

Magnesium Sulfate

A controlled study has shown that magnesium sulfate does not reduce seizure frequency, even in patients with low serum magnesium levels (Wilson and Vulcano, 1984). More recent studies have affirmed the use of benzodiazepines to treat delirium tremens and seizures (Gorelick, 1993).

Phenytoin (Dilantin)

The therapeutic or prophylactic value of a routine prescription of phenytoin to prevent alcohol withdrawal seizures is not established (American Society of Addiction Medicine, 1994). The current consensus is that phenytoin or other anticonvulsant therapy appropriate for the seizure type should be used for patients with an established history of seizure disorder (seizures not caused solely by alcohol withdrawal). Expert opinion is mixed as to whether phenytoin (or other anticonvulsants) should be used in addition to adequate sedative-hypnotic medication in patients who are at an increased risk of alcohol withdrawal seizures because of previous withdrawal seizures, head injury, meningitis, encephalitis, or a family history of seizure disorder. Intravenous phenytoin is not beneficial for patients with isolated acute alcohol withdrawal seizures, but it may be indicated for patients who have multiple alcohol withdrawal seizures. Metabolism of phenytoin varies from patient to patient. It should be administered orally or intravenously because it is poorly absorbed when administered intramuscularly.

Phenobarbital

Phenobarbital can be used for alcohol detoxification when the patient is physically dependent on both sedative-hypnotics and alcohol.

Naltrexone

Naltrexone has been approved by the Food and Drug Administration (FDA) as a treatment adjunct to reduce relapse to alcohol dependence among detoxified alcohol-dependent patients. Naltrexone, previously marketed under the trade name of Trexan, is now marketed under the trade name of ReVia. The name

change was made to prevent possible confusion with the benzodiazepine Tranxene.

Naltrexone is an opioid antagonist that has previously been used primarily to block the effects of heroin and thereby reduce the likelihood of relapse. Its mechanism of action in reducing alcohol consumption is not understood; however, clinical trials support its efficacy when it is used in conjunction with training in coping skills and/or supportive therapy (O'Malley et al., 1992; Volpicelli et al., 1992). It appears to reduce alcohol craving and thus is associated with less frequent and shorter relapses.

The National Institute on Alcohol Abuse and Alcoholism cautions that naltrexone should be administered only by doctors with knowledge of addiction treatment and as part of a structured treatment program. Researchers are still determining which populations are likely to respond best to naltrexone, and possible long-term side effects are under investigation.

Vitamins

Alcohol-dependent patients may have vitamin deficiencies, particularly of thiamine. Patients should receive thiamine in addition to high-potency multivitamins.

Special Problems with Medication Administration

Patients in alcohol withdrawal who are vomiting or who are in acute delirium may not be able to take oral medications. The absorption of diazepam or chlordiazepoxide after intramuscular administration is unpredictable. Intramuscular absorption of lorazepam (Ativan) is more reliable than that of diazepam or chlordiazepoxide. Lorazepam may be administered in doses of 2 mg every hour until signs and symptoms subside.

Outpatient Treatment Concerns

Increasingly, providers and patients are choosing the option of outpatient detoxification in part because of cost and in part because hospitalization (for other than serious sedative dependence) is considered unnecessary in most cases when there are no concurrent medical or severe psychiatric problems (Gerstein and Harwood, 1990). Providers must take into account some additional considerations when designing treatment plans for outpatients:

- Patients may have ready access to AODs at home.
- Patients may continue to use alcohol in addition to the prescribed detoxification medications. If they

develop withdrawal symptoms, they may self-medicate with AODs. The combination of detoxification medications and other drugs may result in an overdose.

- Patients may have difficulty getting from their homes to their programs each day.
- Patients who are undergoing detoxification may experience side effects of withdrawal or breakthrough withdrawal.

Patients may continue to use alcohol in addition to the prescribed detoxification medications. If they develop withdrawal symptoms, they may self-medicate with AODs.

Medical Complications of Alcohol Withdrawal

Fluid and Electrolyte Imbalances

Maintaining the patient's fluid and electrolyte balance is of key importance during detoxification. Most patients can be given fluids orally, beginning with juices and progressing to other liquids, such as soups. Solid foods should be added to the patient's diet only after he or she can tolerate liquids. Patients who are vomiting or having severe diarrhea should first be treated with sips of liquids that contain electrolytes. The amount can be increased to patient tolerance. Patients who become dehydrated should receive intravenous fluids containing electrolytes, dextrose, and thiamine (100 mg/bottle).

Patients withdrawing from alcohol are not always dehydrated; in fact, many are overhydrated. Parenteral fluid therapy may be harmful in these cases. During detoxification from alcohol, patients generally tolerate a mild degree of dehydration better than they do overhydration.

Hypoglycemia

Hypoglycemia is a significant danger during detoxification. Oral fluids should contain carbohydrates; orange juice may be one option. Parenteral fluids should contain 5 percent dextrose.

Fever

Any elevation of temperature in an individual who is undergoing withdrawal should be investigated. If the elevated temperature is a result of withdrawal, there is a need for additional medication and reevaluation of the detoxification schedule. If a patient has no other

signs or symptoms of withdrawal, the elevated temperature is probably caused by an infection, and early aggressive antibiotic therapy may be necessary.

Psychiatric Comorbidity

While medical concerns must be addressed first via detoxification, any underlying psychiatric disorders must be dealt with as well. Failure to do so increases the risk of relapse. How to evaluate psychiatric conditions depends on the drug of abuse and the clinical situation. Because it is often difficult to differentiate between the symptoms of AOD abuse and those of various psychiatric conditions that may exist, it is preferable to do a thorough psychiatric work-up after a patient has withdrawn from the drug of abuse. This may not always be possible.

Suicidal patients can be detoxified, but they should be placed in an acute inpatient psychiatric setting rather than in an outpatient detoxification setting. These patients require close supervision by medical staff who understand both psychiatric and detoxification issues. The individual who takes the patient's history should include questions about suicidal feelings and previous suicide attempts.

More information on psychiatric comorbidity is included in the chapter on special populations (Chapter 4). Another Treatment Improvement Protocol (TIP) in this series, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*, provides practical information about the treatment of patients who have dual disorders.

Suicidal patients can be detoxified, but they should be placed in an acute inpatient psychiatric setting rather than in an outpatient detoxification setting.

Drug Interactions

Certain drugs of abuse and certain medications used in detoxification may interact with others. Thus, it is important to be aware of any other medications that the patient is taking and to consider potential drug interactions. Some examples of dangerous combinations include hypertensive medication and clonidine, phenytoin (Dilantin) and methadone, and rifampin and methadone.

Patient Comfort and Care

Supportive and hygienic care must be provided. Staff should provide whatever assistance is necessary to

help the patient get cleaned up as much as possible immediately after entering the facility and bathed thoroughly as soon as he or she has been medically stabilized. Dental and oral care should be made available. The staff should carefully assess the patient for trauma, including bruises and lacerations. Because of their decreased level of consciousness, severe alcoholics may not be aware of head injuries, lacerations, and the like. Staff should continue to observe patients for head injuries after admission, because some injuries, such as subdural hematomas, may not be immediately evident.

Withdrawal from Opiates

All opiates—heroin, morphine, hydromorphone (Dilaudid), codeine, and methadone—produce similar withdrawal signs and symptoms. However, the time of onset and the duration of the abstinence syndrome vary. The severity of the withdrawal syndrome depends on many factors, including the drug used, the total daily dose, the interval between doses, the duration of use, and the health and personality of the addict. The common signs and symptoms of opiate withdrawal are summarized in Exhibit 3-2.

Symptoms of withdrawal from opiates may be divided into four classes: 1) gastrointestinal distress, including diarrhea and, less frequently, nausea or vomiting; 2) pain, typically either arthralgias or myalgias or abdominal cramping; 3) anxiety; and 4) insomnia.

Opiate Abstinence Syndromes

Signs and symptoms of withdrawal from heroin or morphine begin 8 to 12 hours following the patient's last dose. They subside over a period of 5 to 7 days.

Signs and symptoms of withdrawal from methadone begin 12 hours after the patient's last dose. The peak intensity occurs on the third day of abstinence or later. Symptoms gradually subside, but may continue for 3 weeks or longer. Methadone abstinence syndrome develops more slowly and is more prolonged but usually less intense than other opiate abstinence syndromes.

In July 1993, the FDA approved levo-alpha-acetylmethadol (LAAM) for use as a maintenance medication. It is a Schedule II controlled substance, which categorizes it as a medication with medical uses but also with a high potential for abuse. Few studies have addressed the medically supervised withdrawal of LAAM patients to a drug-free state. Withdrawal from LAAM produces similar symptoms to those produced by withdrawal from methadone.

Medication Treatment for Opiate Withdrawal

Clonidine

Clonidine (Catapres), a medication marketed for the treatment of hypertension, has been used for treatment of the symptoms of opiate withdrawal since 1978 (Gold et al., 1978). Although clonidine has not yet

Exhibit 3-2
Signs and Symptoms of Opiate Abstinence

EARLY

Anxiety
Increased respiratory rate
Sweating
Lacrimation (tearing or crying)
Yawning
Rhinorrhea (runny nose)
Piloerection (goosebumps)
Restlessness
Anorexia
Irritability
Dilated pupils

ADVANCED

Insomnia
Nausea and vomiting
Diarrhea
Weakness
Abdominal cramps
Tachycardia
Hypertension
Muscle spasms
Muscle and bone pain

been approved by the FDA for treatment of opiate withdrawal, its use has become standard clinical practice (Alling, 1992).

Clonidine has some practical advantages over methadone for treating narcotic withdrawal, particularly in drug-free programs (Clark and Longmuir, 1986). These advantages include

- It is not a scheduled medication
- The use of opiates can be discontinued immediately in preparation for naltrexone induction or admission to a drug-free treatment program (for example, a therapeutic community)
- It does not produce opiate euphoria, and patients' need for drugs is therefore reduced.

Although clonidine alleviates some symptoms of opiate withdrawal, it is not effective for muscle aches, insomnia, or drug craving. These symptoms require additional medication.

An appropriate protocol for clonidine is 0.1 mg administered orally as a test dose (0.2 mg for patients weighing more than 200 pounds). If the patient's symptoms are acute, the sublingual route of administration may be used. Clinicians should check the patient's blood pressure after 45 minutes. If diastolic blood pressure is normal for the patient and the patient has no signs of orthostatic hypotension (a drop in systolic blood pressure of 10 mm hg upon standing), the patient may continue clonidine, 0.1 to 0.2 mg orally every 4 to 6 hours. Clonidine is most effective when used for detoxification in an inpatient setting, as side effects can be monitored more closely.

Clonidine transdermal patch. In 1986, a transdermal patch containing clonidine (Catapres-TTS) was approved for use in the United States for the treatment of hypertension. However, addiction specialists quickly grasped its potential for treatment of opiate withdrawal. Although the clonidine patch is commonly used for detoxification, several panelists and reviewers were concerned that the safety of the patch for treatment of opiate withdrawal has not been sufficiently studied in controlled clinical trials. If patients receive too much clonidine from the patch and become hypotensive, the effects are not rapidly reversed even when the patch is removed. Alling (1992) recommends the use of clonidine only if the patient's blood pressure is monitored regularly.

The clonidine patch is a 0.2 mm square that is applied in the same manner as a self-adhesive bandage. It is available in three sizes: 3.5, 7.0, and 10.5 cm². In a 24-hour period, these patches deliver an amount of clonidine equivalent to twice-daily dosing with 0.1, 0.2, or 0.3 mg of oral clonidine, respectively. Once the patch is placed on the epidermal surface, clonidine enters the circulatory system through the

skin. A rate-limiting membrane within the patch governs the maximum amount absorbed. The patch supplies clonidine for up to 7 days. One application of the patch is sufficient.

In a recovery-oriented treatment program, the transdermal patch offers some advantages over oral clonidine. First, it minimizes drug cravings. Nurses in chemical dependency units often interpret patient requests for medications differently than do nurses in a medical or surgical hospital. In a chemical dependency unit, nurses often perceive these requests as drug-seeking behavior, and the result may be a confrontation with the patient about whether or not the medication is needed. For this reason, the use of "as needed" medications should be minimized.

A second advantage of the transdermal patch is that it eliminates disruptions caused by administration of medication. Oral clonidine must be administered several times each day, and chemical dependency counselors often report that groups or counseling sessions are disrupted when patients leave to obtain their medication.

The patch overcomes the problem of missed doses. Asymptomatic patients may forget to go to nurses' stations at scheduled times or miss doses when they are attending outside activities.

The patch also prevents the buildup of withdrawal symptoms during the night. Patients who miss doses of oral clonidine during the night because the nurses are reluctant to wake them sometimes experience opiate withdrawal upon awakening. The patch continues to deliver clonidine throughout the night.

For reasons such as these, staff and patients often prefer the patch over oral clonidine. Patients treated with oral clonidine appear to have more withdrawal symptoms than those treated with transdermal patches. However, controlled studies have not yet confirmed these findings.

Methadone

Methadone can be used for withdrawal from heroin, fentanyl, or any other opiate. For certain patient populations, including those with many treatment failures, methadone is the treatment of choice. Methadone generally is not used with adolescents because FDA regulations prohibit its use with this age group (except in rare exceptions). In this population, there are high risks of addiction and promotion of drug-seeking behavior.

This TIP focuses on the use of methadone for detoxification. For detailed information readers are referred to the TIPs *State Methadone Treatment Guidelines* and *Matching Treatment to Patient Needs in Opioid Substitution Therapy*.

Opiate-dependent inpatients who are being treated for an acute medical illness can be administered methadone for prevention of opiate withdrawal if opiate withdrawal would complicate treatment of their medical conditions. The withdrawal protocols using methadone vary, depending on the setting.

Inpatient drug treatment program licensed for methadone detoxification. A starting dose of 30 to 40 mg per day of oral methadone is adequate to prevent severe withdrawal symptoms in most opiate-dependent patients. The methadone is administered four times daily, beginning with 10 mg doses, and the patient is observed for 2 hours following each dose. If the patient is sleepy, the next dose is decreased to 5 mg. If the patient shows *objective* signs of opiate withdrawal, the dose is increased to 15 mg. After 24 hours, the methadone is withdrawn by 5 mg per day; thus, most patients are withdrawn over 8 days.

Methadone can be administered for detoxification only in a hospital or in an outpatient program that is licensed for methadone detoxification. Opiate-dependent inpatients who are being treated for an acute medical illness can be administered methadone for prevention of opiate withdrawal if opiate withdrawal would complicate treatment of their medical conditions.

Outpatient methadone detoxification clinics. In an outpatient clinic, treatment staff usually administer medication no more than twice a day. Thus 20 mg of methadone, given orally twice daily, is a good starting point. To prevent an unacceptable level of withdrawal symptoms, some outpatients may need up to 60 mg of methadone per day administered in divided doses. After the second day, the methadone is tapered by 2.5 mg per day.

Federal regulations governing methadone detoxification. As of 1989, Federal regulations allow short-term methadone detoxification of 30 days and long-term detoxification of 180 days. As the State methadone licensing agencies develop regulations that parallel the Federal regulations, State-licensed methadone programs can implement long-term methadone detoxification.

Federal regulations allow physicians to administer (but not prescribe) narcotics for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment. Not more than 1 day's medication may be

administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than 3 days and may not be renewed or extended (21 C.F.R. Part 1306.07). Thus, under Drug Enforcement Administration (DEA) guidelines, in States that allow the prescription of narcotics, a physician may administer methadone for 3 days without a special license if the patient is experiencing acute withdrawal symptoms and cannot be immediately referred for treatment. This is considered an emergency situation.

Short-term detoxification. In a short-term detoxification regimen, patients are not allowed to take their methadone home. The initial treatment plan and periodic treatment plan evaluation required for maintenance patients are not necessary; however, the program must assign a primary counselor to monitor a patient's progress toward the goal of short-term detoxification and to provide a drug treatment referral.

A patient is required to wait at least 7 days between concluding a short-term detoxification treatment episode and beginning another. Before a short-term detoxification attempt is repeated, the program physician must document in the patient's record that the patient continues to be or is again physiologically dependent on narcotics. These requirements apply to both inpatient and outpatient short-term detoxification treatment.

Long-term detoxification. Federal methadone treatment guidelines define long-term detoxification treatment as longer than 30 days but not in excess of 180 days. For long-term detoxification, the opioid must be administered by the program physician or by an authorized agent who is supervised by and under the orders of the physician. The drug must be administered on a regimen designed to help the patient reach a drug-free state and to make progress in rehabilitation in 180 days or fewer. The following conditions apply:

- During detoxification, the patient must be under observation while ingesting the methadone for at least 6 days a week.
- Before long-term detoxification can begin, the program physician must document in the patient's record that short-term detoxification is not a sufficiently long enough treatment course to provide the patient with the additional program services that will be necessary for the patient's rehabilitation.
- An initial drug screen is required for each patient. At least one additional random urine test or analysis must be performed monthly.
- An initial treatment plan and monthly treatment plan evaluation are required.

- A patient is required to wait at least 7 days after concluding a long-term treatment episode before beginning another. Before a long-term detoxification attempt is repeated, the program physician must document in the patient's record that the patient continues to be or is again physiologically dependent on narcotic drugs.

These requirements apply to both inpatient and ambulatory long-term detoxification treatment.

In a critical study published in 1977, Senay et al. suggested that "a slow rate of withdrawal, extending 6 or more months, may result in a greater percentage of patients reaching abstinence and maintaining a drug-free status." However, the 180-day detoxification protocol has not received adequate study. More research is needed to compare its effectiveness with that of shorter regimens. Also, the issue of appropriate dosage is still under investigation. A randomized, double-blind clinical trial comparing the effect of 80 mg to 40 mg doses of methadone in patients enrolled in a 180-day program did not show statistically significant differences in retention between the two dosage levels (Banys et al., 1994).

LAAM

As mentioned previously, in July, 1993 the FDA approved LAAM for use as a *maintenance* medication. The trade name of LAAM is ORLAAM. A detailed discussion of the use of LAAM is presented in the TIP entitled *LAAM in the Treatment of Opiate Addiction*.

Until August, 1993, LAAM was a Schedule I controlled substance, which is defined as a drug with a high abuse potential but with no recognized medical use. In August, 1993 the DEA reclassified it as a Schedule II controlled substance, defined as a medication with medical uses as well as a high potential for abuse (21 C.F.R. Part 1308).

FDA methadone regulations have been revised (58 *Fed. Reg.* 38706 Part July 20, 1993) to allow use of LAAM (21 C.F.R. Part 291). The regulations for LAAM are similar to those for methadone, with two exceptions: take-home doses of LAAM are not allowed, and LAAM cannot be administered to pregnant women. Patients who need take-home doses must be switched to methadone. Like methadone, LAAM may be dispensed only by licensed AOD abuse treatment clinics (21 C.F.R. §291.505).

LAAM is a prodrug with little opiate activity. This means that its opiate effects are produced by its long-acting metabolites, nor-LAAM and dinor-LAAM. Since LAAM itself is not a potent opiate, oral ingestion or intravenous injection of LAAM does not produce rapid onset of opiate effects as does the ingestion of methadone, heroin, morphine, and most other opiates.

Take-home doses of LAAM are not allowed, and LAAM cannot be administered to pregnant women. Patients who need take-home doses must be switched to methadone. Like methadone, LAAM may be dispensed only by licensed treatment clinics.

Discontinuation from LAAM maintenance. The metabolites of LAAM are long-acting, and gradual discontinuation of LAAM will result in a slow decline in the plasma levels of nor-LAAM and dinor-LAAM and in the emergence of opiate withdrawal symptoms. Maintenance treatment with LAAM produces significant levels of dependence of the opiate type; therefore, discontinuation of LAAM requires management of opiate withdrawal. Few studies have addressed the medically supervised withdrawal of LAAM patients to a drug-free state. However, no evidence exists to suggest that withdrawal from LAAM is different than withdrawal from methadone or any other opioid. Because LAAM is longer acting than methadone, withdrawal will have a delayed onset and protracted course, although it may be less intense than withdrawal from methadone. Patients, however, tend to perceive a longer period as being "worse," whether the actual intensity of symptoms is greater or not. Special counseling may be needed to address this aspect of withdrawal from LAAM.

The LAAM dose can be reduced gradually at a rate determined by the patient's response. As an alternative, patients who want to withdraw from LAAM treatment can be converted to methadone (at 80 percent of their LAAM dose) with minimal difficulty (Ling et al., 1980). The key consideration may be the patient's support system; take-home methadone entails fewer clinic visits. Although patients can visit the clinic on nondose days for support services only, they are less likely to do so without the incentive of receiving medication. Another option is the use of clonidine in the dosage regimen described previously for treatment of heroin withdrawal, to assist in discontinuing use of LAAM. When involuntary withdrawal from medication is unavoidable, patients should switch to methadone before withdrawal begins.

Heroin Detoxification with LAAM. Although there is substantial medical literature reporting clinical trials with LAAM in treatment of heroin withdrawal, the FDA has not approved LAAM for use in heroin detoxification. It should, therefore, be used for heroin detoxification only under an Investigational New Drug

(IND) exemption. Because LAAM takes from 8 to 12 hours to produce significant opiate effects, it is not a good choice for treatment of acute heroin withdrawal symptoms. Addicts may become impatient while waiting for LAAM to relieve their opiate withdrawal symptoms and may self-medicate their withdrawal symptoms with heroin. As the opiate effects of LAAM develop, the combined effects of heroin and LAAM may result in a life-threatening overdose. Treatment providers may prefer to begin heroin detoxification by stabilizing the patient on methadone, then switch to LAAM for gradual discontinuation over 21 to 180 days. LAAM's long duration of effect makes it a logical option for this process. Additional research to determine how to optimally use LAAM for detoxification is necessary.

Although there is substantial medical literature reporting clinical trials with LAAM in the treatment of heroin withdrawal, the FDA has not approved LAAM for use in heroin detoxification.

Buprenorphine

The FDA has approved buprenorphine for the treatment of pain, and it is being investigated as a treatment for opiate dependence and detoxification. Buprenorphine is a potent analgesic that is available by prescription as a sublingual tablet in many parts of the world. In the United States, it is available by prescription as an analgesic in an injectable form (Buprenex). The doses of buprenorphine under investigation for maintenance treatment are considerably higher than those commonly prescribed for treatment of pain.

Buprenorphine has an unusual pharmacological profile that makes it attractive for the treatment of opiate dependence, and its potential was recognized as early as 1978 (Jasinski et al., 1978). The level of physical dependence produced by buprenorphine is not as great as that produced by methadone or heroin; therefore, most patients find buprenorphine easier to discontinue than methadone. Some patients can eventually be switched from buprenorphine maintenance to treatment with an opiate antagonist such as naltrexone.

Buprenorphine is safer than methadone or LAAM if an overdose is ingested. Its opiate effects appear to plateau at 16 mg (Walsh et al., 1994). Although it is used intravenously by heroin addicts in countries where the sublingual tablet is legally available as an analgesic (San et al., 1992), its abuse potential appears

to be substantially less than that of methadone or heroin. And though it is currently an experimental drug with regard to its use in detoxification, buprenorphine may soon be approved by the FDA.

Discontinuation from buprenorphine maintenance. Buprenorphine produces physical dependence of the opiate type. The dosages of patients who have been maintained on buprenorphine for treatment of opiate dependence or chronic pain must be tapered. The onset of withdrawal symptoms is generally delayed for at least 24 hours, and peak intensity of withdrawal symptoms may not occur for 5 days or more. The intensity of withdrawal symptoms is generally less than that following methadone discontinuation. Buprenorphine can be discontinued by tapering the dosage to zero over 7 to 21 days. Symptoms also may be ameliorated with clonidine, particularly toward the end of the taper (Pickworth et al., 1993).

Buprenorphine for heroin detoxification.

Buprenorphine has been used successfully to detoxify heroin addicts in a number of clinical trials (Bickel et al., 1988) and to assist with methadone discontinuation (Banys et al., 1994).

In 1985, buprenorphine was classified as a Schedule V narcotic, 21 C.F.R. §1308.15(b). A narcotic is defined by the Controlled Substance Act of 1984 as a class of drugs containing opiates and cocaine, 21 U.S.C. §802(17). The narcotic classification is important because Federal law permits prescription of a narcotic to narcotic addicts only in specially licensed treatment programs (21 C.F.R. §291.505). The sole exception is that when a patient is admitted to a hospital for treatment of an acute medical condition (not solely addiction to drugs) he or she may be administered narcotics to prevent opiate withdrawal.

Because buprenorphine has already been approved by the FDA for treatment of pain, physicians could use it in clinical practice, even for unapproved indications, if it were not classified as a narcotic. Until buprenorphine receives FDA approval for treatment of opiate dependence, it should be prescribed for opiate dependence only under an FDA-approved IND exemption. Physicians may be prosecuted for prescribing, dispensing, or administering buprenorphine for treatment of opiate dependence or withdrawal. State medical licensing boards also may discipline physicians for prescribing buprenorphine for treatment of opiate dependence, absent an IND.

Under investigation. Sublingual tablets containing naloxone and buprenorphine are under investigation for use as treatments for opiate dependency. Since the opiate antagonist naloxone would block the immediate effect of buprenorphine, the combination would be

less subject to abuse than buprenorphine alone. If patients dissolve the sublingual tablets, mix them with naloxone, and inject them, they would get no immediate opiate effects. Some buprenorphine opiate effects would eventually occur, however, because naloxone is more rapidly metabolized than buprenorphine. If a dosage form can be developed that minimizes the potential for diversion, buprenorphine could become the first opiate maintenance medication that could be prescribed as part of general medical practice.

Because buprenorphine has already been approved by the FDA for treatment of pain, physicians could use it in clinical practice, even for unapproved indications, if it were not classified as a narcotic.

Dextropropoxyphene

In the 1970s, dextropropoxyphene (Darvon) was among the medications used for opiate withdrawal. Because of abuse of dextropropoxyphene by addicts, the DEA reclassified it as a Schedule IV, narcotic, 21 C.F.R. Part 1308 (1980). The narcotic classification prohibits its use for treatment of opiate dependency in routine clinical practice.

Terminating Opiate Maintenance Treatment

Patients on opiate maintenance are sometimes discontinued from medication for disciplinary reasons. This situation is often awkward for both the program and the patient, particularly if the patient is abusive, threatening, and/or potentially violent.

Involuntary Termination of Opiate Maintenance

The program manager should develop and post prominently on the program premises at least one copy of a written policy covering criteria for involuntary termination from treatment. This policy should describe patients' rights and responsibilities as well as those of program staff. At the time a patient enters treatment, a staff member designated by the program director should inform the patient about the policy and where it is posted. The staff person should inform patients of the conditions under which they might be involuntarily terminated from treatment and of their rights under the termination procedure.

The medication discontinuation should not occur so rapidly that the patient experiences severe opiate withdrawal symptoms. Treatment staff should taper the methadone dosage until the patient is receiving 30 to 40 mg a day. At this point, treatment with clonidine and other medications may begin.

Voluntary Termination of Opiate Maintenance

Patients in methadone treatment, like others who are receiving daily medication on a long-term basis, should be evaluated periodically regarding the risks and benefits of their therapy. For some persons, eventual withdrawal from methadone maintenance is a realistic goal.

Research and clinical experience have not yet identified all the critical variables that determine when a patient can be withdrawn from methadone and remain drug-free. A decision to withdraw voluntarily from methadone maintenance must, therefore, be left to the patient and to the clinical judgment of the physician. Staff should encourage the patient to remain in the program for as long as necessary.

Patient Care and Comfort

Patient care guidelines are similar to those for patients withdrawing from alcohol. Patient comfort is a primary consideration during detoxification, regardless of the detoxification agent. Medications recommended for symptomatic relief of opiate withdrawal are summarized in Exhibit 3-3.

A complete physical examination should be conducted. The patient should be checked for tuberculosis; symptoms of acquired immunodeficiency syndrome and opportunistic infections; hepatitis A, B, and C; and sexually transmitted diseases. Patients should be monitored for anxiety, sweating, chills, nutritional intake, diarrhea and gastrointestinal distress, sleep dysfunction, muscle cramps, aches, and bowel function.

Skin care is also important. Guidelines should be in place for management of conditions such as skin and subcutaneous abscesses due to needle use.

A few patients may remain in bed for several hours or for as long as a day during detoxification; however, most do not need to do so. Opiate addicts generally have less cognitive impairment than do alcoholics. During detoxification, they may view videotapes and participate in group activities.

If the patient might be pregnant, appropriate testing is essential. It is important to evaluate the safety of withdrawing a pregnant woman from opiates

Exhibit 3-3

**Medications Recommended for Symptomatic Relief
of Opiate Withdrawal***

Headache: Acetaminophen (Tylenol), 650 mg every 4 hours if needed

Muscle, Joint, or Bone Pain: Ibuprofen (Motrin, Advil), 600–800 mg every 6–8 hours

Anxiety or Insomnia: Hydroxyzine (Vistaril), 25–50 mg every 8 hours

Abdominal Cramps: Dicyclomine (Bentil), 10 mg every 6 hours

Constipation: Milk of Magnesia, 30 cc daily every other day

Indigestion: Antacid (for example, Mylanta), 30 cc between meals and at bedtime

Loose Stool: Bismuth subcarbonate (Pepto-Bismol), 30 cc after each loose stool up to 8 doses total, for no more than 2 days

*All doses are administered orally.

because of the potential effects on the fetus. Often it is best to put the pregnant patient on methadone maintenance. More on the treatment of pregnant women is found in Chapter 4, Special Populations. Other TIPs in this series, *State Methadone Treatment Guidelines*; *Pregnant, Substance-Using Women*; and *LAAM in the Treatment of Opiate Addiction* include information on issues specific to pregnant women.

Alternatives to Medication Acupuncture

While some clinicians consider acupuncture an acceptable primary detoxification treatment for opiate abusers, there are few controlled studies that support this. Acupuncture can be a useful treatment adjunct to methadone or clonidine detoxification. One study found that "Increased use of acupuncture therapy not only may be an effective adjunct to therapy in current programs for patients with persistent craving for alcohol, but also may allow treatment to be extended to a large group of recidivist alcoholics for whom current therapies are not effective" (Bullock et al., 1989).

Auricular (ear) acupuncture has been used in treatment of opiate withdrawal since 1972, and it is done in clinics throughout the world. "The use of auricular acupuncture in treating acute drug withdrawal began in Hong Kong in 1972. It was used sporadically throughout the United States during the 1970s, and some experimentation with acupuncture was conducted at the Haight Asbury Free Clinic in

San Francisco (Seymour and Smith, 1987). But it has been at Lincoln Hospital in New York, under the guidance of Michael O. Smith, M.D., director of the hospital's division of substance abuse, that the protocol has been refined and expanded and has taken its firmer root" (Brumbaugh, 1993). It is difficult to conduct rigorous double-blind controlled studies with acupuncture because the acupuncturist must insert the needles into very precise locations.

One study (Washburn et al., 1993) compared standard acupuncture with "sham" acupuncture (needles were inserted into points geographically close to standard points). Dropout rates were high in both groups; however, more subjects were retained in the standard than in the "sham" group. Subjects in the standard group also attended the clinic more frequently. According to Washburn et al. (1993),

Of significance was the finding that lighter users attended the acupuncture clinic more days and over a longer period of time than those with heavier habits. Subjects who injected heroin at least three times a day apparently found that acupuncture did not help relieve withdrawal symptoms or reduce craving and, thus, terminated treatment early. That this was true for subjects in both the standard and sham groups suggests that the heroin users may have had little expectation that a drug-free treatment modality would help them. . . . indeed, we found that individuals who injected heroin at least three times a day were less likely to volunteer to participate in the study than were the lighter users. . . . Some of the clients

receiving treatment beyond the detoxification episode were using acupuncture as an adjunct to methadone detoxification and maintenance; others seemed to seek additional treatment to detoxify after relapse to heroin use.

Until controlled clinical data indicate otherwise, acupuncture must be viewed as an adjunctive treatment to detoxification.

One study (Washburn et al., 1993) compared standard acupuncture with "sham" acupuncture. Dropout rates were high in both groups; however, more subjects were retained in the standard than in the "sham" group.

Electrostimulation

Although some studies have shown that neuroelectric therapy (NET) reduces the chronic withdrawal period for some opiate abusers (Patterson, 1983), a recent study found that NET is no more effective than use of a placebo in opiate and cocaine detoxification (Gariti et al., 1992). NET is therefore not recommended.

Withdrawal From Benzodiazepines and Other Sedative-Hypnotics

For therapeutic use, barbiturates and the older sedative-hypnotics have been largely replaced by the benzodiazepines. The withdrawal syndromes from benzodiazepines and other sedative-hypnotics are similar, and the pharmacotherapy treatment strategies apply to both. This section focuses on the benzodiazepines and adds information about treatment of other types of sedative-hypnotic dependence when appropriate (Alling, 1992).

Dependence on benzodiazepines and other sedative-hypnotics usually develops in the context of medical treatment. Benzodiazepines have many therapeutic uses: As therapy for some conditions, such as panic disorder, long-term treatment is appropriate medical practice. Physical dependency is sometimes unavoidable. Benzodiazepine dependency that develops during pharmacotherapy is not necessarily a substance use disorder (Alling, 1992). When the dependency results from patients taking the prescribed doses as directed by a physician, the term "therapeutic discontinuation" is preferable to the term "detoxification."

Abusers of heroin and stimulants often misuse benzodiazepines and other sedative-hypnotics, sometimes to the extent that they develop a physical dependence. In such cases, it is appropriate to think of withdrawal from the sedative-hypnotic as detoxification.

Use of either benzodiazepines or sedative-hypnotics at doses above the therapeutic range for a month or more produces physical dependence. Without appropriate medical treatment, withdrawal from benzodiazepines or other sedative-hypnotics can be severe and life threatening. Withdrawal from benzodiazepines or other sedative hypnotics produces a similar withdrawal syndrome, described below under high-dose sedative-hypnotic withdrawal.

Some people will develop withdrawal symptoms after stopping therapeutic doses of benzodiazepines or other sedative-hypnotics after they have been used daily for 6 months or more. With "low-dose" withdrawal, the benzodiazepines and other sedative-hypnotics can produce qualitatively different withdrawal syndromes. These are described as high-dose sedative-hypnotic withdrawal syndrome and low-dose benzodiazepine withdrawal syndrome.

High-Dose Sedative-Hypnotic Withdrawal Syndrome

Signs and symptoms of high-dose sedative-hypnotic withdrawal include anxiety, tremors, nightmares, insomnia, anorexia, nausea, vomiting, orthostatic hypotension, seizures, delirium, and hyperpyrexia. The syndrome is qualitatively similar for all sedative-hypnotics; however, the time course of symptoms depends upon the particular drug. With short-acting sedative-hypnotics (for example, pentobarbital [Nembutal], secobarbital [Seconal], meprobamate [Miltown, Equanil], and methaqualone) and short-acting benzodiazepines (for example, oxazepam [Serax], alprazolam [Xanax], and triazolam [Halcion]), withdrawal symptoms typically begin 12 to 24 hours after the last dose and reach peak intensity between 24 and 72 hours after the last dose. Patients who have liver disease or who are elderly may develop symptoms more slowly because of decreased drug metabolism. With long-acting drugs (for example, phenobarbital, diazepam [Valium], and chlordiazepoxide [Librium]), withdrawal symptoms peak on the fifth to eighth day after the last dose.

The withdrawal delirium may include confusion and visual and auditory hallucinations. The delirium generally follows a period of insomnia. Some patients may have only delirium, others only seizures; some may have both.

Low-Dose Benzodiazepine Withdrawal Syndrome

In the literature of addiction medicine, low-dose benzodiazepine withdrawal syndrome may be referred to as "therapeutic-dose withdrawal," "normal-dose withdrawal," or "benzodiazepine-discontinuation syndrome." Knowledge about low-dose dependency is based on clinical observations and is still sketchy and controversial. As a practical matter, often it is impossible to know with certainty whether symptoms are caused by withdrawal or whether they mark a return of symptoms that were ameliorated by the benzodiazepine. Patients who are treated with benzodiazepines may have had symptoms such as anxiety, insomnia, or muscle tension before taking the benzodiazepine. When they stop taking the benzodiazepine, these symptoms may reappear.

Some people who have taken benzodiazepines in therapeutic doses for months to years can abruptly discontinue the drug without developing symptoms. Others, taking similar amounts of a benzodiazepine, develop symptoms ranging from mild to severe when the benzodiazepine is stopped or the dosage is substantially reduced.

The risk factors associated with withdrawal are not completely understood. Patients who develop the severe form of low-dose benzodiazepine withdrawal syndrome include those with a family or personal history of alcoholism, those who use alcohol daily, or those who concomitantly use other sedatives. According to one study, "higher doses of benzodiazepine lead to increases of withdrawal severity." This study found that the short-acting, high-potency benzodiazepines appear to produce a more intense low-dose withdrawal syndrome than the long-acting, low-potency ones (Rickels et al., 1990).

During the 1980s, many clinical studies and case reports were published concerning withdrawals that were attributed to therapeutic dose discontinuation. Most patients experienced only a transient increase in symptoms for 1 to 2 weeks after termination of the benzodiazepine. This transient increase in symptoms is known as "symptom rebound" and is defined as an intensified return of the symptoms (for example, insomnia or anxiety) for which the benzodiazepine was prescribed. According to the American Psychiatric Association (APA) (1990), "The most immediate discontinuance symptoms tend to be a rebound worsening of the original symptoms. A more severe withdrawal syndrome consists of the appearance of new symptoms, including perceptual hyperacusis, psychosis, cerebellar dysfunction, and seizures." Original symptoms may reappear when the

therapeutic medication is withdrawn, and it may be difficult to distinguish recurrence of original symptoms from rebound.

Most patients experienced only a transient increase in symptoms for 1 to 2 weeks after termination of the benzodiazepine. This transient increase is called "symptom rebound."

Because of psychiatrists' concerns about benzodiazepine dependency, the APA formed a task force to review these issues. The task force's conclusions (American Psychiatric Association, 1990) were unambiguous about therapeutic dose dependency:

Physiological dependence on benzodiazepines, as indicated by the appearance of discontinuance symptoms, can develop with therapeutic doses. Duration of treatment determines the onset of dependence when typical therapeutic anxiolytic doses are used: clinically significant dependence indicated by the appearance of discontinuance symptoms usually does not appear before four months of such daily dosing. Dependence may develop sooner when higher anti-panic doses are taken daily.

Protracted Withdrawal, Severe Form

A few patients experience a severe, long-lasting withdrawal syndrome, which includes symptoms such as paresthesia and psychoses, never experienced before the benzodiazepines were taken. It is this condition, which may be quite disabling and may last many months, that has generated much of the concern about the long-term safety of the benzodiazepines. However, many psychiatrists believe that the symptoms that occur after discontinuation of therapeutic doses of benzodiazepines are not a withdrawal syndrome but a reemergence or unmasking of the patient's psychopathology.

Protracted Withdrawal, Mild Form

One additional form of withdrawal is sometimes attributed to the benzodiazepines and other sedative-hypnotics as well as to alcohol and opiates. This is a mild form of protracted withdrawal. Its symptoms include irritability, anxiety, insomnia, and mood instability. The symptoms may persist for months following the beginning of abstinence (Geller, 1991).

Medication Treatment for Benzodiazepine Withdrawal

The physician's response during benzodiazepine withdrawal is critical to a successful outcome. Some physicians interpret patients' escalating symptoms as evidence of their need for additional benzodiazepine treatment. Consequently, they prescribe a benzodiazepine, often at higher doses, or switch the patient to another benzodiazepine. Reinstitution of any benzodiazepine agonist may not achieve satisfactory symptom control and may in fact prolong the recovery process.

Another common response is to declare patients addicted to benzodiazepines and refer them to primary chemical dependency treatment. Such a referral is not appropriate unless the patient has a substance use disorder.

Reinstitution of any benzodiazepine agonist may not achieve satisfactory symptom control and may in fact prolong the recovery process.

Treatment of High-Dose Benzodiazepine Withdrawal

Selection of the withdrawal medication. Abrupt discontinuation of a sedative-hypnotic in patients who are severely physically dependent on it can result in serious medical complications and even death. For this reason, medical management is always needed, and treatment is best provided in a hospital. There are three general medication strategies for withdrawing patients from sedative-hypnotics, including benzodiazepines: (1) the use of decreasing doses of the agent of dependence; (2) the substitution of phenobarbital or another long-acting barbiturate for the addicting agent and the gradual withdrawal of the substitute medication (Smith and Wesson 1970, 1971, 1983, and 1985); and (3) the substitution of a long-acting benzodiazepine, such as chlorthalidoxepoxide (Librium), which is tapered over 1 to 2 weeks. The method selected depends on the particular benzodiazepine, the involvement of other drugs of dependence, and the clinical setting in which detoxification takes place.

- **Gradual reduction of the agent of dependency.** This is an appropriate strategy for managing patients who (1) are taking long-acting medications such as chlorthalidoxepoxide (Librium) or diazepam (Valium); (2) can be expected to give accurate accounts of their use of medication; and

(3) are not concurrently abusing alcohol or other drugs (Alling, 1992).

- **Phenobarbital substitution.** The phenobarbital method is the most generally applicable. The pharmacologic rationale for phenobarbital substitution is that this agent is long-acting and produces little change in blood levels between doses. This allows the safe use of a progressively smaller daily dose. Phenobarbital is safer than the shorter-acting barbiturates; lethal doses of phenobarbital are many times higher than toxic doses, and the signs of toxicity (for example, sustained nystagmus, slurred speech, and ataxia) are easily observable. Finally, phenobarbital intoxication usually does not produce disinhibition; consequently, most patients view it as a medication, not as a drug of abuse.

Discontinuation of the benzodiazepine of dependence occurs primarily in medical settings. The patient must be cooperative, be able to adhere to dosing regimens, and not be abusing AODs.

Stabilization. Substituting phenobarbital is the best choice for patients who have lost control of their benzodiazepine use or who are polydrug dependent. Phenobarbital substitution has the broadest use for all sedative-hypnotic drug dependencies and is widely used in drug treatment programs. For that reason, this approach will be described in detail. The patient's history of drug use during the month before treatment is used to compute the stabilization dose of phenobarbital. Although many patients exaggerate the number of pills they are taking, the patient's history is the best guide to initiating pharmacotherapy for withdrawal. Patients who have overstated the amount of drug they have taken will become intoxicated during the first day or two of treatment. The treatment provider can easily manage intoxication by omitting one or more doses of phenobarbital and recalculating the daily dose.

The patient's average daily sedative-hypnotic dose is converted to phenobarbital equivalents, and the daily amount is divided into three doses. (See Exhibits 3-4 and 3-5 for a list of benzodiazepines and other sedative hypnotics and their phenobarbital withdrawal equivalents.) The computed phenobarbital equivalence dosage is given in three or four doses daily. If the patient is using significant amounts of other sedative-hypnotics, including alcohol, the amounts of all the drugs are converted to phenobarbital equivalents and added. (For example, 30 cc of 100-proof alcohol are equated to 30 mg of phenobarbital for withdrawal purposes.) Before receiving each dose of phenobarbital, the patient is checked for signs of phenobarbital toxicity (sustained

Exhibit 3-4
Benzodiazepines and Their Phenobarbital Withdrawal Equivalents

GENERIC NAME	TRADE NAME	THERAPEUTIC DOSE RANGE (MG/DAY)	DOSE EQUAL TO 30 MG OF PHENOBARBITAL FOR WITHDRAWAL (MG)**	PHENOBARBITAL CONVERSION CONSTANT
Benzodiazepines				
alprazolam	Xanax	0.75-6	1	30
chlordiazepoxide	Librium	15-100	25	1.2
clonazepam	Klonopin	0.5-4	2	15
clorazepate	Tranxene	15-60	7.5	4
diazepam	Valium	4-40	10	3
estazolam	ProSom	1-2	1	30
flumazenil	Mazicon	***	***	***
flurazepam	Dalmane	15-30*	15	2
halazepam	Paxipam	60-160	40	0.75
lorazepam	Ativan	1-16	2	15
midazolam	Versed	***	***	***
oxazepam	Serax	10-120	10	3
prazepam	Centrax	20-60	10	3
quazepam	Doral	15*	15	2
temazepam	Restoril	15-30*	15	2
triazolam	Halcion	0.125-0.50*	0.25	120

* Usual hypnotic dose

** Phenobarbital withdrawal conversion equivalence is not the same as therapeutic dose equivalency. Withdrawal equivalence is the amount of the drug that 30 mg of phenobarbital will substitute for and prevent serious high-dose withdrawal signs and symptoms.

*** Not applicable

Information in this exhibit is drawn from two sources, the American Psychiatric Association and the work of Donald R. Wesson, et al. Portions of the exhibit are reprinted with permission from the *American Psychiatric Press Textbook of Substance Abuse Treatment*, Washington, D.C. 1990.

Exhibit 3-5

Other Sedative-Hypnotics and Their Phenobarbital Withdrawal Equivalents

GENERIC NAME	NAME(S)	COMMON THERAPEUTIC INDICATION	DOSE EQUAL TO 30 MG OF THERAPEUTIC DOSE RANGE (MG/DAY)	PHENOBARBITAL FOR WITHDRAWAL (MG)**	CONVERSION CONSTANTS
Barbiturates					
amobarbital	Amytal	sedative	50-150	100	0.33
butabarbital	Butisol	sedative	45-120	100	0.33
butalbital	Fiorinal, Sedapap	sedative/ analgesic*	100-300	100	0.33
pentobarbital	Nembutal	hypnotic	50-100	100	0.33
secobarbital	Seconal	hypnotic	50-100	100	0.33
Others					
buspirone	Buspar	sedative	15-60	***	***
chloral hydrate	Noctec, Somnos	hypnotic	250-1000	500	0.06
ethchlorvynol	Placidyl	hypnotic	500-1000	500	0.06
glutethimide	Doriden	hypnotic	250-500	250	0.12
meprobamate	Miltown, Equanil, Equagesic	sedative	1200-1600	1200	0.025
methyprylon	Noludar	hypnotic	200-400	200	0.15

* Butalbital is usually available in combination with opiate or non-opiate analgesics.

** Phenobarbital withdrawal conversion equivalence is not the same as therapeutic dose equivalency. Withdrawal equivalence is the amount of the drug that 30 mg of phenobarbital will substitute for and prevent serious high-dose withdrawal signs and symptoms.

*** Not cross-tolerant with barbiturates.

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nystagmus, slurred speech, or ataxia). Of these, sustained nystagmus is the most reliable. If nystagmus is present, the scheduled dose of phenobarbital is withheld. If all three signs are present, the next two doses of phenobarbital are withheld, and the daily dosage of phenobarbital for the following day is reduced by half.

If the patient is in acute withdrawal and has had or is in danger of having withdrawal seizures, the initial dose of phenobarbital is administered by intramuscular injection. If nystagmus and other signs of intoxication develop 1 to 2 hours following the intramuscular dosage, the patient is in no immediate danger from barbiturate withdrawal. Patients are maintained on the initial dosing schedule of phenobarbital for 2 days. If the patient displays neither signs of withdrawal nor of phenobarbital toxicity (slurred speech, nystagmus, unsteady gait), phenobarbital withdrawal is begun.

The patient's average daily sedative-hypnotic dose is converted to phenobarbital equivalents, and the daily amount is divided into three doses. The computed phenobarbital equivalent dosage is given in three or four doses daily. If the patient is using significant amounts of other sedative-hypnotics, including alcohol, the amounts of all the drugs are converted to phenobarbital equivalents and added.

Withdrawal. Unless the patient develops signs and symptoms of phenobarbital toxicity or sedative-hypnotic withdrawal, phenobarbital is decreased by 30 mg per day. Should signs of phenobarbital toxicity develop during withdrawal, the daily phenobarbital dose is decreased by 50 percent, and the 30 mg per day withdrawal is continued from the reduced phenobarbital dose. Should the patient have objective signs of sedative-hypnotic withdrawal, the daily dose is increased by 50 percent, and the patient is restabilized before continuing the withdrawal.

Treatment of Low-Dose Benzodiazepine Withdrawal

Clinicians should make decisions regarding the treatment of low-dose withdrawal based on the patient's symptoms. Withdrawal seizures are not usually expected. Patients with an underlying seizure disorder must be maintained on full doses of anticonvulsant medications, and medications that lower seizure threshold should be avoided. Patients

may need much reassurance that the symptoms are transient and that with continued abstinence they will eventually subside.

Patients who have the severe form of withdrawal may need psychiatric hospitalization if symptoms become intolerable. Phenobarbital, in doses of 200 mg per day, generally provides considerable reduction in symptoms. Phenobarbital is slowly tapered over several months.

Withdrawal From Stimulants (Cocaine, Crack Cocaine, Amphetamines, and Methamphetamine)

The two most commonly abused stimulants are cocaine and methamphetamine. Intermittent binge use of both agents is common. The withdrawal symptoms that occur after a 2- to 3-day binge are different than those that occur after chronic, high-dose use. The withdrawal syndromes are similar.

Following a 2- to 3-day binge, stimulant abusers are dysphoric, exhausted, and somnolent for 24 to 48 hours. Because cocaine abusers commonly take alcohol, marijuana, or even heroin with cocaine to reduce the irritability caused by high-dose stimulant abuse, the withdrawal may be in response to the combination of drugs. The patient also may have become dependent on more than one drug.

Following regular use, the withdrawal syndrome consists of dysphoria, irritability, difficulty sleeping, and intense dreaming. Often stimulant abusers experience signs and symptoms of the abuse of multiple drugs. The symptoms subside over 2 to 4 days of drug abstinence.

There is no specific treatment for stimulant withdrawal. Mild sedation with phenobarbital or chloral hydrate for sleep may ameliorate patients' distress.

In the medical literature, descriptions of cocaine withdrawal can be confusing because some authors define cocaine craving as a prominent withdrawal symptom. Scientists are not yet certain that craving is a withdrawal symptom. Cocaine craving usually rapidly diminishes in inpatient cocaine abusers when they are unable to get the drug and no longer come in contact with the environmental stimuli associated with cocaine use.

Although the mechanism of drug craving is not well understood, recent studies have demonstrated that environmental and other stimuli can trigger the physiological process of craving (O'Brien et al., 1991). Therefore, exposure to stimuli (which include other

drugs) must be controlled.

Withdrawal From Other Drugs

Marijuana

There is no acute abstinence syndrome associated with withdrawal from marijuana. Some patients are irritable and have difficulty sleeping for a few days when they discontinue chronic use of marijuana. Persons withdrawing from marijuana, like those withdrawing from cocaine, benefit from a supportive environment during detoxification.

Nicotine

Two issues regarding tobacco smoking merit consideration by staff of AOD detoxification programs. The first is the program management's desire to establish a smoke-free treatment environment to comply with workplace ordinances and to safeguard the health and comfort of patients from exposure to second-hand smoke. The second issue is the patient's dependence on nicotine as a drug of abuse. Both issues are addressed in a theme issue of the *Journal of Substance Abuse Treatment* entitled "Toward a Broader View of Recovery: Integrating Nicotine Addiction and Chemical Dependency Treatments" (Volume 10, Number 2, March/April 1993).

Many programs have implemented smoke-free environments. Some programs treat nicotine as a drug of abuse and require that patients stop smoking as part of their chemical dependency treatment. A growing number of researchers feel that "the acquisition, spread, and even severity of various drug dependencies may be related to prior or current tobacco use patterns" (Henningfield et al., 1990). Most programs provide education about nicotine and encourage patients to quit smoking. Some provide nicotine patches or other medication to manage physiological withdrawal symptoms.

Hallucinogens

Lysergic acid diethylamide (LSD), dimethyltryptamine (DMT), psilocybin, mescaline, 3,4- methylenedioxy-amphetamine (MDA), and 3,4,- methylenedioxy-methamphetamine (MDMA, also called XTC or "ecstasy") do not produce physical dependence.

Treatment professionals have noted a recent resurgence in the use of hallucinogenic drugs such as

LSD, phencyclidine (PCP), and MDMA. These drugs produce no acute withdrawal syndrome.

PCP

Chronic use of PCP can cause a toxic psychosis that takes days or weeks to clear; however, PCP does not have a withdrawal syndrome.

Inhalants/Solvents

Individuals may become physically dependent on hydrocarbons, which include gasoline, glue, and aerosol sprays (including paint, waterproofing material, etc.) and paint thinner. There is clinical evidence that withdrawal from inhalant use is similar to that experienced by persons withdrawing from alcohol. Phenobarbital may be prescribed during detoxification.

Polydrug Use

Addicts rarely use just one drug. Typical combinations and the preferred modes of treatment are shown as follows:

- Alcohol and stimulant: Treat alcohol abuse.
- Alcohol and benzodiazepine: Treat with phenobarbital.
- Cocaine and benzodiazepine: Treat benzodiazepine withdrawal.
- Cocaine and opiate: Treat opiate dependence.
- Cocaine and amphetamine: No detoxification protocol is known.

Opiate-Barbiturate Dependence

Symptoms of withdrawal from opiates and barbiturates have some common features, making it difficult to assess the patient's clinical condition when both drugs are withdrawn at the same time. Many clinicians prefer to gradually withdraw the sedative-hypnotic first, while administering methadone to prevent opiate withdrawal. When the patient is barbiturate-free, the methadone is withdrawn at a level of 5 mg per day. If the sedative-hypnotic was a benzodiazepine (diazepam or chlordiazepoxide), some clinicians prefer to begin with a partial reduction of the sedative-hypnotic. While the patient is still receiving a partial dosage of the sedative, methadone is withdrawn. Finally, the sedative-hypnotic is totally withdrawn.

Chapter 4—Special Populations

Persons in several groups need special consideration during detoxification because of the specific needs they present. Such persons include those who are incarcerated, women, adolescents, the elderly, those who are human immunodeficiency virus (HIV)-positive, or those who have other medical conditions.

Incarcerated Persons

Persons who are incarcerated or detained in holding cells or elsewhere should be assessed for physical dependence on alcohol, sedative-hypnotics, and/or heroin. Untreated withdrawal from alcohol or other sedative-hypnotics can be life threatening. Heroin withdrawal is not life threatening to an individual who is healthy; however, it may be difficult for the patient. Individuals who are on methadone maintenance may experience severe withdrawal symptoms if the medication is abruptly stopped.

Persons who have been on maintenance therapy before being incarcerated should continue to receive their usual dosage of medication if the expected period of incarceration is less than 2 weeks. If incarceration is longer, the maintenance therapy should be gradually discontinued.

The treatment protocols outlined in Chapter 3 are applicable for incarcerated persons who need detoxification. There may, however, be restrictions on the use of methadone or levo-alpha-acetylmethadol in a prison setting. In such cases, staff may need to create linkages with local methadone detoxification programs.

There is an underground market for psychoactive medications, drugs of abuse, or both, in most prisons. Patients may try to deceive staff about their dependence so that they can receive drugs that they then sell to other inmates. They may attempt to convince nurses that they have swallowed their medication when they have not. To ensure appropriate care of inmates, prison medical staff need

special training in patient assessment and detoxification protocols.

Women

Women who enter detoxification will benefit from a comprehensive physical examination, including a gynecological and obstetrical evaluation. Sensitivity to the wishes of the patient regarding examinations and tests is imperative, and the treatment staff must be careful to obtain consent. Unless they are pregnant or nursing, women can usually be treated under the detoxification protocols described in Chapter 3.

Special attention should be given to the detoxification setting. Establishing distance from the environment in which the alcohol and other drug (AOD) abuse has been taking place may be more critical for women than for men.

Pregnant and Nursing Women

Special concerns surround detoxification during pregnancy. The Treatment Improvement Protocol (TIP) entitled *Pregnant, Substance-Using Women* addresses the complex issues involved in treating this population. Conditions that ensure close observation and monitoring of maternal and fetal well-being are explored in depth. The TIP includes guidelines for withdrawal from alcohol, withdrawal from opiates, and the issues related to the use of methadone for stabilization, withdrawal from cocaine, and withdrawal from sedative-hypnotics.

Withdrawal from opiates can result in fetal distress, which can lead to miscarriage or premature labor. Opioid substitution therapy, coupled with good prenatal care, is generally associated with normal deliveries. Although these newborns tend to have a lower birth weight and smaller head circumference than drug-free newborns, no developmental differences at 6 months of age (Zweben and Payte, 1990) have been documented.

Treatment staff should not modify detoxification regimens for nursing women unless there is specific evidence that the pharmacologic product enters the milk in amounts that could be harmful to the infant. Women who are using benzodiazepines (for example, Librium or Xanax) and antidepressant or antipsychotic agents should not breast feed.

All pregnant women and nursing mothers should be informed of the potential risks of drugs that are excreted in breast milk. For more information, see the TIP *Improving Treatment for Drug-Exposed Infants*.

The availability of childcare often influences a woman's ability to enter treatment. At a minimum, detoxification programs should have a linkage to child-care services; onsite services are preferable.

Adolescents

Adolescence is a period of rapid physical and psychosocial change. Issues facing adolescents in detoxification differ from those facing adults in several ways. Chief among these differences is that physical dependence is generally not as severe and response to detoxification is generally more rapid in adolescents than in adults. Adolescents are not as accustomed to pain as are adults; as a result, they may be more resistant to simple procedures, such as having blood drawn. Adolescents also are notorious for leaving treatment against medical advice.

Adolescents undergoing detoxification need nurturing, support, and structure. Treatment providers must be sensitive to their developmental stages. Adolescents should be housed separately from adults. Decisions about involving the family in treatment should be made on a case-by-case basis and based on an assessment of family functioning.

Federal regulations allow methadone detoxification of adolescents, but State regulations vary. Methadone detoxification is rare in this age group. For a complete discussion of this issue, see the TIP entitled *State Methadone Treatment Guidelines*.

Elderly Persons

AOD-related disorders in elderly patients tend to be more severe than those in younger persons, and there is an increased likelihood of medical comorbidity in the elderly. For these reasons, detoxification in a medical setting is often required.

Age does not affect the choice of medication for detoxification; however, dosages may need to be reduced because of slowed metabolism. A complete assessment and careful monitoring of comorbid conditions (for example, respiratory disease, heart disease, or diabetes) is essential. Because many

elderly patients are taking a number of prescription and over-the-counter medications, the possibility of drug interactions cannot be ignored.

Adolescents undergoing detoxification need nurturing, support, and structure. Treatment providers must be sensitive to their developmental stages. Adolescents should be housed separately from adults. Decisions about involving the family in treatment should be made on a case-by-case basis and based on an assessment of family functioning.

Patients Who Are HIV-Positive

AOD abuse and HIV infection often coexist in the same individual, who is usually also at risk of becoming infected with tuberculosis or sexually transmitted diseases. The capacity of AOD abuse treatment programs to address these multiple health problems has expanded greatly in recent years, but there remains a need for comprehensive guidelines for treatment of HIV-positive AOD patients.

Collaborative, efficient approaches must be developed among AOD specialists, public health officials, mental health specialists, and primary healthcare providers in order to prevent further spread of disease and to assure delivery of high-quality care to infected individuals.

Fear of Infection

Those who treat patients with acquired immunodeficiency syndrome are naturally concerned about the risk of infection. Program staff may be concerned that they will be exposed to HIV when drawing blood, and they may have questions about the safety of collecting samples for urinalysis, about dispensing medications, and about simply being in proximity to HIV-infected patients. Programs can manage these concerns by developing guidelines and providing training. Treatment providers should apply clear infection control guidelines derived from hospital universal precautions for handling potentially infectious body fluids. Another TIP in this series, *Screening for Infectious Diseases Among Substance Abusers*, provides a detailed discussion of the infectious diseases common to the AOD abuse treatment population and of the medical management of these diseases by program staff.

Detoxification Medications

A diagnosis of HIV does not change the indications for medication used to treat AOD abuse. The most common medications used to treat substance abuse are methadone, disulfiram, and naltrexone. In addition, benzodiazepines, barbiturates, clonidine hydrochloride, and other medications are commonly used in detoxification. These medications can be used in HIV-infected AOD abuse patients in the same way they are used in uninfected patients. The detoxification process need not be altered by the presence of HIV. Another TIP in this series, *Treatment for HIV-Infected Alcohol and Other Drug Users*, provides detailed protocols for those who are HIV-positive and need treatment for abuse of AODs.

Other Medical Conditions

For patients withdrawing from alcohol, a history of seizures during previous withdrawals strengthens the case for using an anticonvulsant (such as phenytoin [Dilantin], carbamazepine [Tegretol], or phenobarbital) during detoxification. A patient who is dependent on alcohol or sedative-hypnotic agents may have a withdrawal seizure even though he or she does not have a history of seizure disorders. An alcoholic who has a seizure while drinking has an underlying seizure disorder. Treatment staff must consider both possibilities when determining detoxification treatment.

Brain-injured patients are also at risk for seizures. If an AOD-abusing patient who has sustained trauma to the head becomes delirious, one must determine the exact cause of the delirium. Slower medication tapers should be used in patients with seizure disorders. Dosages of anticonvulsant medications should be stabilized before sedative-hypnotic withdrawal begins.

Patients with cardiac disease require close monitoring. Because a withdrawal seizure, or even the physiological stress of withdrawal, may complicate the patient's cardiac condition, it may be necessary to withdraw the drug at a lower-than-normal rate. Treatment providers should also be alert to the possibility of interactions between the cardiac medications and the agents used to manage detoxification.

Severe liver or kidney disease can slow the metabolism of both the drug of abuse and the medication. Use of slower-acting medications and a slower taper are appropriate for detoxification in these patients.

Because of these patients' increased risk of developing addictions, treatment providers should exercise caution when prescribing medication for

chronic pain to patients with a history of AOD abuse. Opioid maintenance may, however, be necessary for patients with chronic, nonmalignant pain. Pain patients do not require detoxification from prescribed medications unless they meet the criteria for opiate abuse or dependence of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Nonsteroidal analgesic medications play a larger role in the management of pain in AOD-abusing patients than in other patients.

Persons With Psychiatric Comorbidity

The term "dual diagnosis" or "dual disorder" is used in the addiction field to refer to patients who have both a substance use disorder and any psychiatric disorder, such as schizophrenia. Estimates of the incidence of psychiatric disorders among substance abusers vary widely. Another TIP in this series, *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse*, provides practical information about the treatment of patients with dual disorders.

As noted in Chapter 2, it is difficult to accurately assess underlying psychopathology in a person undergoing detoxification. Drug toxicity, particularly with amphetamines and cocaine, hallucinogens, or phencyclidine, may mimic psychiatric disorders. For this reason, treatment providers should conduct a psychiatric evaluation after several weeks of abstinence.

Treatment providers should exercise caution when prescribing medication for chronic pain to patients with a history of AOD abuse. Pain patients do not require detoxification from prescribed medications unless they meet the criteria for opiate abuse or dependence of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.

At the time they are evaluated for detoxification, some patients with underlying psychiatric disorders are already taking antidepressants, neuroleptics, anxiolytics (benzodiazepines or other sedative-hypnotics), or lithium. Although staff may believe that these patients should immediately discontinue all mind-altering medication, such a course of action is not always in the best interest of the patient. Abrupt cessation of psychotherapeutic medications may cause

withdrawal symptoms or reemergence of symptoms of the underlying psychopathology.

For the staff of a "drug-free" program, use of anxiolytics by a patient can pose a significant conflict with program ideology. If a patient who was abusing alcohol was also taking alprazolam (Xanax) for a panic disorder, for example, some programs would want the individual to discontinue the alprazolam. Indeed, unless the alprazolam was initiated during a period of extended alcohol abstinence, the diagnosis of panic disorder may not be correct. If panic attacks resume during alcohol detoxification because the alprazolam has been discontinued, however, the patient might leave therapy. As a general rule, therapeutic doses of medication should be continued during alcohol withdrawal if the patient has been taking it as prescribed, with respect to both amount and timing of dose. Decisions about discontinuing the medication should be temporarily deferred. If, however, the patient has been abusing the prescribed medication or the psychiatric condition was clearly caused by the alcohol abuse, the rationale for discontinuing the medication is more compelling.

During detoxification, some patients decompensate into psychosis, depression, or severe anxiety. In such cases, careful evaluation of the withdrawal medication regimen is of paramount importance. If the decompensation is a result of inadequate dosing with the withdrawal medication, the appropriate response is to increase that medication. If it appears that the withdrawal medication is adequate, other medications may be needed. Before choosing such an alternative, it is important to take into account additional considerations, such as the side effects of the added medication and the possibility of interaction with the withdrawal medication.

A patient who is psychotic may need to take neuroleptics. Medications that have a minimal effect on the seizure threshold are recommended, particularly if the patient is being withdrawn from alcohol or sedative-hypnotic medication. Small, frequent doses of haloperidol (Haldol), such as 1 mg every 2 hours, may be used until the patient's symptoms of psychosis dissipate. The case for the emergency use of antidepressants is less convincing because of the 2- to 3-week lag time between initiation of medication and therapeutic response.

After detoxification is complete, the patient's need for the medication should be reassessed. A trial period with no medications is sometimes the best way to assess the patient's need.

The Importance of Cultural Competence of Staff

Detoxification protocols such as those described in Chapter 3 may be used effectively with persons of all races, cultures, and ethnic groups. However, treatment components and procedures should be reviewed to ensure that they are culturally sensitive and culturally relevant. Staff should be trained to avoid discriminatory language and behaviors.

The diversity of the counselors should reflect that of the surrounding community. Additionally, counselors must be specially trained and selected for cultural appropriateness. They must be aware, for example, that cultural attitudes toward communication styles vary with regard to preferred space (physical distance), appropriate physical contact, eye contact, and terminology. A treatment staff who are competent in the languages spoken by the clientele help the program retain more patients. Language competency entails not only the ability of a staff person to communicate with a patient but also familiarity with trends in street terminology.

Providers should evaluate written and visual materials provided to patients and families for readability as well as for cultural appropriateness. If the population is predominantly Spanish-speaking, materials, including intake and assessment forms and educational materials, should be printed in Spanish. At least some of the staff should speak Spanish.

An individual's response to authority differs from culture to culture. The counselor's sensitivity to such differences is essential in determining the patient's response to care and in engaging the patient in the detoxification process. Treatment providers should keep in mind that diversity exists within ethnic groups as well. For example, Spanish-speaking cultures are often thought of as one group (Hispanic) and assumed to be essentially identical. However, Hispanic cultures actually consist of a wide variety of different cultures such as Mexican, Puerto Rican, Cuban, and Central and South American, all of which differ significantly from one another. People of all ethnic groups vary by personality, geographic origin, socioeconomic class, religious upbringing, and other factors, all of which play a role in their individual "cultures." Treatment providers should assess each patient individually. Finally, the counselor should not presume the degree to which "cultural" factors are a determinant of current behavior.

Chapter 5—Improving Quality and Measuring Outcomes of AOD Detoxification Services

Effective measurement of treatment outcomes has long been a critical issue in the development of the Nation's alcohol and other drug (AOD) abuse treatment system. Studies of methadone maintenance treatment programs indicate that variables such as adequacy of methadone dosing levels, staff turnover rates, and differences among counselors correlate significantly with patient performance. These factors are, nonetheless, rarely taken into account by standard measures of treatment effectiveness (Gerstein and Harwood, 1990).

This chapter provides general information on quality improvement and outcomes measurement. A more detailed discussion of these issues as they relate to AOD abuse treatment is found in another Treatment Improvement Protocol (TIP) in this series, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*. It is intended as an aid in developing, implementing, and managing outcome monitoring systems.

Quality Improvement

Quality Assurance Checklist

The move toward healthcare reform and the growing concern for financial accountability have made service providers increasingly aware of the need to ensure quality care. One potentially useful document, prepared by an organization with standing in the addictions field, is a 10-step quality assurance checklist issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)(see Exhibit 5-1).

Quality Improvement Indicators

Patient-Based Quality Improvement Indicators

The specific indicators of quality shown in Exhibit 5-1 are of particular importance. Staff can perform chart reviews to verify the quality improvement indicators.

Routine weekly reviews of charts of 25 percent of the patients seen, with followup of any problems discussed in weekly case conferences, is a standard recommended by JCAHO. Treatment staff should complete and document each of the following steps in the patient's record. If a step has not been performed, a reason for the omission should be included.

1. Admission procedures
 - Document the level of withdrawal; take previous medical history and drug use history; conduct physical examination; address legal issues; obtain patient consent for treatment
 - Develop an individualized treatment plan
 - Develop and initiate a plan for discharge and aftercare
 - Conduct formal assessment.
2. Primary services
 - Evaluate the patient's physical and psychological status (must include a medical history and physical examination within 24 hours, if these were not performed at admission)
 - Develop a plan documenting the anticipated course of medical and social management
 - Develop a plan for continuing care (involving the patient's family or significant others in treatment, where possible)
 - Perform routine drug screens
 - Flag files to indicate (1) previously treated patients and (2) patients with special medical problems, such as insulin-dependent diabetes, a history of seizures, drug sensitivities, or psychiatric comorbidity
 - Consult previous admission data and treatment plans, if available.
3. Financial information
 - Obtain at admission; seek reauthorizations as required
 - Provide assistance in obtaining entitlements such as Medicaid.

Exhibit 5-1
JCAHO Quality Assurance Guidelines*

1. Assign responsibility
2. Delineate scope of care and services
3. Identify important aspects of care and services
4. Identify indicators of outcome (no less than two; no more than four)
5. Establish thresholds for evaluation
6. Collect data
7. Evaluate data
8. Take action
9. Assess action taken
10. Communicate

* *The Accreditation Manual for Hospitals*. Joint Commission on Accreditation of Healthcare Organizations. Oak Brook, Illinois. 1991.

4. Discharge and aftercare
 - Identify patient's continuing needs for medical care, housing, legal assistance, food stamps, child care, or other services
 - Address legal problems (for example, for court-referred patients)
 - Comply with legal mandates and reporting requirements.

Program-Based Quality Improvement Indicators

The program's internal management information system should include clinical reports, incident reports, followup reports from referral resources, insurance and accreditation reports, and public health and other Government inspection reports. In addition, any other quality-improvement reports that have been generated to analyze trend data drawn from patient charts should be included. Every treatment program should have such a system in place to capture and compile these data so that program administrators can take a step back from reviewing the charts of individual patients to look at the entire patient population. The following indicators should be documented:

- Patient demographic data
- Primary and secondary drugs used at admission

- Sources of referral into the program, plus any changes in referral patterns
- Accuracy and timeliness of intake assessments (for example, significant problems not identified at initial assessment, changes in the treatment plan, indications that clinical care was not appropriately individualized)
- Admissions processed within designated time frames
- Number of people interviewed who were not admitted (where they went and why)
- Number of individuals on the waiting list for admission and the average length of time on the waiting list (with note made of any changes cyclically and over time)
- Ratio of planned discharges versus the number of patients who left against advice (the case manager's unscheduled discharge report is a key document for this indicator)
- Staff data on training completed, turnover rates, internal promotion and transfer rates, staff complement (overall and by specialized unit), staff credentials, and training relative to job responsibilities and program licensure requirements
- Safety, security, sanitation, and insurance inspection reports
- Financial performance (for example, evidence that

reimbursements are billed accurately and promptly, all eligible funds are applied for, appropriate financial procedures are in place, and financial records are in order and independently audited on a regular schedule).

The National Institute on Drug Abuse has published a technology transfer package to help program administrators and staff who have no previous experience or formal training in evaluation to plan and conduct evaluations of their programs. The package is titled *How Good Is Your Drug Abuse Treatment Program?* and includes an overview and case study manual, an evaluation guide, a resource manual, and looseleaf worksheets and agendas. The procedures and steps discussed in the guide conform to the standards of JCAHO. It is available free of charge from the National Clearinghouse for Alcohol and Drug Information at (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired) at (800) 487-4889.

Outcomes Measurement

A recent contribution to the literature on addiction treatment is the public policy statement on recommendations for design of treatment efficacy research with emphasis on outcome measures (American Society of Addiction Medicine, 1994). These recommendations, developed from a consensus process involving more than 70 experts in the addictions field, begin by identifying the nine "essential elements" of studies that assess quality of treatment. They include

- The starting number of patients
- Initial patient characterization
- Comparison with two or more groups
- Description of the treatment program
- Continuing-care compliance, frequency, and duration
- Discharge category
- Number of patients followed up on
- Followup time
- Cost.

Within this framework, the American Society of Addiction Medicine recommends measurement of eight variables, as shown in Exhibit 5-2, but cautions that confirmation of patient self-reports of AOD use or nonuse is desirable, through either biochemical analysis or corroborative reports.

An appropriate system for measuring outcomes, no matter how simple or complex, must also take into account the goals of detoxification. Three desirable

goals are to safely manage withdrawal; to engage the patient in treatment; and to provide withdrawal that is humane and respects the patient's dignity. The following list presents detoxification-specific outcomes indicators that are appropriate for these goals and may be used in conjunction with other measures.

Indicators for Goal 1: To safely manage withdrawal

- Rate of completed detoxification
- Incidence of adverse reactions because of a mistaken diagnosis or assessment
- Deviations from average length of stay for the program under study
- Rates and reasons for incomplete stays (for example, patients who have transferred from the program or left against advice)
- Rates of patient participation in various program elements
- Numbers of incident reports (for example, calls to fire or police department)
- Incidence of patient injury.

Indicators for Goal 2: To engage the patient in treatment

- Percentage of patients for whom discharge and continuing care plans were developed
- Percentage of patients who completed their discharge and continuing care plans
- Reasons for failure to complete plans (analyzed in clusters and trends over time)
- Percentage of patients who have previously completed detoxification with information on salient variables
- Self-reported patient satisfaction with treatment.

Indicators for Goal 3: To provide patient withdrawal that is humane and respects the patient's dignity

- Number of incidents involving patient rights
- Number of times that patient records were released pursuant to a properly signed consent or court order and the number of incidents in which information was inadvertently released without consent or a compelling court order
- Number of times that patients were deprived of rights that are generally accorded to program participants.

Exhibit 5-2

ASAM-Recommended Variables for Patient Outcome

1. Substance use
 - Status of use of the primary drug of dependence
 - Status of use of other drugs of dependence (including nicotine)
 - History of any use, since the start of treatment, of medications prescribed for their psychotropic action or which have psychotropic side effects
2. Readmission for AOD treatment due to relapse or threatened relapse
3. Health status
 - Use of health services, including illnesses, hospitalizations, and outpatient visits for medical, psychiatric, or dental care since treatment began
 - Confirmatory information (for example, through biochemical markers and standardized interviews)
4. Employment function status
 - Employment status at followup
 - Number (or percent) of days worked compared with days eligible to work
5. Legal problems (during periods when not confined)
 - Driving-under-the-influence violations
 - Arrests
6. Evaluation of the patient's relationship with close family and significant others
 - Status of marital or other partnership relationships
 - Satisfaction with the quality of those relationships
 - Custodial status of children, if any
7. Assessment of global functioning, provided that assessment instruments are appropriately peer reviewed and validated
8. Assessment of psychological (emotional) and social functioning
9. Assessment of major life stressors in the period following treatment

Chapter 6—Costs and Current Payment Mechanisms for AOD Detoxification

In the United States, alcohol and other drug (AOD) detoxification services are provided in many different settings: general medical and psychiatric hospitals, inpatient AOD treatment programs, outpatient clinics, and social model detoxification programs. There is no one national reporting system that tallies the number of detoxification episodes each year in the United States. Discussions of the costs associated with detoxification must address the following considerations:

- In a general medical hospital, detoxification may be provided incidentally to treatment of injuries or complications of AOD dependence.
- Detoxification services may not be documented in the medical records or through insurance billing because the indication of AOD abuse may jeopardize insurance coverage and may alter the confidentiality requirements for the records.
- Methadone and other drug treatment clinics often provide detoxification services as a component of comprehensive treatment.
- State reporting systems do not distinguish admissions that involve detoxification.

Given the uncertainties inherent in estimating the number of detoxification episodes and the settings in which they occur, the annual cost of detoxification services in the United States is unknown.

Current Sources of Funding For AOD Services

Overview of the Public Funding System

Current patterns of funding for AOD treatment are poorly coordinated and inflexible. The percentage of public funding earmarked for treatment has never been able to keep pace with demand. The following areas are of key concern:

- **The need for coordination.** More than three dozen Federal agencies fund AOD abuse treatment programs. No formal system exists to coordinate Federal agency activities. Furthermore, more than 75 congressional committees or subcommittees have oversight and funding authority over AOD abuse programs (Wilford, 1993).
- **The need for flexibility.** Many Federal programs are categorical. This approach restricts efforts to construct an integrated, comprehensive treatment system. Ancillary service components such as transportation and childcare are overlooked, and in their absence clients are unable to gain access to available treatment services (Center for Health Policy Research, 1993).
- **The need for improved access.** Medicaid, one of the most promising sources of funding for AOD services, is difficult to use (Center for Health Policy Research, 1993; Wilford, 1993).

Federal Funding

The Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the Department of Health and Human Services (DHHS), is the major source of Federal support for treatment and related services for persons who are mentally ill or chemically dependent. SAMHSA is comprised of three agencies: 1) the Center for Substance Abuse Treatment (CSAT); 2) the Center for Substance Abuse Prevention, and 3) the Center for Mental Health Services.

SAMHSA administers the DHHS AOD block grant program, which is the primary source of long-term Federal funding to the States for publicly supported AOD abuse treatment and prevention programs. In creating SAMHSA in 1992, Congress divided the block

grant program into two parts: one for mental health and one for substance abuse prevention and treatment. The latter was authorized at \$1.13 billion for fiscal year 1993, of which 35 percent was targeted to alcohol abuse services, 35 percent to drug abuse services, and 20 percent to prevention. Half of the remaining 10 percent was earmarked as a set-aside for special programs. Currently, this set-aside targets pregnant women and women with dependent children. According to the Center for Health Policy Research (CHPR), the remaining 5 percent was used by SAMHSA for technical assistance, data collection, program evaluation, and the creation of a national prevention database (Center for Health Policy Research, 1993).

Block grant funds are awarded to the single State agency in each State. The States distribute the funds according to their own priorities, within established Federal guidelines. Each State that receives block grant funds is required to submit a plan to the Federal Government. This plan must incorporate input from the public. Allocation procedures at the State level vary considerably. Each State, moreover, has a different format for reporting use of funds; consequently, tracking resource allocation and use of set-asides is difficult.

Categorical SAMHSA programs that may provide support for detoxification services include CSAT's Capacity Expansion Program, Cooperative Agreements for Drug Abuse Treatment Improvement—Campus Treatment Program, and Cooperative Agreements for Drug Abuse Treatment Improvement in Crisis Areas (Target Cities) Program. CSAT's major demonstration program for Pregnant and Postpartum Women and Their Infants does not cover detoxification services. (For detailed information on CSAT programs, please contact the appropriate program division. See Appendix C for addresses and phone numbers.)

Other Federal Support

Categorical programs from other Federal agencies may also provide support for detoxification services as part of a comprehensive health model. Information on these programs may be found in a report entitled *An Analysis of Resources to Aid Drug-Exposed Infants and Their Families* (Center for Health Policy Research, 1993), as well as in directories of Federal grant and contract assistance programs.

State Funding: Medicaid

Medicaid is a cooperative Federal and State program that is administered by the Health Care Financing Administration. Medicaid is an entitlement program

and therefore not subject to the congressional appropriations process. States receive Federal contributions based on per capita income; in poorer States, the Federal contribution may be as high as 83 percent—in wealthier States, 50 percent. States may increase the Federal match by voluntarily raising their contribution to the program. The States participate in Medicaid voluntarily and administer the program within broad Federal guidelines. Eligibility requirements, covered benefits, and provider payment mechanisms vary enormously.

Although not designed to fund AOD abuse treatment services, Medicaid has become the most stable source of funding for such services. Medicaid reimbursement for AOD abuse treatment doubled between 1982 and 1987 (Center for Health Policy Research, 1993; Wilford, 1993). As with the overall program, there is little consistency from State to State with regard to individual coverage for AOD abuse treatment or the treatment settings for which services are reimbursed. Federal statutes stipulate that Medicaid is to cover "medical and remedial" services. It will cover most hospital-based services. In regard to AOD abuse treatment services, for example, a majority of States may cover a hospital stay for a 3² to 6-day inpatient detoxification and a limited number of visits for followup outpatient counseling (Center for Health Policy Research, 1993). To improve access to extended treatment, Gates (1992) has suggested that States reimburse for detoxification services contingent on coordination with long-term treatment placement or that they design specialized case-management services as part of the State plan.

Medicaid beneficiaries have few long-term options for coverage of AOD abuse treatment. This lack may contribute to the cycle of relapse and return to episodic hospital-based detoxification for some persons. Medicaid inpatient payment statistics reflect the unrealistic structure of the Medicaid reimbursement system. In fiscal 1994, the portion of Medicaid hospital costs attributable to AOD abuse treatment was expected to exceed \$7.4 billion. Approximately 20 percent of annual Medicaid expenditures for hospital care are associated with substance abuse (Center on Addiction and Substance Abuse at Columbia University, 1993).

Many States are discouraged by the complex regulations that govern Medicaid. Some application procedures make it difficult for individuals to obtain benefits. Other States have responded creatively to the challenge (Center for Health Policy Research, 1993).

States also have demonstrated resourcefulness in developing ways to raise State revenue and thereby

gain access to additional Medicaid funding (Gates, 1992). One technique is to transfer general State revenues intended for AOD services to the State Medicaid agency rather than to the State Division of Alcohol and Drug Abuse. The transferred funds become eligible for the Federal match. Some States apply revenues from alcohol excise taxes to their Medicaid match funds. Some States allow persons filing income tax returns to designate that a portion of their refunds be directed to AOD abuse treatment. Still others have enacted laws under which revenue generated by the sale of property confiscated during convictions for drug-related crimes are applied to the Medicaid match. And some practices are under close scrutiny by Federal agencies and may not have produced long-term solutions that are viable or cost effective.

Funding and State Healthcare Reform

Healthcare reform efforts, a matter of major debate at the Federal level at the time this consensus panel convened, are having a strong impact on clinical practice. Many States have already taken the lead in healthcare reform. Since the national healthcare reform act was not passed by Congress, States will continue to develop reform strategies consistent with a managed care environment. In all likelihood, the primary efforts for healthcare reform effort will proceed individually, State-by-State, rather than on a national basis.

Facing growing financial pressures to contain costs, many States have enacted comprehensive healthcare reform legislation. Coverage for addictive disorders has been the subject of extensive State house debate; "of more than 70 major reform bills considered in 45 States during 1993, two thirds contained some benefits for AOD abuse treatment" (Callahan, 1994).

Toward a Model AOD Detoxification Services and Benefits System

Drawing on clinical experience, the continuum of care set forth in the CHPR Model, and an appreciation of fiscal realities, the panelists agreed that the following principles should govern the design and implementation of AOD detoxification services and benefits systems. Many of the recommendations concerning the number of treatment episodes and lengths of stay are based on the Legal Action Center's *Model Legislation Mandating a National Health Insurance Benefit for Prevention and Treatment for Alcoholism and Drug Addiction* (Legal Action Center, 1993).

Each client should be assessed before entering detoxification. The severity of predicted withdrawal symptoms, the intensity of care needed to ensure appropriate management, and identified psychosocial and family-support needs should determine the selection of treatment setting and the duration and type of services offered.

A majority of patients safely undergo detoxification without being admitted either to a hospital or to a residential setting. Nonetheless, patients' clinical and other needs, not the likelihood for reimbursement, should govern the choice of treatment setting. Inpatient detoxification should not be arbitrarily limited, for example, to patients with concurrent psychiatric problems.

The care system should be grounded in the understanding that individuals entering AOD detoxification programs have diverse and wide-ranging needs. While most patients will not require every available service, the system should be structured to meet each discrete need as well as any combination of needs. In most cases, development of such a structure will require the creation of a system of referral and interagency linkages. Timely and dependable communication among such agencies is essential. If, for example, a woman who has primary childcare responsibilities enters a residential detoxification setting or is admitted to a hospital, appropriate childcare services, possibly including room and board, should be available.

Ideally, there should be no caps on the number of covered inpatient detoxification episodes and no limits on length of stay. At a minimum, each participant in a health benefits plan should be eligible for 10 days of treatment in a hospital, nonhospital, or ambulatory detoxification program, as medically necessary, during any calendar year. If medical conditions require additional lengths of stay, benefits should be available.

Alcoholism is a chronic disease, and most alcoholics will experience at least one relapse. Some patients experience several detoxification episodes before they enter long-term treatment and achieve lasting abstinence. Given this reality, no arbitrary limits should be placed upon the number of detoxification episodes for which a patient will receive reimbursement or upon the length of these episodes.

- Ideally, health plans should provide benefits that ensure short-term inpatient treatment (30 days per year) in a hospital or freestanding facility, as well as long-term treatment (up to 18 months) in residential programs for persons who have undergone AOD detoxification.
- Outpatient treatment options should be broad. Within any calendar year, they should include, at a

minimum, as many as 160 days of intensive and/or nonintensive outpatient visits and as many as 60 family outpatient visits.

- Planners must examine the issue of client copayments.

One view holds that even a modest copayment may pose a burden to many clients and may discourage those initially seeking services as well as those patients remaining in aftercare. Others believe that revenue gained from such payments may be more than offset by the negative effect on patient retention rates and, in the long term, recidivism. However, some clinicians believe that even modest copayments reinforce the notion of commitment to treatment. Requiring patients to pay something may assign to treatment an importance equal to that of abusing AODs. Clinicians who hold this view do not necessarily recommend full copayments as an effort to raise revenue because they are aware that, especially in public sector programs, most clients lack the financial means to pay. They argue that

- Case management and pharmacotherapeutic intervention should be offered to all patients, as clinically appropriate.
- Benefit plans should cover the provision of patient and family education programs in all detoxification settings. Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome education is especially important.
- Benefit plans must include provisions for appropriate utilization review. Uniform patient placement criteria for AOD detoxification services should be developed and used to support the utilization-review process. Utilization review should be performed only by individuals who have adequate knowledge of AOD treatment issues.

Some States, including Oregon and Massachusetts, have begun to develop patient placement criteria based on the American Society of Addiction Medicine Model (1991) and to tailor them to local needs. Properly used, such criteria ensure greater uniformity in care and more appropriate and cost-effective allocation of resources. They provide a safety net that protects the client from falling to an inappropriate level of care.

Patient placement criteria, however, may be subject to misinterpretation. For example, should a criteria set support a specific detoxification setting under well-specified conditions, benefits managers might seize on that recommendation to the exclusion of others and use it to justify expansion of lower cost and potentially inappropriate services. Individual clinical need as the primary concern in patient placement cannot be overemphasized.

Unregulated utilization review decisions by health professionals who are not experienced in AOD issues and treatment have led to the denial of needed AOD abuse treatment services and inappropriately restricted lengths of stay. Improperly performed and regulated, utilization review may be counterproductive and may ultimately increase the costs associated with AOD abuse.

Healthcare providers, administrators, benefits managers, and legislators should examine the merits of developing new configurations for the delivery of AOD detoxification services. New, intermediate-level service configurations are needed that will bridge service gaps and ensure cost-effective, high-quality delivery of care. Issues associated with the development of such settings, including allocation of staff, licensing requirements, prescribing authority, and interagency networking, should be explored.

A Model for Estimating the Cost of AOD Abuse Treatment

The panel discussed various models available in the literature that service providers and administrators may use in developing cost estimates. One model they found particularly useful can be found in the book *Treating Drug Problems* (Gerstein and Harwood, 1990). The authors present and illustrate the use of a formula for estimating the cost of AOD abuse treatment.

The process begins with the acknowledgement that it is impossible to meet all needs. As treatment resources are limited, providers must establish priorities to ensure the optimum use of energy and financial resources. The authors developed an estimate for expansion of public coverage of certain AOD abuse treatment services nationwide and recommended consideration of the following four priorities as quoted below:

- "End delays in admission when treatment is appropriate, as evidenced by waiting lists
- "Improve treatment (by raising the levels of service intensity, personnel quality and experience, and retention rates of existing modalities; by having programs assume more integrative roles with respect to related services; and by instituting systematic performance monitoring and follow-up)
- "Expand treatment through more aggressive outreach to pregnant women and young mothers, as this could result in a great reduction of external social costs
- "Further expand community-based and

institutionally based treatment services to provide treatment of criminal justice clients."

Next, the model suggests three strategic options for attaining service delivery goals:

- A *core strategy* to deal with existing waiting lists, remedy deficiencies in program quality and management, and implement modest program initiatives for young women and children.
- A *comprehensive strategy*, adding to the core plan a substantially greater induction of criminal justice clients and a more ambitious plan for treating drug-abusing and drug-dependent mothers. This comprehensive plan would . . . provide the optimal level of public treatment resources.
- An *intermediate strategy* to be enacted between the core and comprehensive approaches.

Having established quantifiable targets (such as "Increase daily treatment enrollment by 66,000") and using documented sources to develop assumptions about variables such as capital costs, training needs, and the number of individuals who could be expected to enter treatment, the authors estimate the cost of services to meet the four goals under each of the three strategies (Gerstein and Harwood, 1990).

Estimated Costs Based on Field Review Data

Field reviewers of this Treatment Improvement Protocol (TIP) were asked to provide specific cost data for a medical model detoxification program, a social model detoxification program, and an intensive outpatient program. Some general information on

medical model and social model detoxification programs is included in this TIP in Exhibits 6-1, 6-2, and 6-3. Data on intensive outpatient costs are not included as there is a comprehensive section on costing for this type of treatment program in the TIP entitled *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*.

The cost data presented here are based on information provided from field reviewers in six different regions of the country and include both private and public programs. The types of the represented localities are rural, suburban, and urban. Because of regional and programmatic differences, it is not possible to ascertain definitive costs for the delivery of detoxification services. The actual costs vary considerably depending on the size of the program, the rent or purchase price of treatment facilities, and varying labor costs from one region of the country to another. Costs are examples only but may provide useful estimates of these models of detoxification services. It is important to emphasize that the cost data that appear in Exhibits 6-1, 6-2 and 6-3 were not gathered in a controlled study. The following marks indicate characteristics of the programs represented by the exhibits:

- * Described by program director as modified medical model, not necessarily consistent with the modified medical model discussed in the TIP. (Costs are *estimates* for 20 beds based on *actual* experience with a six-bed program. Estimates and costs reflect a 90 percent utilization rate.)
- ** Represents the number of clients/patients that can be treated at one time
- *** Includes admissions not over 24 hours.

Exhibit 6-1
Detoxification Programs—Sample Program Data

Program Identification No.	1	2	3	4	5	6
Program Type						
Medical Subacute		✓	✓			✓
Social Model	✓			✓	✓	✓
Modified Medical				✓*		
Region	Northeast	MidAtlantic	Midwest	West	Northwest	South
Locale	Small Metropolitan	Suburban	Large Metropolitan	Rural	Rural	Large Metropolitan
Medical Model						
Daily Residential Capacity**		14***	3-5	20		25
Annual Census***		900 (9 mo.)	550	875 *		250
Social Model						
Daily Residential Capacity**	8			20 *	4	25
Annual Census***	350			875 *	190-250	250
Institutional Status	Private Nonprofit	Public Nonprofit	Private Nonprofit	Private Nonprofit	Private Nonprofit	Private Nonprofit

Exhibit 6-2
Projected Annual Budget Sample
Social Model Detoxification Program

Program Identification No.	1	4	5	6
Core Staffing Costs/FTEs				
Registered Nurse	\$ 42,341.00 (2)	\$ 11,326.00 (.33)	0	\$ 78,000.00 (3)
Aide	45,645.00 (3)	140,00.00 (10)	0	37,440.00 (3)
Addictions Counselor	15,500.00 (1)	52,000.00 (2)	\$ 68,352.00 (3)	37,000.00 (2)
Social Worker	0	0	3,000.00 (.25)	26,000.00 (1)
Financial Benefits Manager	0	5,000.00 (.25)		22,500.00 (1)
Total Core Staffing	\$104,486.00 (6)	\$208,326.00 (12.58)	71,352.00	\$200,940.00
Payroll Taxes and Benefits	17,890.00	47,915.00	14,800.00	40,188.00
Consultant Physician	1,020.00	12,000.00 (.12)	840.00	0
Direct Operating Costs				
Supplies (office/activities)	(in admin.)	6,445.00	2,200.00	5,000.00
Meds, lab fees, contr. services	6,700.00	1,100.00	360.00	30,000.00
Telephone	3,130.00	3,255.00	720.00	6,000.00
Vehicle	0	2,000.00	0	500.00
Accounting/Legal Expense	(in admin.)	1,953.00	300.00	6,000.00
Staff Development	1,725.00	2,000.00	600.00	3,000.00
Office and Postage	(in admin.)	3,075.00	500.00	3,000.00
Equipment	1,345.00	2,500.00	450.00	5,000.00
Local Travel	400.00	2,475.00	1,685.00	3,000.00
Miscellaneous	575.00	10,485.00	250.00	800.00
Administrative Mgmt.	5,640.00	30,342.00	2,400.00 (1)	70,000.00
Facility				
Building	27,100.00	72,000.00	6,000.00	0
Food	15,590.00	39,600.00	2,800.00	30,000.00
Maintenance	3,690.00	4,800.00	1,000.00	5,000.00
TOTAL COSTS	\$189,311.00	\$450,271.00	\$106,257.00	\$408,428.00

Exhibit 6-3
Projected Annual Budget Sample
Medical Model Detoxification Program

Program Identification No.	2	3	4*	6
Core Staffing Costs/FTEs			(Modified medical)*	
Registered Nurse	\$ 288,000.00 (8)	0	\$ 33,000.00 (1)	\$ 78,000.00 (3)
Aide	80,000.00 (4)	\$ 71,400.00 (5)	140,000.00 (10)	37,440.00 (3)
Addictions Counselor	77,000.00 (3)	0	52,000.00 (2)	18,500.00 (1)
Social Worker	40,000.00 (1)	40,000.00 (2)	15,000.00 (.5)	26,000.00 (1)
Financial Benefits Mgr.	21,000.00 (1)	0	5,000.00 (.25)	22,500.00 (1)
Total Core Staffing	\$ 506,000.00 (17)	\$111,400.00 (7)	\$245,000.00 (13.75)	\$182,440.00 (9)
Payroll Taxes and Benefits	197,000.00	34,035.00	56,350.00	36,488.00
Consultant Physician	26,000.00 (.4)	18,548.00	25,000.00 (.25)	0
Direct Operating Costs				
Supplies (office/activities)	4,000.00	163,983.00	6,445.00	5,000.00
Meds, lab fees, contr. services	105,000.00	(none given)	5,000.00	30,000.00
Telephone	5,000.00	3,937.22	3,255.00	6,000.00
Vehicle	4,000.00	3,748.75	2,000.00	500.00
Accounting/Legal Expense	28,000.00	(none given)	1,953.00	6,000.00
Staff Development	8,000.00	1,148.84	2,000.00	3,000.00
Office and Postage	6,000.00	869.59	3,075.00	3,000.00
Equipment	10,000.00	(none given)	2,500.00	5,000.00
Local Travel	2,000.00	(none given)	2,475.00	2,500.00
Miscellaneous	8,000.00	264.55	50,085.00***	6,000.00
Administrative Mgmt.	56,000.00	56,578.00	30,342.00	70,000.00
Facility				
Building	40,000.00	29,600.00	90,000.00	24,000.00
Food	(in meds., lab, etc.)	(in building)	(in miscellaneous)	(in building)
Maintenance	(in meds., lab, etc.)	(in building)	(in building)	(in building)
TOTAL COSTS	\$1,005,000.00	\$425,112.95	\$525,480.00	\$379,928.00

Appendix A—Bibliography

- Allredge, B.K., Lowenstein, D.H. Status epilepticus related to alcohol abuse. *Epilepsia*. 1993; 34:1033-1037.
- Alling, F.A. Detoxification and treatment of acute sequelae. In: Lowinson, J.H., Ruiz, P., Millman, R.B., eds. *Substance Abuse: A Comprehensive Textbook*. Baltimore, Maryland: Williams and Wilkins; 1992: 402-415.
- Alling, F.A., Johnson, F.D., Elmoghazy, E. Cranial electrostimulation (CES) use in the detoxification of opiate-dependent patients. *Journal of Substance Abuse Treatment*. 1990; 7:173-180.
- Alterman, A.I., Droba, M., Antelo, E., et al. Amantadine may facilitate detoxification of cocaine addicts. *Drug and Alcohol Dependence*. 1992; 31:19-29.
- American Academy of Pediatrics, Committee on Drugs. The transfer of drugs and other chemicals into human milk. *Pediatrics*. 1994; 93:137-150.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition, Revised*. Washington, DC: American Psychiatric Association; 1994.
- American Psychiatric Association, Task Force on Benzodiazepine Dependency. *Benzodiazepine Dependence, Toxicity, and Abuse*. Washington, DC: American Psychiatric Press; 1990.
- American Society of Addiction Medicine. Public policy statement on recommendations for design of treatment efficacy research with emphasis on outcome measures. *Journal of Addictive Diseases*. 1994; 13:119-124.
- American Society of Addiction Medicine, Committee on Practice Guidelines. *The Role of Phenytoin in the Management of Alcohol Withdrawal Syndrome (Draft)*. Washington, DC: American Society of Addiction Medicine; 1994.
- Ayd, F.J. Prescribing anxiolytics and hypnotics for the elderly. *Psychiatric Annals*. 1994; 24:91-96.
- Baker, F. *Coordination of Alcohol, Drug Abuse, and Mental Health Services*. Rockville, Maryland: Office for Treatment Improvement; 1991. DHHS publication no. (SMA) 93-1742. Technical Assistance Publication (TAP) Series, Number 4.
- Banys, P., Clark, H.W., Tusel, D.J., et al. An open trial of low-dose buprenorphine in treating methadone withdrawal. *Journal of Substance Abuse Treatment*. 1994; 11:9-15.
- Banys, P., Tusel, D.J., Sees, K.L., Reilly, P.M., Delucchi, K.L. Low (40 mg) versus high (80 mg) dose methadone in a 180-day heroin detoxification program. *Journal of Substance Abuse Treatment*. 1994; 11:225-232.
- Bickel, W.K., Stitzer, M.L., Bigelow, G.E., et al. A clinical trial of buprenorphine: comparison with methadone in the detoxification of heroin addicts. *Clinical Pharmacology and Therapeutics*. 1988; 43:72-78.
- Bradley, B.P., Gossop, M., Phillips, G.T., Legarda, J.J. The development of an opiate withdrawal scale (OWS). *British Journal of Addiction*. 1987; 82:1139-1142.
- Brewer, C., Rezae, H., Bailey, C. Opiate withdrawal and naltrexone induction in 48-72 hours with minimal drop-out using a modification of the naltrexone clonidine technique. *British Journal of Psychiatry*. 1988; 153:340-343.

- Brown, L.S. Jr., Hickson, M.J., Ajuluchukwu, D.C., Bailey, J. Medical disorders in a cohort of New York City drug abusers: much more than HIV disease. *Journal of Addictive Diseases*. 1993; 12:11-27.
- Brumbaugh, A.G. Acupuncture: new perspectives in chemical dependency treatment. *Journal of Substance Abuse Treatment*. 1993; 10:35-43.
- Bullock, M.L., Culliton, P.D., Olander, R.T. Controlled trial of acupuncture for severe recidivist alcoholism. *Lancet*. 1989; 1:1435-1439.
- California Department of Alcohol and Drug Programs. *Evaluating Recovery Services: The California Drug and Alcohol Assessment (CALDATA)*. Sacramento, California: California Department of Alcohol and Drug Programs; 1994.
- Callahan, J.F. Health care reform alert: states take action. *American Society of Addiction Medicine News*. 1994; 9:1-2.
- Castaneda, R., Cushman, P. Alcohol withdrawal: a review of clinical management. *Journal of Clinical Psychiatry*. 1989; 278-284.
- Center for Health Policy Research. *An Analysis of Resources to Aid Drug-Exposed Infants and Their Families*. Washington, DC: The George Washington University, Intergovernmental Health Policy Project; 1993.
- Center for Substance Abuse Treatment. *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*. Rockville, Maryland: US Department of Health and Human Services; 1994. DHHS publication no. (SMA) 94-2078. Treatment Improvement Protocol (TIP) Series, Number 9.
- Center for Substance Abuse Treatment. *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*. Rockville, Maryland: US Department of Health and Human Services; 1995. DHHS publication no. (SMA) 95-3031. Treatment Improvement Protocol (TIP) Series, Number 14.
- Center for Substance Abuse Treatment. *Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents*. US Department of Health and Human Services; 1993; 47-57. DHHS publication no. (SMA) 93-2010. Treatment Improvement Protocol (TIP) Series, Number 4.
- Center for Substance Abuse Treatment. *Improving Treatment for Drug-Exposed Infants*. Rockville, Maryland: US Department of Health and Human Services; 1993. DHHS publication no. (SMA) 93-2011. Treatment Improvement Protocol (TIP) Series, Number 5.
- Center for Substance Abuse Treatment. *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*. Rockville, Maryland: US Department of Health and Human Services; 1994. DHHS publication no. (SMA) 94-2077. Treatment Improvement Protocol (TIP) Series, Number 8.
- Center for Substance Abuse Treatment. *LAAM in the Treatment of Opioid Addiction*. Rockville, Maryland: US Department of Health and Human Services; 1995. DHHS publication no. (SMA) 95-3052. Treatment Improvement Protocol (TIP) Series, Number 22.
- Center for Substance Abuse Treatment. *Matching Treatment to Patient Needs in Opioid Substitution Therapy*. Rockville, Maryland: US Department of Health and Human Services; 1995. DHHS publication no. (SMA) 95-3049. Treatment Improvement Protocol (TIP) Series, Number 20.
- Center for Substance Abuse Treatment. *Pregnant, Substance-Using Women*. Rockville, Maryland: US Department of Health and Human Services; 1993. DHHS publication No. (SMA) 93-1998. Treatment Improvement Protocol (TIP) Series, Number 2.
- Center for Substance Abuse Treatment. *Screening for Infectious Diseases Among Substance Abusers*. Rockville, Maryland: US Department of Health and Human Services; 1993. DHHS publication no. (SMA) 93-2048. Treatment Improvement Protocol (TIP) Series, Number 6.
- Center for Substance Abuse Treatment. *State Methadone Treatment Guidelines*. Rockville, Maryland: US Department of Health and Human Services; 1993. DHHS publication no. (SMA) 93-1991. Treatment Improvement Protocol (TIP) Series, Number 1.
- Center for Substance Abuse Treatment. *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders*. Rockville, Maryland: US Department of Health and Human Services; 1995. DHHS publication no. (SMA) 95-3021. Treatment Improvement Protocol (TIP) Series, Number 13.

- Center for Substance Abuse Treatment. *Treatment for HIV-Infected Alcohol and Other Drug Abusers*. Rockville, Maryland: US Department of Health and Human Services; 1995. DHHS publication no. (ADM) 95-3038. Treatment Improvement Protocol (TIP) Series, Number 15.
- Center on Addiction and Substance Abuse at Columbia University. *The Cost of Substance Abuse to America's Health Care System. Report 1: Medicaid Hospital Costs*. New York: Columbia University; 1993.
- Centers for Disease Control and Prevention. *The Public Health Impact of Needle Exchange Programs in the United States and Abroad: Summary, Conclusions, and Recommendations*. Atlanta, Georgia: Centers for Disease Control and Prevention; 1993.
- Charney, D.S., Heniniger, G.R., Kleber, H.D. The combined use of clonidine and naltrexone as a rapid, safe, and effective treatment of opiate withdrawal from methadone. *American Journal of Psychiatry*. 1986; 143:831-837.
- Clark, H.W., Longmuir, N. Clonidine transdermal patches: a recovery-oriented treatment of opiate withdrawal. *California Society for the Treatment of Alcoholism and Other Drug Dependencies News*. 1986; 13:1-2.
- Cochin, J., Kornetsky, C. Development and loss of tolerance to morphine in the rat after single and multiple injections. *Journal of Pharmacological and Experimental Therapeutics*. 1964; 145:1-10.
- Cushman, P., Dole, V.P. Detoxification of rehabilitated methadone-maintained patients. *Journal of the American Medical Association*. 1973; 225:747-752.
- Cuthill, J.D., Beroniade, M.D., Salvatori, V.A., Viguie, F. Evaluation of clonidine suppression of opiate withdrawal reactions: a multidisciplinary approach. *Canadian Journal of Psychiatry*. 1990; 35:377-382.
- Czechowicz, D. *Detoxification Treatment Manual*. National Institute on Drug Abuse. Rockville, Maryland: National Institute on Drug Abuse; 1979. Treatment Program Monograph Series Number 6.
- Devenyi, P., Harrison, M.L. Prevention of alcohol withdrawal seizures with oral diazepam loading. *Canadian Medical Association Journal*. 1985; 132:798-800.
- Fuller, R.K., Gordis, E. Refining the treatment of alcohol withdrawal. Editorial. *Journal of the American Medical Association*. 1994; 272:557-558.
- Fultz, J.M., Senay, E.C. Guidelines for the management of hospitalized narcotic addicts. *Annals of Internal Medicine*. 1975; 82:815-818.
- Galanter, M. Network therapy for the office practitioner. In: Galanter, M., Kleber, H.D., eds. *American Psychiatric Press Textbook of Substance Abuse Treatment*. Washington, DC: American Psychiatric Press; 1994: 253-262.
- Gallant, D. Alcohol. In: Galanter, M., Kleber, H.D., eds. *American Psychiatric Press Textbook of Substance Abuse Treatment*. Washington, DC: American Psychiatric Press; 1994: 67-89.
- Gariti, P., Auriacombe, M., Incmikoski, R., et al. A randomized double-blind study of neuroelectric therapy in opiate and cocaine detoxification. *Journal of Substance Abuse*. 1992; 4:299-308.
- Gates, D. *Medicaid Financing of Alcohol and Drug Abuse Treatment for Pregnant Women, Mothers, and Their Children*. Washington, DC: National Health Law Program; 1992.
- Geller, A. Protracted abstinence. In: Miller, N.S., ed. *Comprehensive Handbook of Drug and Alcohol Addiction*. New York: Marcel Dekker; 1991: 905-913.
- Gerstein, D.R., Harwood, H.J., eds. *Treating Drug Problems. Vol. 1: A Study of the Evolution, Effectiveness, and Financing of Public and Private Drug Treatment Systems*. Washington, DC: National Academy Press; 1990.
- Gold, M.S., Redmond, D.E., Kleber, H.D. Clonidine blocks acute opiate-withdrawal symptoms. *Lancet*. 1978; 2:599-602.
- Gorelick, D.A. Overview of pharmacologic treatment approaches for alcohol and other drug addiction: intoxication, withdrawal, and relapse prevention. *Psychiatric Clinics of North America*. 1993; 10:171-179.
- Harwood, H.J. Economics and drugs: promises, problems, and prospects. In: Cartwright, W.S., Kaple, J.M., eds. *Economic Costs, Cost-effectiveness, Financing, and Community-Based Drug Treatment*. Rockville, Maryland: National Institute of Drug Abuse; 1991:

- 46-56. DHHS publication no. (ADM) 91-1823. NIDA Research Monograph Number 113.
- Hayashida, M., Alterman, A.I., McLellan, A.T., et al. Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome. *New England Journal of Medicine*. 1989; 320:358-365.
- Hayner, G., Galloway, G., Wiehl, W.O. Haight Ashbury Free Clinic's drug detoxification protocols—part 3: benzodiazepines and other sedative-hypnotics. *Journal of Psychoactive Drugs*. 1993; 25:331-335.
- Helf, C. *Substance Abuse and Mental Health Benefits Under State Health Care Reform*. Washington, DC: The George Washington University Intergovernmental Health Project; 1994.
- Henningfield, J.E., Clayton, R., Pollin, W. Involvement of tobacco in alcoholism and illicit drug use. *British Journal of Addiction*. 1990; 85:279-292.
- Henningfield, J.E., Cohen, C., Heishman, S.J. Drug self-administration methods in abuse liability evaluation. *British Journal of Addiction*. 1991; 86:1571-1577.
- Hoffman, A.L., Slade, J., Following the pioneers: addressing tobacco in chemical dependency treatment. *Journal of Substance Abuse Treatment*. 1993; 10:153-160.
- Hoffman, N.G., Halikas, J.A., Mee-Lee, D., Weedman, R.D. *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*. Chevy Chase, Maryland: American Society of Addiction Medicine; 1991.
- Institute of Medicine. *Broadening the Base of Treatment for Alcohol Problems*. Washington, DC: National Academy Press; 1990.
- Jacob, M.S., Zilm, D.H., Macleod, S.M., Sellers, E.M. Propranolol-associated confused states during alcohol withdrawal. *Journal of Clinical Psychopharmacology*. 1983; 3:185-187.
- Jasinski, D.R., Fudala, P.J., Johnson, R.E. Sublingual versus subcutaneous buprenorphine in opiate abusers. *Clinical Pharmacology Therapy*. 1989; 13:513-519.
- Jasinski, D.R., Johnson, R.E., Kocher, T.R. Clonidine in morphine withdrawal: differential effects on signs and symptoms. *Archives of General Psychiatry*. 1985; 42:1063-1066.
- Jasinski, D.R., Pevnick, J.S., Griffith, J.D. Human pharmacology and abuse potential of the analgesic buprenorphine. *Archives of General Psychiatry*. 1978; 35:501-516.
- Johnson, R.E., Cone, E.J., Henningfield, J.E., Fudala, P.J. Use of buprenorphine in the treatment of opiate addiction: I. physiologic and behavioral effects during a rapid dose induction. *Clinical Pharmacology Therapy*. 1989; 13:335-343.
- Johnson, R.E., Jaffe, J.H., Fudala, P.J. A controlled trial of buprenorphine treatment for opioid dependence. *Journal of the American Medical Association*. 1992; 267:2750-2755.
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO). *The Accreditation Manual for Hospitals*. Oak Brook, Illinois: JCAHO; 1993.
- Judson, B.A., Goldstein A., Inturrisi, C.E. Methyl acetate (LAAM) in the treatment of heroin addicts, II: double-blind comparison of gradual and abrupt detoxification. *Archives of General Psychiatry*. 1983; 40:834-840.
- Judson, B.A., Himmelberg, D.U., Goldstein, A. The naloxone test for opiate dependence. *Clinical Pharmacology and Therapeutics*. 1980; 27:492-501.
- Kleber, H.D. Our current approach to drug abuse: progress, problems, proposals. *New England Journal of Medicine*. 1994; 330:361-364.
- Kleber, H.D. Treatment of narcotic addicts. *Psychiatric Medicine*. 1987; 3:389-418.
- Kleber, H.D., Riodan, C.E. The treatment of narcotic withdrawal: a historical review. *Journal of Clinical Psychiatry*. 1982; 43:30-34.
- Kokka, N., Sapp, D.W., Taylor, A.M., Olsen, R.W. The kindling model of alcohol dependence: similar persistent reduction in seizure threshold to pentylenetetrazol. *Alcoholism: Clinical and Experimental Research*. 1993; 17:525-531.

- Koob, G. Neurobiological approaches to brain-behavior interaction: summary and overview. In: Frascella, J., Brown, R.M., eds. *Neurobiological approaches to brain-behavior interaction*. Rockville, Maryland: National Institute of Drug Abuse; 1992: 237-247. DHHS publication no. (ADM) 92-1846. NIDA Research Monograph Number 124.
- Kosten, T.R., Kleber, H.D. Buprenorphine detoxification from opioid dependence: a pilot study. *Life Science*. 1988; 42:635-641.
- Kosten, T.R., Rounsaville, B.J., Kleber, H.D. Concurrent validity of the Addiction Severity Index. *Journal of Nervous and Mental Disease*. 1985; 171:606-610.
- Kozlowski, L.T., Henningfield, J.E., Keenan, R.M., et al. Patterns of alcohol, cigarette, and other drug use in two drug-abusing populations. *Journal of Substance Abuse Treatment*. 1993; 10:171-179.
- Kraus, M.L., Gottlieb, L.D., Horwitz, R.I., Anscher, M. Randomized clinical trial of atenolol in alcohol withdrawal. *New England Journal of Medicine*. 1985; 313:905-909.
- Kreek, M.J. Methadone disposition during the perinatal period in humans. *Pharmacology, Biochemistry, and Behavior*. 1979; 11:7-13.
- Lechtenberg, R., Worner, T.M. Total ethanol consumption as a seizure risk factor in alcoholics. *Acta Neurologica Scandinavica*. 1992; 85:90-94.
- Legal Action Center. *Confidentiality: A Guide to the Federal Laws and Regulations*. New York: Legal Action Center; 1991.
- Legal Action Center. *Model Legislation Mandating a National Health Insurance Benefit for Prevention and Treatment for Alcoholism and Drug Addiction*. New York: Legal Action Center; 1993.
- Legard, J.J., Grossop, M. A 24-hour inpatient detoxification treatment for heroin addicts: a preliminary investigation. *Drug and Alcohol Dependence*. 1994; 35:91-93.
- Ling, W., Blakis, M., Holmes, E.D., Klett, C.J., Carter, W.E. Restabilization with methadone after methadyl acetate maintenance. *Archives of General Psychiatry*. 1980; 37:194-196.
- Malcolm, R., Ballenger, J.C., Sturgis, E.T., Anton, R. Double-blind controlled trial comparing carbamazepine to oxazepam treatment of alcohol withdrawal. *American Journal of Psychiatry*. 1989; 146:617-621.
- Marlatt, G.A., Barrett, K. Relapse prevention. In: Galanter, M., and Kleber, H.D., eds. *American Psychiatric Press Textbook of Substance Abuse Treatment*. Washington, DC: American Psychiatric Press; 1994: 285-299.
- Martin, W.R., Jasinski, D.R. Physiological parameters of morphine dependence in man: tolerance, early abstinence, protracted abstinence. *Journal of Psychiatric Research*. 1969; 7:9-17.
- Maslow, A.H. *Motivation and Personality*. New York: Harper and Row; 1954.
- McLellan, A.T., Luborsky, L., O'Brien, C.P., Woody, G.E. An improved evaluation instrument for substance abuse patients: the Addiction Severity Index. *Journal of Nervous and Mental Disease*. 1980; 168:26-33.
- Miller, N.S., ed: *Principles of Addiction Medicine*. Chevy Chase, Maryland: American Society of Addiction Medicine; 1994.
- National Council Against Health Fraud. Acupuncture: position paper of the National Council Against Health Fraud. *American Journal of Acupuncture*. 1991; 19:273-279.
- National Institute on Drug Abuse. *Effectiveness of Drug Abuse Treatment Programs*. Rockville, Maryland: National Institute on Drug Abuse; 1981. DHHS publication no. (ADM) 81-1143.
- National Institute on Drug Abuse. *Research on the Treatment of Narcotic Addiction: State of the Art*. Rockville, Maryland: National Institute on Drug Abuse; 1987. DHHS publication no. (ADM) 87-1281.
- Nightingale, S.L. From the Food and Drug Administration: levomethadyl approved for the treatment of opiate dependence. *Journal of the American Medical Association*. 1993; 270:1290.
- O'Brien, C.P., Childress, A.R., McLellan, A.T. Conditioning factors may help to understand and prevent relapse in patients who are recovering from drug dependence. Washington, DC: Department of

- Health and Human Services. DHHS publication no. (ADM) 91-1754. 1991. NIDA Research Monograph Number 106.
- O'Connor, P.G., Waugh, M.E., Schottenfeld, R.S., Diakogiannis, I.A., Rounsaville, B.J. Ambulatory opiate detoxification and primary care: a role for the primary care physician. *Journal of General Internal Medicine*. 1992; 7:532-534.
- Office of National Drug Control Policy. *National Drug Control Strategy*. Washington, DC: Government Printing Office; 1990.
- O'Malley, S.S., Jaffee, A.J., Change, G., et al. Naltrexone and coping skills therapy for alcohol dependence. *Archives of General Psychiatry*. 1992; 49:881-887.
- Patterson, M.A. *Getting Off the Hook: Addictions Can Be Cured by NET*. Wheaton, Illinois: Harold Shaw; 1983.
- Pickens, R.W., Fletcher, B.W. Overview of treatment issues. In: Pickens, R.W., Leukefeld, C.G., Schuster, C.R., eds. *Improving Drug Treatment*. Rockville, Maryland: National Institute of Drug Abuse; 1991: 1-19. DHHS publication no. (ADM) 91-1754. NIDA Research Monograph Number 106.
- Pickworth, W.B., Johnson, R.E., Holicky, B.A., Cone, E.J. Subjective and physiologic effects of intravenous buprenorphine in humans. *Clinical Pharmacology and Therapeutics*; 1993.
- Preston, K.L., Bigelow, G.E., Liebson, I.A. Buprenorphine and naloxone alone and in combination in opioid-dependent humans. *Psychopharmacology*. 1988; 94:484-490.
- Rickels, K., Schweizer, E., Case, W.G., Greenblatt, D.J. Long-term therapeutic use of benzodiazepines: I. effects of abrupt discontinuation. *Archives of General Psychiatry*. 1990; 47:899-907.
- Robert Wood Johnson Foundation. *Substance Abuse: The Nation's Number One Health Problem-Key Indicators for Policy*. Princeton, New Jersey: Robert Wood Johnson Foundation; 1993.
- Roy-Byrne, P.P., Cowley, D.S., eds. *Benzodiazepines in Clinical Practice: Risks and Benefits*. Washington, DC: American Psychiatric Press; 1991.
- Saitz, R., Mayo-Smith, M.F., Roberts, M.S., et al. Individualized treatment for alcohol withdrawal: a randomized double-blind controlled trial. *Journal of the American Medical Association*. 1994; 272:519-523.
- San, L., Cami, J., Fernandez, T., et al. Assessment and management of opioid withdrawal symptoms in buprenorphine-dependent subjects. *British Journal of Addiction*. 1992; 87:55-62.
- San, L., Torrens, M., Castillo, C., Porta, M., de la Torre, R. Consumption of buprenorphine and other drugs among heroin addicts under ambulatory treatment: results from cross-sectional studies in 1988 and 1990. *Addiction*. 1993; 88:1341-1349.
- Schweizer, E., Rickels, K., Case, W.G., Greenblatt, D.J. Long-term therapeutic use of benzodiazepines. II. Effects of gradual taper. *Archives of General Psychiatry*. 1990; 47:908-915.
- Sees, K.L., Clark, H.W. When to begin smoking cessation in substance abuse. *Journal of Substance Abuse Treatment*. 1993; 10:189-195.
- Sellers, E.M., Naranjo, C.A., Harrison, M., et al. Diazepam loading: simplified treatment of alcohol withdrawal. *Clinical Pharmacology Therapy*. 1983; 34:822-826.
- Sellers, E.M., Sullivan, J.T., Somer, G., Sykora, K. Characterization of DSM-III-R criteria for uncomplicated alcohol withdrawal provides an empirical basis for DSM-IV. *Archives of General Psychiatry*. 1991; 48:442-447.
- Senay, E.C., Dorus, W., Goldberg, F., Thornton, W. Withdrawal from methadone maintenance: rate of withdrawal and expectation. *Archives of General Psychiatry*. 1977; 34:361-367.
- Seymour, R., Smith, D.E. *Drugfree*. New York: Sarah Lazin Books; 1987.
- Shaw, J.M., Kolesar, G.S., Sellers, E.M., Kaplan, H.L., Sandor, P. Development of optimal treatment tactics for alcohol withdrawal. I. Assessment and effectiveness of supportive care. *Journal of Clinical Psychopharmacology*. 1981; 1:382-389.
- Shiffman, S., Zettler-Segal, M., Kassel, J. Nicotine elimination and tolerance in non-dependent cigarette smokers. *Journal of Psychopharmacology*. 1992; 109:449-456.

- Smith, D.E., Wesson, D.R. A new method for treatment of barbiturate dependence. *Journal of the American Medical Association*. 1970; 213:294-295.
- Smith, D.E., Wesson, D.R. A phenobarbital technique for withdrawal of barbiturate abuse. *Archives of General Psychiatry*. 1971; 24:56-60.
- Smith, D.E., Wesson, D.R. Benzodiazepine dependency syndromes. In: Smith, D.E., Wesson, D.R., eds. *The Benzodiazepines: Current Standards for Medical Practice*. Hingham, Massachusetts: MTP Press; 1985: 235-248.
- Smith, D.E., Wesson, D.R. Benzodiazepine dependency syndromes. *Journal of Psychoactive Drugs*. 1983; 15:85-95.
- Smith, D.E., Wesson, D.R. Benzodiazepines and other sedative-hypnotics. In: Galanter, M., Kleber, H.D., eds. *American Psychiatric Press Textbook of Substance Abuse Treatment*. Washington, DC: American Psychiatric Press; 1994: 179-190.
- Smith, D.E., Wesson, D.R. Phenobarbital technique for treatment of barbiturate dependence. *Archives of General Psychiatry*. 1971; 24:56-60.
- Sorensen, J.L., Batki, S.L., Good, P., Wilkinson, K. Methadone maintenance program for AIDS-affected opiate addicts. *Journal of Substance Abuse Treatment*. 1989; 6:87-94.
- Sorensen, J.L., Costantini, M.F., Wall, T.L., Gibson, D.R. Coupons attract high-risk untreated heroin users into detoxification. *Drug and Alcohol Dependence*. 1993; 31:247-252.
- Sorensen, J.L., Hargreaves, W.A., Weinberg, J.A. Withdrawal from heroin in three or six weeks. Comparison of methyl acetate and methadone. *Archives of General Psychiatry*. 1982; 39:167-171.
- Spencer L., Gregory, M. Clonidine transdermal patches for use in outpatient opiate withdrawal. *Journal of Substance Abuse Treatment*. 1989; 6:113-117.
- Stockwell, T., Bolt, L., Milner, I., et al. Home detoxification from alcohol: its safety and efficacy in comparison with inpatient care. *Alcohol and Alcoholism*. 1991; 26:645-650.
- Stuppaeck, C.H., Pycha, R., Miller, C., et al. Carbamazepine versus oxazepam in the treatment of alcohol withdrawal: a double-blind study. *Alcohol and Alcoholism*. 1992; 26:153-158.
- Sullivan, J.T., Sellers, E.M. Detoxification for triazolam physical dependence. *Journal of Clinical Psychopharmacology*. 1992; 12:124-127.
- Sullivan, J.T., Sellers, E.M. Treating alcohol, barbiturate, and benzodiazepine withdrawal. *Rational Drug Therapy*. 1986; 20:1-8.
- Sullivan, J.T., Swift, R.M., Lewis, D.C. Benzodiazepine requirements during alcohol withdrawal syndrome: clinical implications of using a standardized withdrawal scale. *Journal of Clinical Pharmacology*. 1991; 11:291-295.
- Sullivan, J.T., Sykora, K., Schneiderman, J., Naranjo, C., Sellers, E. Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar). *British Journal of Addiction*. 1989; 84:1353-1357.
- The White House. *Health Security Benefit Act: Benefit Modification*. Washington, DC: US Government Printing Office; November 1994.
- Tims, F.M., Fletcher, B.W., Hubbard, R.L. Treatment outcomes for drug abuse clients. In: Pickens, R.W., Leukefeld, C.G., Schuster, C.R. *Improving Drug Abuse Treatment*. Rockville, Maryland: National Institute of Drug Abuse; 1991: 93-113. DHHS publication no. (ADM) 91-1754. NIDA Research Monograph Number 106.
- Turner, J., Shiffren, I. Community support system: how comprehensive? In: Stein, L., ed. *Community Support Systems for the Long-Term Patient*. San Francisco, California: Jossey-Bass; 1979: 1-13.
- Tyrer, P., Rutherford, D., Huggett, T. Benzodiazepine withdrawal symptoms and propranolol. *Lancet*. 1981; 1:520-522.
- Verma, N.P., Policherla, H., Buber, B.A. Prior head injury accounts for the heterogeneity of the alcohol-epilepsy relationship. *Clinical Electroencephalography*. 1992; 23:147-151.
- Volpicelli, J.R., Alterman, A.L., Hayashida, M., O'Brien, C.P. Naltrexone in the treatment of alcohol dependence: initial observations. In: Reid, L.B., ed. *Opioids, Bulimia, Alcohol Abuse and Alcoholism*. New York: Springer-Valley; 1992: 95-214.

- Volpicelli, J.R., Davis, M.A., Olgin, J.E. Naltrexone blocks the post-shock increase of ethanol consumption. *Life Sciences*. 1986; 38:841-847
- Walsh, S.L., Preston, K.L., Stitzer, M.L., Cone, E.J., Bigelow, G.E. The acute effects of buprenorphine and methadone in nondependent humans. *Clinical Pharmacology and Therapeutics*. 1994; 55:569-580.
- Wartenberg, A.A., Nirenberg, T.D., Liepman, M.R., et al. Detoxification of alcoholics: improving care by symptom-triggered sedation. *Alcoholism: Clinical and Experimental Research*. 1990; 14:71-75.
- Washburn, A.M., Fullilove, R.E., Fullilove, M.T., et al. Acupuncture heroin detoxification: a single-blind clinical trial. *Journal of Substance Abuse Treatment*. 1993; 10:345-351.
- Washton, A.M., Resnick, R.B., Geyer, G. Opiate withdrawal using lefexidine, a clonidine analogue with fewer side effects. *Journal of Clinical Psychiatry*. 1983; 44:335-337.
- Weber, E.M. Testimony before the US House of Representatives Committee on Ways and Means, Subcommittee on Health, on the Health Care Security Act: Benefits. Presented on behalf of the Legal Action Center and the National Coalition of State Alcohol and Drug Treatment and Prevention Associations; November 15, 1993; Washington, DC.
- Weedman, R.D. *Admission, Continued Stay, and Discharge Criteria for Adult Alcoholism and Drug Dependence Treatment Services*. Irvine, California: National Association of Addiction Treatment Providers; 1987.
- Wesson, D.R., Smith, D.E. Cocaine: treatment perspectives. In: Kozel, N.J., Adams, E.H., eds. *Cocaine Use in America: Epidemiologic and Clinical Perspectives*. Rockville, Maryland: National Institute on Drug Abuse; 1985: 193-203. DHHS publication no. ADM 85-1414. NIDA Research Monograph Number 61.
- White House Domestic Policy Council. *The President's Health Security Plan*. New York: Times Books; 1993.
- Whitehead, J.P. Acupuncture in the treatment of addiction: a review and analysis. *International Journal of Addictions*. 1978; 13:1-16.
- Whitfield, C.L., Thompson, G. Lamb, A., et al. Detoxification of 1024 alcoholic patients without psychoactive drugs. *Journal of the American Medical Association*. 1978; 239:1409-1410.
- Wien, H.L., Cheung, S.Y.C. Treatment of drug addiction by acupuncture and electrical stimulation. *American Journal of Acupuncture*. 1973; 1:71-75.
- Willford, B.B., Morgan, J. *Families at Risk: Analysis of State Initiatives to Aid Drug-Exposed Infants and Their Families*. Washington, DC: The George Washington University Intergovernmental Health Policy Project; 1993.
- Wilson, A., Vulcano, B. A double-blind, placebo-controlled trial of magnesium sulfate in the ethanol withdrawal syndrome. *Alcoholism: Clinical and Experimental Research*. 1984; 8:542-545.
- Worner, T.M., Lechtenberg, R. Effect of gender on neurologic findings in alcoholics. *Journal of Addictive Disease*. 1991; 10:35-47.
- Zweben, J.E., Payte, J.T. Methadone maintenance in the treatment of opioid dependence: a current perspective. *The Western Journal of Medicine: Addiction Medicine and the Primary Care Physician (Special Issue)*. 1990; 52:588-599.

Other Authorities:

- 21 C.F.R. Parts 291, 1306, 1307, 1308.
- 42 C.F.R. Part 2 §§2.2, 2.3, 2.4, 2.11, 2.12, 2.13, 2.14, 2.16, 2.22, 2.31, 2.32, 2.34, 2.51, 2.52, 2.53, 2.61, 2.63, 2.64, 2.65, 2.66 (1987).
- 45 Fed. Reg. 42264 (July 24, 1980).
- 58 Fed. Reg. 38706 (July 20, 1993).
- 21 U.S.C. §§290dd-2(2)(C); 802.17; 872(c).
- 42 U.S.C. §241(d).
- Substance Abuse and Mental Health Services Administration, U.S.C. §290dd-2.
- Hasenie v. United States*, 541 F.Supp. 999 (D. Md. 1982).
- Simmons v. City of Philadelphia*, 947 F.2d 1042 (3d Cir. 1991).
- Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal.3d 425 (1976).

Appendix B—Glossary

Abstinence facilitation. An outpatient treatment strategy designed to help persons who are addicted to drugs stop using them. Commonly used in association with the medical treatment of cocaine abuse.

Acute abstinence syndrome. The aggregate of withdrawal signs and symptoms that occur shortly after a person who is physically dependent on a drug stops taking it. The adjective "acute" distinguishes this variant from the "protracted" or "chronic" drug withdrawal or abstinence syndrome.

Acute psychosis. A disturbance in thinking that is often accompanied by delusions and visual or auditory hallucinations. An acute psychosis may be caused by alcohol or other drug (AOD) withdrawal, drug toxicity (most commonly in conjunction with abuse of cocaine, methamphetamine, or psychedelic agents), or schizophrenia.

Analgesia. Relief from pain.

Anhedonia. Absence of pleasure from acts that would ordinarily be enjoyable.

Anorexia. Diminished appetite; aversion to food.

Arthralgia. Joint pain.

Ataxia. Unsteady walking or staggering, caused by an inability to coordinate the muscles.

Authorizing order. An order issued by a court that permits an AOD abuse treatment program to make a disclosure about a patient that would otherwise be forbidden.

Cellulitis. Inflammation of the cellular or connective tissues.

Chronic obstructive pulmonary disease. A combination of chronic bronchitis and emphysema. Characterized by persistent disruption of the flow of air in and out of the lungs.

Clouded sensorium. Confusion.

"Cold turkey." Popular term used to describe the process of opiate withdrawal that is not treated with medication. During withdrawal, the person's skin is covered with goose bumps and resembles that of a turkey.

Decisional capacity. The ability of a patient to make an informed choice.

Delirium. A state of mental confusion characterized by difficulty in responding to stimuli and an absence of orientation to place and time. May be accompanied by auditory, visual, or tactile hallucinations. May be caused by drug withdrawal or severe intoxication with phencyclidine.

Delirium tremens. A severe form of alcohol withdrawal characterized by confusion, auditory or visual hallucinations, and severe shakiness. Commonly called "DTs."

Delusions. Fixed, irrational ideas not shared by others and not responding to a logical argument.

Diaphoresis. Profuse sweating that is not in response to high temperature or exercise. A common symptom of opiate or sedative-hypnotic withdrawal.

Disclosure. A "communication of patient-identifying information, the affirmative verification of another person's communication of patient-identifying information, or the communication of any information from the record of a patient who has been identified" (42 C.F.R. §2.11).

Drug receptors. Specialized areas on the surface of brain cells to which drugs attach and through which they produce their effects.

Drug tolerance. The body's ability to endure increasing quantities of a drug. As the brain cells adapt to the presence of a drug, more of the drug is required to produce the same effect.

Dual diagnosis. The presence of both an AOD abuse problem and a psychiatric disorder.

Duty to warn. The legal obligation of a healthcare provider to notify law-enforcement officials or the potential victim when a patient presents a serious danger of violence to an identifiable individual.

Dysphoria. An unpleasant mood.

Electrolytes. Compounds in the blood that conduct electricity and can be decomposed by it. They include, for example, sodium, potassium, and chloride ions. Electrolyte imbalance can be caused by protracted vomiting, diarrhea, or dehydration. It also may result from failure to administer the correct type or quantity of intravenous fluids.

Encephalopathy. Any disease or disorder that affects the brain.

Grand mal seizures. A type of seizure in which a person falls to the ground unconscious and suffers generalized muscle contractions. The person usually remains unconscious for a time and may have no recall of the episode on awakening. **Petit mal seizures**, by contrast, are characterized by a momentary loss of awareness; an observer may think the person experiencing the seizure is simply daydreaming.

Hyperpyrexia. Extremely high fever.

Hyperreflexia. An exaggerated response of muscle reflexes that indicates that the nervous system is in a pathologically excited state. May occur during withdrawal from sedative-hypnotic agents or alcohol.

Hypertension. Abnormally high blood pressure. Usually defined as a resting blood pressure greater than 140 mm hg (systolic) and 90 mm hg (diastolic).

Involuntary commitment. Process by which patients who have not committed any crime are brought into treatment against their wishes by relatives or the police or through a court proceeding. Involuntary commitment is also known as "protective custody" or "emergency commitment."

Medical comorbidity. Presence of two serious illnesses at once; for example, drug addiction and acquired immunodeficiency syndrome.

Medical emergency. A condition that poses an immediate threat to the health of any individual and that requires immediate medical intervention (42 C.F.R.).

Medically debilitated. Term used to describe an individual who is both AOD-dependent and who has a chronic or severe medical disease such as emphysema.

Medication discontinuation. The process through which therapeutic doses of a prescribed medication are tapered or withdrawn. Detoxification, by contrast, refers to discontinuation of the use of an illicit drug or a self-administered prescription medication.

Myalgia. Muscle pain. A common complaint during opiate withdrawal.

Narcotic-dependent. (Federal methadone guidelines): Term used to describe an individual who physiologically needs heroin or a morphine-like drug to prevent the onset of signs of withdrawal.

Narcotic treatment program. According to Federal methadone guidelines, an organization (or a person, including a private physician) that administers or dispenses a narcotic drug to an addict for maintenance or detoxification treatment; provides, when appropriate or necessary, a comprehensive range of medical and rehabilitative services; is approved by the State authority and the Food and Drug Administration; and is registered with the Drug Enforcement Administration to use a narcotic drug for the treatment of narcotic addiction.

Network treatment. "An approach to rehabilitation in which specific family members and friends are enlisted to provide ongoing support and to promote attitude change. Network members are part of the therapist's working 'team' and not subjects of treatment themselves" (Galanter, 1994).

Neuroadaptation. The process by which the function of the brain cells changes in response to exposure to drugs. These adaptive changes may include increases in the number of receptor sites, alterations in the shape of the receptors, or changes in the chemical functioning of the cell.

Nonmalignant pain. Chronic pain that is not caused by cancer. Also called "chronic benign pain."

Nystagmus. A jerky movement of the eyes. May be seen in persons who are intoxicated as a result of ingestion of alcohol, sedative-hypnotic agents, or phencyclidine.

Orthostatic hypotension. A rapid drop in blood pressure (usually defined as 10 mm hg or greater) that occurs when a person stands up. Such an individual may become dizzy or even faint. May be a sign of sedative-hypnotic withdrawal or opiate intoxication. Also called "postural hypotension."

Pancreatitis. Inflammation of the pancreas. Alcohol abuse is the most common cause of chronic pancreatitis and a principal cause of acute pancreatitis.

Paresthesia. An abnormal burning, pricking, tickling, or tingling sensation.

Patient-identifying information. The "name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information . . ." (42 C.F.R. §2.11).

Pentobarbital challenge. A method of assessing physical dependence on alcohol or other sedative-hypnotic agents. The challenge consists of administering standard doses of pentobarbital to a patient and observing the effects. Patients who become intoxicated on 200 mg or less of pentobarbital do not have substantial tolerance to sedatives and are presumed not to be physically

dependent on these substances.

Physical dependence. A condition in which the brain cells have adapted as a result of repeated exposure to a drug and consequently require the drug in order to function. If the drug is suddenly made unavailable, the cells become hyperactive. The hyperactive cells produce the signs and symptoms of drug withdrawal.

Protracted abstinence syndrome. The aggregate of signs and symptoms of drug withdrawal. These signs and symptoms may continue for weeks or months after cessation of drug use. (Also see "acute abstinence syndrome.")

Record. "Any information, whether recorded or not, relating to a patient received or acquired by a Federally assisted alcohol or drug program" (42 C.F.R. §2.11).

Recrudescence. Reappearance of symptoms after a period of remission.

Relapse prevention. In common usage, any strategy or activity designed to assist a drug user who has become abstinent from returning to drug use. Relapse prevention also refers to specific cognitive-behavioral treatment "that combines behavioral skill-training procedures with cognitive intervention techniques to assist individuals in maintaining desired behavioral changes." It draws from both health psychology and social-cognitive therapy and uses a "psychoeducational self-management approach to substance abuse designed to teach patients new coping responses (e.g., alternatives to addictive behavior), to modify maladaptive beliefs and expectancies concerning substance abuse, and to change personal habits and lifestyles" (Marlatt and Barrett, 1994).

Signs. Observable or measurable changes in a patient's physiology; for example, increased blood pressure or dilated pupils. Such changes may not be perceived by the patient.

Somnolence. Sleepiness, drowsiness.

Symptom rebound. Transient, intensified return of symptoms following termination of therapeutic doses of a benzodiazepine. The most common withdrawal consequence of prolonged benzodiazepine use.

Symptoms. Subjective changes in mood, feelings, or bodily sensations.

Tachycardia. Rapid heartbeat (generally more than 100 beats per minute).

Therapeutic dosage. The amount of a drug required to produce a beneficial effect.

Triage. Process by which patients are assessed to determine the type of services and level of care they will require.

Up-regulation. An increase in the number of receptors on the brain cells that is caused by continuous contact with drugs.

Appendix C—Resource List

The following organizations and agencies provide information and materials that may be useful to staff and clients of alcohol and other drug abuse detoxification programs.

American Society of Addiction Medicine

5225 Wisconsin Avenue, NW Suite 409
Washington, DC 20015

Phone: (202) 244-8948

Fax: (202) 537-7252

The American Society of Addiction Medicine (ASAM) is an association of physicians dedicated to improving the treatment of alcoholism and other addictions, educating physicians and medical students, promoting research and prevention, and enlightening the medical community and the public about these issues. ASAM has chapters in 22 States.

ASAM publishes a quarterly medical journal, the *Journal of Addictive Disease*; a bimonthly newsletter, ASAM News, and practice guidelines such as the *ASAM Patient Placement Criteria*. It also provides continuing medical education opportunities, including the National Conference on Nicotine Dependence, and the Annual Medical-Scientific Conference.

ASAM administers a national certification examination for physicians.

Center for Substance Abuse Prevention

5600 Fishers Lane, Rockwall II
Rockville, Maryland 20857
Phone: (301) 443-0365

The Center for Substance Abuse Prevention (CSAP) is part of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. Until 1992, CSAP was known as the Office for Substance Abuse Prevention, or OSAP.

CSAP's National Clearinghouse for Alcohol and

Drug Information (NCADI) distributes printed and audiovisual materials. NCADI coordinates the Regional Alcohol and Drug Awareness Network (RADAR), which facilitates access to State and local sources of information about alcohol, tobacco, and other drugs.

NCADI

P.O. Box 2345
Rockville, Maryland 20847-2345

Phone: (301) 468-2600

(800) 729-6686

CSAP's Resource Center of Substance Abuse Prevention and Disability answers questions about alcohol, tobacco, and other drug abuse prevention and treatment issues for persons with disabilities. Services include customized database searches and fact sheets.

Phone: (202) 783-2900

TTY/TDD: (202) 737-0725

CSAP's *Drug-Free Workplace Helpline* provides telephone consultation, resource referrals, networking services, and publications to business, industry, and unions to assist in planning and implementing drug-free workplace programs.

Phone: (800) 843-4971

The CSAP Training System provides training for community prevention workers, health professionals, volunteers, and others.

Phone: (301) 572-0200

Center for Substance Abuse Treatment

5600 Fishers Lane, Rockwall II Building
Rockville, Maryland 20857

Division of State Programs
Phone: (301) 443-3820

Office of Scientific
Analysis and Evaluation
Phone: (301) 443-6549

Division of National
Treatment Demonstrations
Phone: (301)-443-7745

Division of Clinical Programs
Phone: (301) 443-8160

The Center for Substance Abuse Treatment (CSAT) is part of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. Until 1992, CSAT was known as the Office for Treatment Improvement, or OTI.

Phone (English): (800) 662-4357
Phone (Spanish): (800) 662-9832

CSAT and the National Institute on Drug Abuse operate a Drug Abuse Information and Treatment Referral Line that provides information about drug use, treatment, support groups, and services. Information counselors can discuss problems and provide referrals to State and local drug treatment facilities and programs.

Department of Housing and Urban Development
451 Seventh Street, SW
Washington, DC 20410

Phone: (301) 251-5154
(800) 245-2691

The Department of Housing and Urban Development (HUD) Office for Drug-Free Neighborhoods offers a helpline that provides information on preventing drug abuse and drug trafficking in public and assisted housing.

Drug Enforcement Administration
Drug and Chemical Evaluation Section
600 Army-Navy Drive
Arlington, Virginia 22202

Phone: (202) 307-7183

The Drug Enforcement Administration or DEA provides information about drug regulations.

Food and Drug Administration
Center for Drug Evaluation and Research
Office of Compliance
Division of Scientific Investigation
Regulatory Management Branch, HFD-342
7520 Standish Place, Room 115
Rockville, Maryland 20855

Phone: (301) 594-1029

The Food and Drug Administration or FDA provides information on Federal regulations concerning use of methadone.

National Acupuncture Detoxification Association
349 East 140th Street
Bronx, New York 10454
or
3115 Broadway #51
New York, New York 10027

Phone: (718) 993-3100
or
Phone: (201) 783-3772

The purpose of the National Acupuncture Detoxification Association (NADA) is to provide training and consultation in the use of acupuncture as an adjunct to AOD treatment. NADA training includes didactic work as well as an apprenticeship program.

NADA sponsors annual educational conferences in the United States and Europe. Full membership in NADA is open only to persons who have completed the training program; however, associate members also are welcome.

The NADA Literature Clearinghouse
P.O. Box 1927
Vancouver, Washington 98668-1927
Phone: (206) 254-0186
Fax: (206) 260-8620

Distributes written materials, videotapes, and audiotapes.

Guidepoints: Acupuncture in Recovery
J&M Reports
7402 NE 58th Street
Vancouver, Washington 98662-5207
Phone: (360) 254-0186

Guide points: Accupuncture in Recovery is a monthly independent international newsletter offering objective

reporting on research, clinical practice, public policy, and clinical matters related to the use of acupuncture in treating addictive and mental disorders. Not affiliated with any advocacy group. Subscriptions cost \$180 per year. Reduced rates are available for new subscribers.

National AIDS Clearinghouse

P.O. Box 6603
Rockville, Maryland 20850

English Helpline:

Phone: (800) 342-AIDS

Spanish Helpline:

Phone: (800) 344-SIDA

TTY/TDD Helpline:

Phone: (800) 243-7889

Operated by the Centers for Disease Control and Prevention (CDC), the National AIDS Clearinghouse is a central source of information on acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus infection, including information on the relationship between alcohol and

other drug (AOD) abuse and AIDS. Staff have access to educational materials and databases of materials, service organizations, funding sources, and conferences.

Information on Clinical Trials

Phone: (800) 874-2572

Bulk Publications

Phone: (800) 458-5231

National Institute on Drug Abuse

5600 Fishers Lane
Rockville, Maryland 20857

Phone: (301) 443-1124

Fax: (301) 443-7397

The National Institute on Drug Abuse (NIDA) is part of the National Institutes of Health of the U.S. Department of Health and Human Services. A catalog of training materials in AOD abuse, AIDS, and related areas is available from NIDA's Community and Professional Education Branch.

Appendix D—Acronyms

AA	Alcoholics Anonymous	DSM-III-R	<i>Diagnostic and Statistical Manual of Mental Disorders</i> , edition 3, revised. Superseded in 1994 by DSM-IV-R.
AIDS	acquired immunodeficiency syndrome		
AMSAODD	American Medical Society on Alcoholism and Other Drug Dependencies (now the American Society of Addiction Medicine [ASAM])	DTs	delirium tremens
AOD	alcohol and other drug	FDA	Food and Drug Administration
APA	American Psychiatric Association	FR	<i>Federal Register</i>
ASAM	American Society of Addiction Medicine	GC/MS	gas chromatography/mass spectrometry
ASI	Addiction Severity Index	HBV	hepatitis B virus
AZT	azidothymidine	HCFA	Health Care Financing Administration
CARF	Commission on Accreditation of Rehabilitation Facilities	HCV	hepatitis C virus
CDC	Centers for Disease Control and Prevention	HIV	human immunodeficiency virus
CDRH	chemical dependency recovery hospital	HUD	(Department of) Housing and Urban Development
CFR	Code of Federal Regulations	ICD-9	International Classification of Diseases, ninth revision
CNS	central nervous system	IND	investigational new drug
CSAP	Center for Substance Abuse Prevention	IV	intravenous
CSAT	Center for Substance Abuse Treatment	JCAHO	Joint Commission on Accreditation of Healthcare Organizations
DEA	Drug Enforcement Administration	LAAM	levo-alpha-acetyl-methadol
DHHS	Department of Health and Human Services	NA	Narcotics Anonymous
		NAPAN	National Association for the Prevention of Addiction to Narcotics

Appendix D—Acronyms

NCA	National Council on Alcoholism (now the National Council on Alcoholism and Drug Dependency [NCADD])	PPD	purified protein derivative
		RIA	radioimmunoassay
NCADD	National Council on Alcoholism and Drug Dependency	SAMHSA	Substance Abuse and Mental Health Services Administration
NIDA	National Institute on Drug Abuse	SMA	State Methadone Authority
NIMH	National Institute on Mental Health	SSA	single State agency
ONDCP	Office of National Drug Control Policy	STD	sexually transmitted disease
OSHA	Office of Safety and Health Administration	TB	tuberculosis
		TLC	thin-layer chromatography

Appendix E—Legal and Ethical Issues for Detoxification Programs¹

A host of legal and ethical issues affect the operation of alcohol and other drug (AOD) detoxification programs. Some have to do with consent to treat. For example, staff members often deal with patients who are inebriated or intoxicated. How can they obtain a consent to enter detoxification treatment from such individuals? Are there special consent issues when the patient is a minor?

The staff of detoxification programs are also concerned about the standards of treatment that will apply, especially as managed care becomes more commonplace. Will the staff be held liable for any decisions of a managed care entity that result in harm to a patient? If an insurance carrier decides it will not cover an additional day of detoxification treatment when the program believes an additional day is necessary, what should staff members do?

In some States, detoxification programs treat patients who have been brought in involuntarily by the police or committed to treatment by the court system. What are the legal responsibilities of staff in such cases? Prisons and jails sometimes maintain detoxification units. Do special standards apply to the professionals practicing in such facilities?

Other legal and ethical issues arise during the daily operation of detoxification programs. Some programs use medications, including scheduled drugs, to help ease the detoxification process. What laws should staff be aware of with regard to the use of these medications? How should staff handle drugs that patients bring into the program when they are admitted?

Finally, additional issues arise because of the Federal laws and regulations guaranteeing confidentiality of information about patients. How can a detoxification program and the diverse agencies responsible for the patient's welfare communicate without violating these rules? How should a program, for example, gather information from other (collateral) sources, such as relatives, employers,

criminal justice agencies, schools, or medical personnel? May a program contact a parent of a minor patient without the minor's consent? May a program communicate with an employer who has referred a patient to treatment? What should a program do if a patient does not want to disclose his or her treatment to an insurance carrier? Are there special rules about sharing information with criminal justice agencies? If the patient is threatening harm to him- or herself or another, may the program call the authorities? How can programs handle intoxicated patients who decide not to enter detoxification and insist on driving home? May programs call the police if a patient becomes violent? Should they report suspected child abuse or neglect?

This chapter attempts to answer these and other questions. It is divided into five sections:

- An overview of consent to treatment, standards of care, and medication and drug control
- Federal laws and regulations protecting the patient's right to confidentiality
- Rules governing the use of consent forms
- Rules governing communication of patient information
- Exceptions to rules prohibiting disclosure of patient information.

The answers to many of the questions addressed in this chapter are governed by State rather than Federal laws, and the laws vary from State to State. Consequently, while this chapter offers general advice concerning management of a patient who is too intoxicated to give informed consent, program staff who are faced with this situation should consult with a local attorney who is familiar with this area and the related issue of confidentiality. In some States, the law is still developing. As an example, a program's duty to warn of a patient's threat to harm others is constantly changing as State courts consider current cases. Programs dealing with this and other issues need up-to-the-minute legal counsel.

Consent to Treatment, Standards of Care, and Medication and Drug Control

Consent to Treatment

Adults generally have the right to consent to or to refuse treatment—a right that is grounded in State law, judicial decision, and the United States Constitution. The right to consent to or refuse treatment—in other words, to make an informed choice—is normally based upon a process: The treatment provider presents the patient with a diagnosis, a prognosis, a description of available alternative treatments and their risks and benefits, and a prediction of the likely outcome if there is no treatment. This process requires that the patient have the ability, sometimes called "decisional capacity," to make an informed choice.

Intoxicated or Incapacitated Patients

Detoxification programs, perhaps more than any other kind of AOD abuse treatment program, deal with patients whose capacity to make rational decisions may be impaired. Persons who are intoxicated often demonstrate diminished mental capacity. Individuals who are incapacitated by AODs may be unconscious, or their judgment may be so impaired that they are incapable of making a rational decision about their basic needs, including their need for treatment. How can detoxification programs secure consent when the patient's decisional capacity is diminished?

Staff should assess each patient in order to determine whether he or she is able to give informed consent. If a patient is not able to do so because he or she is intoxicated or incapacitated by AOD use, the program should obtain consent as soon as the patient has regained his or her faculties. In the meantime, the program may obtain consent to treat from a relative or parent, if the patient is accompanied to the program. (In obtaining consent, the program must be aware of the Federal confidentiality laws, as described later in this chapter.) The validity of a third party's consent may depend upon State law.

Minor Patients

Many States have passed laws permitting minors to consent to AOD abuse treatment without parental involvement. Program staff should become familiar with the laws in their State, by consulting either with their single State agency (SSA) or an attorney familiar with the law in this area.²

In those States that require parental consent for

treatment, programs must be aware that the Federal confidentiality regulations require them to obtain a minor's consent before they contact the minor's parent (42 C.F.R. §2.14).³ Thus, if a minor seeks treatment but refuses to authorize the program to speak to his or her parent, the program may inform the minor that it cannot provide services unless he or she consents to have the program contact the parent.

The Federal regulations do contain one exception. A program director may communicate with a minor's parents without his or her consent provided that

- The program director believes that the minor, because of extreme youth or medical condition, does not have the capacity to decide rationally whether to consent to the notification; and
- The program director believes the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or someone else.

If these two conditions do not exist, the program must explain to the minor that, while he or she has the right to refuse to consent to any communication with a parent, the program can provide no services without such communication and parental consent, §2.14(d). Section 2.14(d) applies only to applicants for services. It does not apply to minors who are already patients; their consent to communicate with their parents is always required, as explained below.

Although programs in those States that permit minors to consent to treatment do not need to be concerned about whether they may provide services, they may still have to confront the fact that, in the absence of parental consent, it may be impossible to secure payment for these services. In States where parental consent is not required for treatment, the Federal regulations permit a program to withhold services if the minor will not authorize a disclosure that the program needs in order to obtain financial reimbursement for that minor's treatment. Such a practice, however, may abridge State or local law.

Standards of Care

Managed Care and Treatment Standards

The staff members of AOD detoxification programs expect the care they provide their patients to come under the scrutiny of licensing or accrediting agencies, peer review organizations, and patient advocacy groups. With the advent of managed care, treatment providers are finding themselves under the scrutiny of a fourth group: third-party payers, who are interested not only in quality of care but also in cost containment.

Oversight by a managed care entity may be most problematic in cases where that entity disagrees with

the detoxification program's judgment that a patient needs another day in the program and informs the program that it will not pay for such care. One option is for staff to explain the problem to the patient and try to obtain his or her agreement to pay for the additional day of treatment.⁴ In many cases, the patient will be unable to do so. A second option is to try to arrange to have the patient admitted to a publicly funded program. A third option is to discharge the patient.

From a legal standpoint, if public care is unavailable and the patient cannot pay, programs should probably continue to treat the patient. The law in this area is unsettled. If the program discharges a patient against the judgment of its staff and the patient's outcome is adversely affected, the patient can sue the program for malpractice. This is an unfortunate situation, even if the program wins or convinces the court to place responsibility where it belongs—on the managed care entity. Programs should also be aware that it is possible to get third-party payers to change a negative decision. Should this need arise, consultation with an attorney who can help them advocate for the patient is helpful.

Involuntary Patients

In some States, detoxification programs handle patients who are brought in by the police or by relatives or who are "involuntarily committed" to treatment by the courts. (Involuntary commitment is also known as "protective custody" and "emergency commitment.") States that place the duty to accept involuntary patients on programs often grant them immunity from criminal and civil liability. Such immunity, however, does not protect a program against a malpractice claim.

Jail or prison inmates are another group of involuntary patients. Persons who are incarcerated are entitled to adequate medical care and can sue a provider for malpractice or negligence.⁵ Thus, involuntary patients are entitled to care that generally meets professional standards. Professionals who manage programs in prisons or jails or whose programs accept involuntary patients should stay abreast of standards in this area that have been developed by professional organizations and government agencies.

Medication and Drug Control

Use of Medication During Detoxification

Programs often use medications, including some scheduled drugs, to help patients through the detoxification process. Program staff must be aware

of Federal and State laws and regulations governing the dispensing, storage, and inventory of all medications. These laws and regulations often require that medications be dispensed by certain classes of professionals. Separate provisions often govern the storage, prescription, and dispensing of scheduled drugs. Programs may inquire about such regulations from their SSAs and State departments of health, the Federal Drug Enforcement Administration, or the Federal Food and Drug Administration.

Drugs Brought Into the Program by Patients

Patients sometimes enter AOD detoxification with drugs on their person or in their luggage. Staff may wish to search all newly admitted patients and the belongings they bring with them. The safest approach is to tell the patient at admission that this is a standard part of the process and that he or she must agree to the search in order to enter detoxification. The program also may incorporate this notice in its admission papers, thereby ensuring that the patient agrees to it in writing.

If a staff member finds drugs on a patient or in a patient's luggage, what should the program do? State regulations sometimes govern how a program may dispose of drugs. They may require, for example, that the drugs be flushed down the toilet, destroyed, or turned over to the police.⁶ (The Federal confidentiality laws and regulations, however, prohibit programs from turning patients who are in possession of drugs over to the police.) If a program does destroy drugs brought into treatment by patients, it is advisable for staff members responsible for such destruction to carry it out under observation and maintain a record of the act, so that a patient cannot later make a false accusation about what occurred. State regulations also govern the methods for handling prescription and over-the-counter medications that patients bring into treatment. Programs should check with their SSA for further guidance about State mandates.

Drugs Brought Into the Program by Visitors

While programs cannot turn patients with illegal drugs over to the police, no such restrictions apply to visitors who enter the program facility with drugs. As long as no disclosure is made about a patient, such persons may be reported to the police. A program that plans to search visitors for drugs must obtain their consent, although it may make visiting privileges contingent on consent to search. The use of force should be avoided, as a visitor could sue the program for battery or false imprisonment.

Federal Law Protecting the Patient's Right to Confidentiality

Two Federal laws (42 U.S.C. §§290dd-2 (1992) and a set of Federal regulations (C.F.R. Part 2) guarantee the strict confidentiality of information about all persons receiving AOD abuse prevention and treatment services.⁷ They are designed to protect privacy rights and thereby attract individuals into treatment. The regulations are more restrictive of communications than are those governing the doctor-patient relationship or the attorney-client privilege. Violating the regulations is punishable by a fine of up to \$500 for a first offense or up to \$5,000 for each subsequent offense (§2.4).

While some persons may view the restrictions that Federal regulations place on communications as a hindrance, if not a barrier, to program goals, due foresight can eliminate most of the problems that arise from the regulations. Familiarity with the regulations will facilitate communication and minimize the incidence of confidentiality-related conflicts among program, patient, and outside agency.

Types of Programs Covered by the Regulations

Any program that specializes, in whole or in part, in providing detoxification, treatment, counseling and assessment, and referral services, or a combination thereof, for patients with alcohol or other drug problems must comply with the Federal confidentiality regulations, §2.12(e). It is the kind of services provided, not the label, that determines whether a program must comply with the Federal law. Calling itself a "prevention program" does not insulate a program that also offers treatment services from the need to comply with confidentiality regulations. Although the Federal regulations apply only to programs that receive Federal assistance, the word "assistance" is broadly interpreted and includes indirect forms of Federal aid such as tax-exempt status or State or local funding that is derived, in whole or in part, from the Federal Government.

Federal Confidentiality Laws

The Federal confidentiality laws and regulations protect any information about a patient if the patient has applied for or received any alcohol- or drug-abuse-related services—including assessment, diagnosis, detoxification, counseling, group counseling, treatment, and referral for treatment—from

a covered program. The restrictions on disclosure apply to any information that would identify the patient as an AOD abuser, either directly or by implication. The rule applies from the moment the patient makes an appointment. It applies to patients who are civilly or involuntarily committed, minor patients, patients who are mandated into treatment by the criminal justice system, and former patients. Finally, the rule applies whether or not the person making the inquiry already has the information, has other ways of getting it, enjoys official status, is authorized by State law, or comes armed with a subpoena or search warrant.⁸

Conditions Under Which Confidential Information May Be Shared

Information that is protected by the Federal confidentiality regulations may always be disclosed after the patient has signed a proper consent form. (As explained earlier in this chapter, if the patient is a minor, parental consent must also be obtained in some States.) The regulations also permit disclosure without the patient's consent in several situations, including communicating information to medical personnel during a medical emergency or reporting child abuse to the authorities.

The most commonly used exception to the general rule prohibiting disclosures is for a program to obtain the patient's consent. The regulations' requirements regarding consent are somewhat unusual and strict and must be carefully followed.

Rules Governing Informed Consent

Required Items

Disclosures are permissible if a patient has signed a valid consent form that has not expired or been revoked (§2.31).⁹ According to this section, a proper consent form must be in writing and must contain each of the items that appear in Exhibit E-1.

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. A sample consent form may be found in Exhibit E-2. The following required items merit further explanation:

- The purpose of the disclosure
- How much and what kind of information will be disclosed.

These two items are closely related. All disclosures, especially those made pursuant to a

consent form, must be limited to information that is necessary to accomplish the need for or purpose of the disclosure, §2.13(a). It would be improper to disclose everything in a patient's file if the person making the request needed only one specific piece of information.

In completing a consent form, one must determine the purpose of or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed and to restrict the disclosure to what is essential to accomplish the identified need or purpose. As an illustration, if a patient needs to have the fact that he or she has entered a detoxification program verified in order to be eligible for a benefit program, the purpose of the disclosure would be "to verify treatment status," and the amount and kind of information to be disclosed would be "enrollment in treatment." The disclosure would then be limited to a statement that "Jane Doe [the patient] is receiving counseling at XYZ Program."

- **The patient's right to revoke consent**

The patient may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has made a disclosure prior to the revocation, the program has "acted in reliance" on the consent and is not required to try to retrieve the information it has already disclosed.

The regulations state that acting in reliance includes providing services in reliance on a consent form permitting disclosures to a third-party payer. Thus, a program may bill the third-party payer for past services to the patient even after consent has been revoked. A program may not, however, make any disclosure to the third-party payer in order to receive reimbursement for services provided after the patient has revoked consent §2.31(a)(8).

- **Expiration of the consent form**

The form must also contain a date, an event, or a condition on which it will expire, if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given," §2.31(a)(9). If the purpose of the disclosure is expected to be accomplished in 5 or 10 days, it is better to stipulate that amount of time rather than to request a longer period or have a uniform 60- or 90-day expiration date for all forms.

The consent form may specify an event or a condition for expiration, rather than a date. For example, if a patient has been placed on probation at work on the condition that he or she attend the detoxification program, the consent form should not expire until the expected time of completion of the probationary period. Alternatively, if a patient is being referred by the program to a specialist for a single appointment, the consent form should provide that it will expire after he or she has seen "Dr. X," unless the patient is expected to need ongoing consultation with the specialist.

- **Signatures of minors and parental consent**

In order for a program to release information about a minor, even to his or her parent or guardian, the minor must have signed a consent form. The program must obtain the parent's signature only if it was required by State law to obtain parental permission before providing treatment to the minor (§2.14). ("Parent" includes parent, guardian, or other person legally responsible for the minor.) In other words, if State law does not require the program to get parental consent in order to provide services to a minor, parental consent is not required to make disclosures, §2.14(b). If, by contrast, State law requires parental consent to provide services to minors, parental consent also is required to make any

Exhibit E-1

Patient Consent Form: Required Items*

- Name or general description of the program(s) making the disclosure
- Name or title of the individual or organization that will receive the disclosure
- Name of the patient who is the subject of the disclosure
- Purpose of or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the patient may revoke the consent at any time, except to the extent that the program has already acted in reliance on it
- Date, event or condition upon which the consent expires, if not previously revoked
- Signature of the patient (and, for minors in some States, his or her parent)
- Date on which the consent is signed

* As set forth in §2.31(a).

Exhibit E-2

Consent for the Release of Confidential Information

I, _____, authorize
(Name of patient)

(Name or general designation of program making disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information: _____
(Nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is to: _____

(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

Dated: _____
(Signature of participant)

(Signature of parent, guardian, or
authorized representative when required)

disclosures. The program must always obtain the minor's consent for disclosures; it cannot rely on the parent's signature alone. The single limited exception to this rule has been discussed in Section I.A.2 above.

Required Notice Against Redisclosing Information

Once the consent form has been properly completed, one formal requirement remains. Any disclosure made with written patient consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient may not make any further disclosure unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient at the time of disclosure or earlier.

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. A patient may, of course, sign a consent form authorizing such a redisclosure. A sample Notice of Prohibition appears in Exhibit E-3.

Decisions Concerning Disclosure

The fact that a patient has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order, §§2.3(b); 2.61(a)(b). The only obligation the program has is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid, §2.31(c).

In most cases, the decision whether or not to make a disclosure pursuant to a consent form is within the discretion of the program, unless State law requires or prohibits disclosure once consent is given. In general, it is best to follow this rule: disclose only what is necessary, for only as long as is necessary, in light of the purpose of the communication.

Rules Governing Communication of Information

Seeking Information From Collateral and Referral Sources

Making inquiries of parents, other relatives, healthcare providers, employers, schools, or criminal justice agencies might seem at first glance to pose no risk to a patient's right to confidentiality, particularly if the person or entity approached for information referred the patient to treatment. Nonetheless, it does.

When a program that screens, assesses, or treats a patient asks a relative or parent, a doctor, an employer, or a school to verify information it has obtained from the patient, it is making a "patient-identifying disclosure." Patient-identifying information is information that identifies someone as an AOD abuser. In other words, when program staff seek information from other sources, they are letting these sources know that the patient has asked for detoxification services. The Federal regulations generally prohibit this kind of disclosure, unless the patient consents.

How should a program go about making such requests? The easiest way is to get the patient's consent to contact the relative, doctor, employer, school, or healthcare facility. When filling out the consent form, staff should give thought to the "purpose of the disclosure" and "how much and what kind of information is to be disclosed." For example, if a program is assessing a patient for treatment and seeks records from a mental health provider, the purpose of the disclosure would be "to obtain mental health treatment records to complete the assessment." The "kind of information disclosed" would be limited to a statement that "Robert Roe (the patient) is being assessed by the XYZ Program." No other information about Robert Roe would be released. If the program not only seeks records but also wishes to discuss with

Exhibit E-3

Prohibition on Redisclosing Information Concerning AOD Abuse Treatment Patients

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

the mental health provider the treatment he or she provided the patient, the purpose of the disclosure would be "to discuss mental health treatment provided to Robert Roe by the mental health program." If the program merely seeks information, the kind of information disclosed would, as in the example above, be limited to a statement that "Robert Roe is being assessed by the XYZ Program;" however, if the program needs to disclose information it has gained in its assessment of Robert Roe to the mental health provider in order to further the discussion or coordinate care, the kind of information disclosed would be "assessment information about Robert Roe."

A program that routinely seeks collateral information from many sources could consider asking the patient to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Such a form must still include "the name or title of the individual or the name of the organization" for each collateral source the program may contact.

Even when information is disclosed over the telephone, program staff are required to notify the recipient of the information of the prohibition on redisclosure. Mention should be made of this restriction during the conversation; for example, the staff member could say, "I'll be sending you a written statement that the information I gave you about Mr. Roe may not be redisclosed."

Communications with employers may warrant special consideration. When a patient enters treatment voluntarily, program staff should maintain an open mind about whether communications with an employer would be beneficial to the patient. A patient who tells program staff that his or her employer will not be sympathetic about the decision to enter treatment may well have an accurate picture of the employer's attitude. Should staff insist on communicating with the employer, the patient may lose his or her job. If such communication takes place without the patient's consent, the program may be faced with a lawsuit.

Communications with Insurance Carriers

Programs must obtain a patient's written consent on the form required by the Federal regulations in order to communicate with any third-party payer who may be responsible for funding the patient's treatment. Some patients do not want their treatment reported to the insurer. Patients whose employers are self-insured may fear they will be fired, demoted, or disciplined, should their employer learn they have a substance

abuse problem.¹⁰ Patients whose treatment is covered by health insurance may fear they will lose their benefits and be unable to obtain other coverage once their current insurer discovers they have been treated for a substance abuse problem.¹¹ What should programs do in these circumstances?

The program clearly cannot make a disclosure to a third-party payer without the patient's consent. If the third-party payer is the patient's employer, the program would not only be violating the Federal regulations but also would be risking a lawsuit, should the patient be fired or disciplined. If the third-party payer is an insurance company, the program is taking similar risks: If the patient's insurance is canceled or he or she cannot obtain coverage elsewhere, the program may face a lawsuit.

If a patient does not want the insurance carrier to be notified and is unable to pay for treatment, the program may refer the patient to a publicly funded program, if one is available.¹² Programs should consult State law to learn whether they may refuse to admit a patient who is unable to pay and who will not consent to the necessary disclosures to his or her insurance carrier.

Insurance carriers, particularly managed care entities, are demanding more and more information about the patients covered by their policies and the treatment provided to those patients. Programs need to be sensitive about the amount and kind of information they disclose, because the insurer may use this information to deny benefits to the patient. For example, if, in response to a request from the insurer, the program releases the patient's entire chart, the insurer may learn from the intake notes that the patient's substance abuse problem included both alcohol and illegal drugs. The insurer may then deny benefits, arguing that since its policy does not cover treatment for abuse of drugs other than alcohol, it will not reimburse for treatment when abuse of both alcohol and drugs is involved. As a second example, the insurer may learn that the patient began drinking at age 11 and deny benefits for a "preexisting condition." Treatment notes may contain personal information about the patient's family life that is extraneous for insurance company review, the sole purpose of which is to determine whether treatment should be covered and, if so, what kind.

Communication Among Agencies

Communication With Other Care Providers

Detoxification programs sometimes need to maintain ongoing communication with the referral source or with other professionals providing services to patients.

The best way to proceed is to get the patient's consent.

In wording the consent form, one should take care to permit the kinds of communications necessary. For example, if the program will need ongoing communication with a mental health provider, the "purpose of the disclosure" would be "coordination of care for Mildred Moe;" "how much and what kind of information to be disclosed" might be "treatment status, treatment issues, progress in treatment." If the program is treating a patient who is on probation at work and whose continued employment is contingent on treatment, the "purpose of disclosure" might be "to assist the patient to comply with employer's mandates" or "supply periodic reports about treatment;" "how much and what kind of information will be disclosed" might be "progress in treatment." The kinds of information that would be disclosed in the two examples are quite different. The program might well share detailed clinical information about a patient with a mental health provider, if it would assist in coordinating care. Disclosure to an employer, by contrast, would generally be limited to a brief statement about the patient's progress in treatment. Disclosure of clinical information to an employer generally would be inappropriate.

The program should also be careful in setting the expiration date or event on which expiration of the consent form is based. A consent form with a mental health provider might expire when treatment ends, while a form permitting disclosures to an employer might expire when the patient's probationary period at work ends.

Referral for Further Treatment

When a staff member of a detoxification program refers a patient to another treatment program and makes an appointment for the patient, he or she is making a disclosure covered by the Federal regulations—a disclosure that the patient has sought or received detoxification services. A consent form is, therefore, required. If the detoxification program is part of a larger program to which the patient is being referred, a consent form may not be necessary under the Federal rules, since there is an exception for information disclosed to staff within the same program.

Transferring Patients to the Hospital

Detoxification programs, particularly those with limited medical resources, often must transfer patients to a hospital for intensive medical management and care. How should programs handle such transfers, since they involve a disclosure of patient-identifying

information?

Programs may deal with this issue in two ways. First, they may ask all patients admitted to detoxification to sign a consent form permitting disclosure to the cooperating hospital, should hospitalization be required. Second, they may take advantage of a provision in the Federal regulations that permits a program to make disclosures in a "medical emergency" to medical personnel "who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual." The regulations define "medical emergency" as "a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention" (§2.51). If a patient's condition requires emergency treatment, the program may use this exception to communicate with medical personnel at a hospital. Whenever a disclosure is made to cope with a medical emergency, the program must document in the patient's records the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Mandatory Reporting to Public Health Authorities

All States require that new cases of acquired immunodeficiency syndrome be reported to public health authorities, which submit this information to the Federal Centers for Disease Control and Prevention. In some cases, they also use it for other purposes. Some States also require the reporting of new cases of human immunodeficiency virus infection. States also require reporting of certain infectious diseases, such as tuberculosis and sexually transmitted diseases. The public health authority often uses reports of infectious diseases to engage in "contact tracing," that is, finding others to whom an infected person may have spread the disease.

The types of information that must be reported and for which diseases, who must report, and the purposes to which the information is put vary from State to State. Therefore, program directors must examine their State laws to discover (1) whether they or any member of their staff is a mandated reporter, (2) when reporting is required, (3) what information must be reported and whether it includes patient-identifying information, and (4) what will be done with the information reported.¹³

If State law permits the use of a code rather than a patient's name, the program may make the report without the patient's consent, since no patient-identifying information is being revealed.

If patient-identifying information must be reported, there are a number of ways programs can comply with State mandatory reporting laws without violating the Federal confidentiality regulations. They include the following:

- **Obtaining consent.** The easiest way to comply with a State law that mandates reporting of patient-identifying information to a public health authority is to obtain the patient's consent. The information reported by the program may not be redisclosed by the public health authority unless the consent form is drafted to permit redisclosure.
- **Reporting without making a patient-identifying disclosure.** If the program is part of another health care facility (for example, a general hospital or mental health program), it can include the patient's name in reports if it does so under the name of the parent agency, as long as no information is released that would link the patient with AOD abuse treatment.
- **Using a Qualified Service Organization Agreement (QSOA).** A detoxification program that is required to report patients' names to a public health department also may enter into a QSOA with a general medical care facility or a laboratory that conducts testing or other services for the program. The QSOA, which is explained in detail later in this chapter, permits the detoxification program to report the names of patients to the medical care facility or laboratory, which may then report the information, including patient names, to the public health department. However, no information is provided that would link those names with AOD abuse treatment.
- **Reporting under the audit and evaluation exception.** One of the exceptions to the general rule prohibiting disclosure without patient consent permits programs, under certain conditions, to disclose information to auditors and evaluators (§2.53). This provision is discussed earlier in this chapter. The U.S. Department of Health and Human Services (DHHS) has written two opinion letters that approve the use of the audit and evaluation exception to report HIV-related information to public health authorities.¹⁴ Read together, these two letters suggest that AOD programs may report patient-identifying information even if that information will be used by the public health department to conduct contact tracing, as long as the health department does not disclose the name of the patient to the "contacts" it approaches. The letters also suggest that the public health authorities could use the information to contact the infected patient directly.

As its name implies, §2.53 is intended to permit an outside entity, such as a peer review organization or an accounting firm, to examine or copy a program's records in order to determine whether it is operating in accordance with regulations. It was not intended to permit an outside entity to gain information to perform other tasks or accomplish other social ends. The legal validity of these two letters may, therefore, be considered debatable.

Telephone Calls to Patients

If someone telephones a patient at a detoxification program, the staff may not reveal that the patient is at the program unless the program has a written consent form signed by a patient to make a disclosure to that particular caller. Given this restriction, how should a program handle telephone calls to patients? There are at least four options:

- The program can obtain the patient's written consent to accept telephone calls from particular people and consult a list of these individuals' names when the patient receives a phone call.
- If the patient has not consented to receive calls from a particular person, the staff member can put the caller on hold and ask the patient if he or she wants to speak to the caller. If the patient wants to accept the call, the patient, not the staff member, is making the disclosure that he or she is at the detoxification program. If the patient does not want to speak to the caller, the staff member must tell the caller, "I'm sorry, but I can't tell you whether Tommy Toe is here." At no time may the program reveal, even indirectly, that the person being inquired after is a patient at the program.
- The program can uniformly take messages for patients, telling all callers, "I'm sorry, but I cannot tell you if Tommy is here, but if he is I will give him this message." Again, this leaves it up to the patient whether to make a disclosure about being in treatment.
- The program can set up a "patient phone" that is answered only by patients. Since only patients would answer the telephone and give the phone number to others if the number were unlisted, the program would be making no disclosures. The program should caution patients to act discreetly and thoughtfully when handling calls for others.

Patients Mandated into Treatment by the Criminal Justice System

Detoxification programs treating patients who are required to enter and participate in treatment as part

of a criminal justice sanction must follow the Federal confidentiality rules. In addition, some special rules apply when a patient is in treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding, and information is being disclosed to the mandating agency.

A consent form or court order is still required before any disclosure may be made about an offender who is mandated into assessment or treatment. However, the rules concerning the length of time that a consent remains valid are different, and a "criminal justice system consent" may not be revoked before its expiration event or date.

The regulations require that the following factors be considered in determining how long a criminal justice system consent will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the offender is involved
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Anything else the patient, program, or criminal justice agency believes is relevant.

These rules allow programs to continue to use a traditional expiration condition for a consent form that once was the only one allowed, namely, "when there is a substantial change in the patient's criminal justice system status." A substantial change in status occurs whenever the patient moves from one phase of the criminal justice system to the next. For example, if a patient is on probation or parole, a change in criminal justice status would occur when the probation or parole ended, either by successful completion or revocation. Thus, the program could provide treatment or periodic reports to the probation or parole officer monitoring the patient and could even testify at a revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing. This formula appears to work well.

Concerning revocability of the consent (that is, the conditions under which the offender can take back his or her consent), the regulations provide that the form may state that consent may not be revoked until a specified date arrives or condition occurs. The regulations permit the criminal justice system consent form to be irrevocable, so that a patient who has agreed to enter treatment in lieu of prosecution or punishment cannot later prevent the court, probation department, or other agency from monitoring his or her progress. Although a criminal justice system consent may be made irrevocable for a specified period of time, its irrevocability must end no later

than the final disposition of the criminal proceeding. Thereafter, the patient may freely revoke consent.

Several other considerations relating to criminal justice system referrals are important. First, any information received by one of the eligible criminal justice agencies from a treatment program may be used by that justice agency only in connection with its official duties with respect to that particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals, §2.34(d). Second, whenever possible, the judge or referring agency should require that a proper criminal justice system consent form be signed by the patient at the time he or she is referred to the treatment program. If this is not possible, the treatment program should have the patient sign a criminal justice system consent form at his or her first appointment. With a properly signed criminal justice consent form, the detoxification program can communicate with the referring criminal justice agency, even if the patient appears for assessment or treatment only once. This avoids the problems that may arise if a patient mandated into treatment does not sign a proper consent form and leaves before the assessment or treatment has been completed.

If a program fails to have the patient sign a criminal justice system form and the patient fails to complete the assessment or treatment, the program has few options when faced with a request for information from the referring criminal justice agency. The program could attempt to locate the patient and ask him or her to sign a consent form. The patient is, however, unlikely to do so. It is uncertain whether a court can issue an order to authorize the program to release information about a referred patient who has left the program in this type of case, because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a patient for a crime only when the crime was "extremely serious." A parole or probation violation generally will not meet that criterion.

Therefore, unless the judge, criminal justice agency, or program obtains consent at the beginning of the assessment or treatment process, the program may be prevented from providing any information to the referring criminal justice agency.

If a patient referred by a criminal justice agency never applies for or receives services from the program, that fact may be communicated to the referring agency without patient consent, §2.13(c)(2). As soon as a patient has made an appointment to visit the program, a signed consent form or a court order is needed for any disclosures.

Duty to Warn

Patient Threats

For most treatment professionals, the decision whether to report a patient's threat to commit a crime is a troubling one. Many professionals believe that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly if the crime is a serious one. While these issues may not arise often, programs may face questions about their "duty to warn" someone of a patient's threatened suicide, a patient's threat to harm another, or a patient's insistence on driving while impaired.

There is a developing trend in the law to require therapists who have learned that a patient presents a "serious danger of violence to another" to take "reasonable steps" to protect an intended victim. This trend started with the case of *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for monetary damages because he failed to warn a potential victim his patient threatened to, and then did, kill. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

While strictly speaking the *Tarasoff* ruling applies only in California, courts in a number of other States have followed it in finding therapists and others liable for damages when they failed to warn a potential victim of threats disclosed during therapy by their patients. Most of these cases are limited to situations where patients threaten a specific victim; they do not generally apply where a patient makes a threat without identifying the intended target. States that have enacted laws on the subject have similarly limited the duty to warn to situations in which the identity of the potential victim has been revealed.

Faced with a potential "duty to warn" question, program staff must answer two, or sometimes three, questions:

1. Is there a legal duty to warn in this particular situation under State law?
2. If there is no State legal requirement to warn an intended victim or the police, does the program believe a moral obligation to warn exists?

The first question may be answered only by an attorney familiar with the law in the State in which the program operates. If the answer is "no," it is advisable to discuss the second question with a

knowledgeable lawyer as well.

3. If the answer to questions 1 or 2 is "yes," can the program warn the potential victim or someone likely to be able to take action without violating the Federal confidentiality regulations?

There is an apparent conflict between the Federal confidentiality requirements and the duty to warn imposed by States that have adopted the principles of the *Tarasoff* case. Simply put, the Federal confidentiality law and regulations prohibit a program from making the type of disclosure that *Tarasoff* and similar cases require,¹⁵ unless it can do so by using one of the regulation's narrow exceptions.

When a patient threatens harm to self or another, a program has four options:

1. It can go to court and request a court order authorizing the disclosure. The program must take care that the court abides by the requirements of the Federal confidentiality regulations.¹⁶
2. The program can make a disclosure that does not identify as a patient the individual who threatens to commit the crime. This can be accomplished either by making an anonymous report or, for a program that is part of an entity whose sole focus is not AOD treatment, by making the report in the larger entity's name. For example, a counselor employed by a detoxification program that is part of a mental health facility could telephone the police or the potential target of an attack, identify herself as a "counselor at the Johnson City Mental Health Clinic," and explain the risk. This would convey the vital information without identifying the patient as an alcohol or drug abuser. Counselors at freestanding detoxification units may not give the name of the program.
3. The program can make a report to "medical personnel" if the threat presents a "medical emergency" that poses an immediate threat to the health of any individual and "requires immediate medical intervention" (§2.51). For example, a program could notify a private physician about a suicidal patient so that medical intervention can be arranged.

4. The program can obtain the patient's consent. This may be unlikely, unless the patient is suicidal.

If none of these options is practical, what should a program do? It is, after all, confronted with conflicting moral and legal obligations. If a program believes there is clear and imminent danger to a patient or another person, it is probably prudent to report the danger to the authorities or the threatened individual. This is especially true in States that already follow the *Tarasoff* rule. While each case presents different questions, it is doubtful that any

prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a program or counselor who warned about potential violence when he or she believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn might well result if a threat were actually carried out. In any event, the program should try to make the warning in a manner that does not identify the individual as an AOD abuser.

As in other areas where the law is developing, programs should find a lawyer familiar with State law who can provide advice on a case-by-case basis. "Duty to warn" issues also present an area in which staff training, as well as a staff review process, may be helpful.

Driving While Impaired

Suppose that an intoxicated patient arrives at a detoxification program but decides not to enter treatment. If the patient is not in condition to drive home, what should the program do? First, it can offer the patient a ride home or taxi fare for a ride home. Second, it can maintain a room where such a person can "sleep it off." (The program would be wise to obtain the person's consent to alert his or her family.) This strategy can also be used by detoxification programs that do not admit patients who are inebriated.

What if the patient refuses both offers and leaves the premises, intending to drive home? Does the program have a duty to call the police to prevent an accident? Does it risk a lawsuit if it fails to do so? This is a question of State law.

In most States, it is unlikely that the program would be liable, particularly if it had made an effort to stop the patient from driving. As noted above, in States that follow the *Tarasoff* doctrine, liability has generally been limited to those situations where a patient threatens to harm a specific person. Liability has generally not been imposed in situations where a patient poses a threat to the community in general.

Liability concerns aside, the program may nonetheless believe it is obligated to call the police if its attempts to prevent the patient from driving fail. In doing so, it must take care not to violate the patient's confidentiality. For example, the program can call the police and tell them that the driver of a 1991 tan Nissan with a license number "XYZ 123," who is heading downtown from the intersection of Maple and Third streets, is not in a condition to operate a vehicle. The program should ask the police to respond immediately. The program may not tell the police that the patient has a substance abuse problem.

This means it may not tell the police that the patient is impaired by alcohol or drugs and cannot reveal the program's name, since to do so would tell the police that the patient has a substance abuse problem.

In order to get the patient's license number and a description of his or her car, it may be necessary to detain the patient. If it does so, the program should avoid using force, since the patient could sue the program for battery or false imprisonment.

Dealing With Police

Programs sometimes unknowingly admit patients who are sought by the police. If the police discover that someone they are seeking is at the program and come armed with an arrest warrant, what should the program do? How should programs handle search warrants? The answers to these questions are quite different.

Arrest Warrants

An arrest warrant gives police the authority to search the program facilities; however, the program is not authorized to help the police by pointing out the offender.¹⁷ The unfortunate result is that the confidentiality of all patients in the program may be compromised when the police enter and search for a fugitive. There is no solution to this problem, unless the police secure a court order under §2.66, which would authorize the program to disclose the identity of the patient. If the program cannot convince the police to obtain a court order, it can try to convince the patient to surrender voluntarily. (Voluntary surrender by a patient is a disclosure by the patient, not the program.) It is usually in the patient's best interest to surrender voluntarily, since arrest is probably inevitable and cooperation may positively influence the prosecutor and judge when the question of bail arises. The risk is that the patient will attempt to escape, which might expose the program to a charge of assisting unlawful escape. To reduce this possibility, the program should work with the police so that law enforcement personnel have secured the area around the program.

Search Warrants

A search warrant does not authorize the program to permit the police to enter the premises. Even if signed by a judge, a search warrant is not the kind of "court order" that the Federal regulations require before the program can allow anyone to enter and see patients or patient records when patients have not consented. Law enforcement officials are unlikely to know about the restrictions of the Federal regulations, however,

and they will probably believe that a search warrant permits them to enter and search the program. What should a program do?

Presented with a search warrant, program staff should show the officer a copy of the Federal regulations and explain their restrictions. Staff can suggest that the officer obtain a court order that will authorize the program to make the disclosure called for in the search warrant. No harm will ordinarily be caused by resultant delay (although the police may not agree with this view). The program should call its lawyer and let him or her talk with the police. Failing that, a program could try to call the prosecutor who has sent the police, explain the regulations, and point out that any evidence seized without the proper court order may be excluded at trial, since it will have been seized illegally.

If none of these steps works, the program must permit the police to enter. Refusal to obey a direct order of the police may be a crime, even if the police are wrong, and forcible resistance would be unwise. If the program has made a good faith effort to convince the law enforcement authorities to pursue the proper route, it is unlikely that it would be held liable for allowing entry when argument fails.

Conclusion

Programs should develop protocols for dealing with arrest and search warrants and have a copy of the Federal regulations available at all times to show law enforcement officials. Programs should establish a relationship with an attorney who can be called upon to help in these situations. Finally, programs should reach out to law enforcement agencies before a crisis arises and work with them to develop ways of dealing with these issues. If the regulations are explained when there is no emergency and there can be no suspicion that the program is hiding anyone or anything, and a protocol is established, unpleasant confrontations may be avoided.

Reporting Criminal Activity by Patients

What should a program do when, for example, a patient tells a counselor that she intends to get her children some new clothes by shoplifting—a crime the counselor knows she has committed many times in the past? Does the program have a duty to tell the police? Does a program have a responsibility to call the police when a patient discloses to a counselor that he or she participated in a serious crime some time in the past? What can a program do when a patient commits a crime at the program or against an employee of the

program? Each of these questions requires separate analysis.

Threatened Criminal Activity

A program generally does not have a duty to warn another person or the police about a patient's intended actions, unless the patient presents a serious danger of violence to an identifiable individual. In the example above, shoplifting rarely involves violence, and it is unlikely that the counselor will know which stores are to be victimized. Petty crimes like shoplifting are important issues, but they should be dealt with therapeutically. They are not something a program should necessarily report to the police.

Past Criminal Activity

Suppose that a patient admits during a counseling session that he killed someone during a robbery 3 months ago. Does the program have a responsibility to report that?

In a situation where a program thinks it might have to report a past crime, three questions must be answered:

- 1. Is there a legal duty under State law to report the past criminal activity to the police?**

The answer to this question is generally no. In most States, there is no duty to report to the police a crime committed in the past. Even those States that continue to make failure to report a crime rarely prosecute violators of the law.

- 2. Does State law permit a counselor to report the crime to law enforcement authorities if he or she wants to?**

Whether or not there is a legal obligation to report past crimes to the police, State law may protect conversations between counselors of detoxification programs and their patients and may exempt counselors from any requirement to report past criminal activity by patients. Such laws are designed to protect the special counselor-patient relationship.

State laws vary widely on the protection they accord communications between patients and counselors. In some States, admissions of past crimes may be considered privileged, and counselors may be prohibited from reporting them; in others, admissions may not be privileged. Moreover, each State uniquely defines the kinds of relationships protected. Whether a communication about past criminal activity is privileged (and therefore cannot be reported) may depend on the counselor's profession and whether he or she is State-licensed or certified. Any program that is concerned about this issue should ask a local attorney for an opinion letter about whether there is a

duty to report and whether any counselor-patient privilege exempts counselors from that duty.

3. If State law requires a report, or if it permits one and the program decides to make a report, how can the program comply with the Federal confidentiality regulations and State law?

Any program that decides to make a report to law enforcement authorities about a patient's prior criminal activity must do so without violating either the Federal confidentiality regulations or State laws. It may comply with the Federal regulations by following one of the first three methods described in the discussion of duty to warn, namely:

- It can make a report in a way that does not identify the individual as a patient in a detoxification program
- If the crime is sufficiently serious, it can obtain a court order permitting it to make a report
- If the patient is an offender who has been mandated into treatment by a criminal justice agency, the program can make a report to that agency, provided it has a criminal justice system consent form signed by the patient that is worded broadly enough to allow disclosure of this sort of information.

Because of the complicated nature of this issue, any program considering reporting a patient's admission of criminal activity should seek the advice of a lawyer familiar with local law as well as the Federal regulations.

Crimes on Program Premises or Against Program Personnel

When a patient has committed or threatens to commit a crime on program premises or against program personnel, the regulations are more straightforward. They permit the program to report the crime to a law enforcement agency or to seek its assistance. Without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient at the program, §2.12(c)(5).

Reporting Child Abuse and Neglect

All 50 States have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report and when, and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral

report, and many have toll-free numbers to facilitate reporting. Half of the States require both oral and written reports. All States extend immunity from prosecution to persons reporting child abuse and neglect. Most States provide for penalties for failure to report.

Because of the variations in State laws, programs should consult these documents to ensure that their reporting practices are in compliance. Since many State statutes require that staff report instances of abuse to administrators, who are then required to make an official report, programs concerned about this issue should establish reporting protocols under which staff may bring incidents of suspected child abuse to the attention of program administrators, who must then shoulder the responsibility to make the mandated reports.

The Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. This exception to the general rule prohibiting disclosure of any information about a patient, however, applies only to initial reports of child abuse or neglect. Unless the patient consents or the appropriate court issues a special court order, programs may not respond to followup requests for information, or even to subpoenas, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report.

Conducting Research

Research about and evaluation of the efficacy of different methods of detoxification are essential if advances in treatment are to be made. But can detoxification programs share patient-identifying information with researchers and program evaluators? The confidentiality regulations do permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, providing certain safeguards are met (§§2.52, 2.53).

Research

Detoxification programs may disclose patient-identifying information to persons conducting "scientific research" if the program director determines that the researcher (1) is qualified to conduct the research, (2) has a protocol under which patient-identifying information will be kept in accordance with the regulations' security provisions (see §2.16, as described below), and (3) has provided a written statement from a group of three or more independent individuals who have reviewed the protocol and determined that it protects patients' rights.

Researchers are prohibited from identifying an individual patient in any report or from otherwise disclosing any patient identities, except back to the program.¹⁸

Audit and Evaluation

Federal, State, and local government agencies that fund or are authorized to regulate a program, private entities that fund or provide third-party payments to a program, and peer review entities performing a utilization or quality control review may review patient records on the program premises in order to conduct an audit or evaluation.¹⁹ Any person or entity that reviews patient records to perform an audit or conduct an evaluation must agree in writing that it will use the information only to carry out the audit or evaluation and that it will redisclose patient information only (1) back to the program, (2) in accordance with a court order to investigate or prosecute the program (§2.66), or (3) to a Government agency overseeing a Medicare or Medicaid audit or evaluation, §2.53(a), (c), (d). Any other person or entity that is determined by the program director to be qualified to conduct an audit or evaluation and that agrees in writing to abide by the restrictions on redisclosure also may review patient records.

Followup Research

Research that follows patients for any period of time after they leave treatment presents a special challenge under the Federal regulations. The detoxification program, researcher, or evaluator who seeks to contact former patients to gain information about how they are faring after leaving treatment must do so without disclosing to others any information about their connection to the detoxification program. If followup contact is attempted by telephone, the caller must make sure he or she is talking to the patient before identifying himself or herself or mentioning a connection to the detoxification program. For example, asking for "Willy Woe," when his wife or child has answered the phone, and announcing that one is calling from the "ABC Detoxification Program" (or the "Drug Research Corporation") violates the regulations. The program or research agency may form another entity, without a hint of detoxification (or drugs or alcohol) in its name (for example, Health Research, Inc.) that can contact former patients without worrying about disclosing information simply by giving its name. When a representative of such an entity calls former patients, however, care must be taken that the patient is actually on the line before revealing any connection with the detoxification

program.

If followup is done by mail, the return address should not disclose any information that could lead someone seeing the envelope to conclude that the addressee had been in treatment.

Five Other Exceptions to the General Confidentiality Rule

Reference has been made to other exceptions the Federal confidentiality rules make to the general rule prohibiting disclosure. Presented below are five additional categories of exceptions to the general rule.

Communications That Do Not Disclose Patient-Identifying Information

The Federal regulations permit programs to disclose information about a patient if the program reveals no patient-identifying information. Thus, a program may disclose information about a patient if that information does not identify the patient as an AOD abuser or does not verify anyone else's identification of the patient as an AOD abuser.

A program may make a disclosure that does not identify a patient in two ways. First, it may report aggregate data that give an overview of the patients served in the program or some portion of its population. For example, a program could tell the newspaper that in the last 6 months it had 43 patients, 10 female and 33 male. Second, a program may communicate information about a patient in a way that does not reveal the patient's status as a drug or alcohol abuse patient, §2.12(a)(i). For example, a program that provides services to patients with other problems or illnesses as well as alcohol or drug addiction may disclose information about a particular patient as long as the fact that the patient has a substance abuse problem is not revealed. To cite a more specific example, a counselor from a program that is part of a general hospital could call the police about a threat a patient made, as long as he or she does not disclose that the patient has an alcohol or drug abuse problem or is a patient of the detoxification program.

Programs that provide only alcohol or drug services or that provide a full range of services but are identified by the general public as drug or alcohol programs cannot disclose information that identifies a patient under this exception, since letting someone know a counselor is calling from the "XYZ Detoxification Program" will automatically identify the patient as someone who got services from the program. However, a freestanding program may

sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the patient's status as an alcohol or drug abuser.

Court-Ordered Disclosures

A State or Federal court may issue an authorizing order that will permit a program to make a disclosure about a patient that would otherwise be forbidden. A court may issue one of these orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require, or even to permit, a program to disclose information²⁰ (§2.61).

Before a court can issue an authorizing order, the program and any patient whose records are sought must be given notice of the application for the order and some opportunity to make an oral or a written statement to the court.²¹ Generally, the application and any court order must use fictitious names for any known patient. All court proceedings in connection with the application must remain confidential, unless the patient requests otherwise, §§2.64(a), (b), 2.65, 2.66.

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court may find "good cause" only if it determines that the public interest and the need for disclosure outweigh any adverse effect that the disclosure will have on the patient, the doctor-patient or counselor-patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court also must find that other ways of obtaining the information are unavailable or would be ineffective, §2.64(d).²² The judge may examine the records before making a decision, §2.64(c).

There are also limits on the scope of disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order and restricted to those persons who need the information for that purpose. The court also should take any other steps that are necessary to protect the patient's confidentiality, including sealing court records from public scrutiny, §2.64(e).

The court may order disclosure of "confidential communications" by a patient to the program only if the disclosure is necessary to protect against a threat to life or of serious bodily injury or to investigate or prosecute an extremely serious crime (including child abuse), or is in connection with a proceeding at which the patient has already presented evidence concerning confidential communications (§2.63).

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual." The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The medical emergency exception permits disclosure only to medical personnel. It cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including parents. Under this exception, however, a program could notify a private physician about a suicidal patient so that medical intervention could be arranged. The physician, in turn, could notify a patient's parents or other relatives, as long as no mention were made of the patient's AOD problem. Whenever a disclosure is made to cope with a medical emergency, the program must document in the patient's records the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Qualified Service Organization Agreements

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into a QSOA. A QSOA (Exhibit E-4) is a written agreement between a program and a person providing services to the program, in which that person (1) acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the program, he or she is fully bound by [the Federal confidentiality] regulations; and (2) promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations, §§2.11, 2.12(c)(4).

A QSOA should be used only when an agency or official outside of the program, for example, a clinical laboratory or data-processing agency, is providing a service to the program itself. An example is when laboratory analysis or data processing is performed for the program by an outside agency. A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. QSOAs may not be used between programs providing alcohol and drug services.

Exhibit E-4
Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____

(Name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide the following services:

(Nature of services to be provided)

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and
2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 CFR Part 2.

Executed this _____ day of _____, 199__.

President
XYZ Service Center
(Address)

Program Director
(Name of Program)
(Address)

Internal Program Communications

The Federal regulations permit some information to be disclosed to individuals within the same program:

The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program, §2.12(c)(3).

In other words, staff (including full- or part-time employees and unpaid volunteers) who have access to

patient records because they work for or administratively direct the program may consult among themselves or otherwise share information if their substance abuse work so requires.

Does this exception allow a detoxification program that is part of a larger entity, such as a hospital, to share confidential information with others that are not part of the detoxification unit? The answer to this question is quite complicated. In brief, there are circumstances under which the detoxification unit may share information with other units that are part of the greater entity to which it belongs. Before such an internal communication system is set up within a large institution, however, it is essential that an expert in the area be consulted.

Other Requirements

Patient Notice and Access to Records

The Federal confidentiality regulations require programs to notify patients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to patients when they enter the program or shortly thereafter, §2.22(a). The regulations contain a sample notice that may be used for this purpose.

Unless State law grants the right of patient access to records, programs have the right to decide when to permit patients to view or obtain copies of their records. The Federal regulations do not require programs to obtain written consent from patients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, locked file cabinet, safe, or other similar container. The program should establish written procedures that regulate access to and use of patient records. The program director or a single staff person should be designated to process inquiries and requests for information (§2.16).

Conclusion

Administrators and staff members of AOD detoxification programs should become thoroughly familiar with the many legal issues affecting their work. Such knowledge can prevent costly mistakes. Because legal requirements often vary by State and change over time, it is also essential that programs find a reliable source to whom they may turn for up-to-date information, advice, and training.

Endnotes

1. This appendix was written for the panel by Margaret K. Brooks, Esq.
2. For a discussion of AOD abuse treatment of adolescents and informed consent, see Dubler, N.N. Legal and ethical issues in the treatment of substance-abusing adolescents. In: *Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents*. Rockville, Maryland: Center for Substance Abuse Treatment, 1993: 47-57. Treatment Improvement Protocol (TIP) Series Number 4.
3. Citations throughout this chapter in the form "§2..." refer to specific sections of 42 *Code of Federal Regulations* (C.F.R.), Part 2, Implementing the Substance Abuse and Mental Health Services Administration (42 U.S.C. §290dd-2) (1987).
4. For a discussion of procedures that programs may use to collect patient fees, see *Confidentiality: A Guide to the Federal Laws and Regulations*. New York: The Legal Action Center, 1991.
5. In *Simmons v. City of Philadelphia*, 947 F.2d 1042 (3d Cir. 1991), the mother of a man who was intoxicated when arrested and committed suicide while incarcerated successfully sued the City for failing to maintain a protocol to deal with emotionally disturbed intoxicated inmates, who comprised the majority of persons committing suicide while in prison.
6. The DEA regulations permit "any person in possession of any controlled substance and desiring or required to dispose of such substance [to] request the Special Agent in Charge of the Administration in the area in which the person is located for authority and instructions to dispose of such substance," 21 C.F.R. §1307.21(a). The regulation sets forth how such a request should be made. Subsection 1307.21(d) specifically states that the regulation "shall not be construed as affecting or altering in any way the disposal of controlled substances through procedures provided in laws and regulations adopted by any State."
7. Only patients who have "applied for or received" services from a program are protected. If a patient has not personally sought help from the program or has not yet been evaluated or counseled by a program, the program is free to discuss the patient's drug or alcohol problems with others. The Federal regulations govern from the moment the patient applies for services or the program first conducts an evaluation or begins counseling.
8. Search and arrest warrants are discussed below. For an explanation about how to deal with subpoenas, see *Confidentiality: A Guide to the Federal Law and Regulations*. New York: The Legal Action Center, 1995.
9. No information that is obtained from a program (even if the patient consents) may, however, be used in a criminal investigation or prosecution of a patient, unless a court order has been issued under the special circumstances set forth in §2.65 (42 U.S.C. §§290dd-2; 42 C.F.R. §2.12[a],[d]).
10. Although Federal and, in some cases, State laws may prohibit the employer from firing employees or taking other action simply because they have entered treatment, discriminatory practices against recovering people continue.
11. Some States prohibit insurance companies from discriminating against individuals who have received substance abuse treatment; however, discriminatory practices continue. Insurance companies routinely share information about policy holders. Although the Federal regulations prohibit insurance companies from sharing information from a treatment program with other carriers, that prohibition is no guarantee that such redisclosure will not take place.
12. If a patient who has signed a consent form permitting the program to make disclosures to a third-party payer later revokes his or her consent, the program can bill the third-party payer for services provided before consent was revoked. A program cannot, however, make any

- disclosures to the third-party payer in order to receive reimbursement for services rendered after the patient revoked consent, §2.31(a)(8).
13. If the State's reporting law is intended only to gather information for research purposes, detoxification programs can include patients' names in their reports, if the public health department complies with §2.52 of the Federal regulations. That section permits release of patient-identifying information to researchers when (1) they are qualified to conduct the research, (2) they have a research protocol to protect patient-identifying information, and a group of three or more individuals independent of the research project have reviewed the protocol and found it adequate, and (3) they agree not to redisclose patients' names or identifying information except back to the program and not to identify any patient in a report. In most cases, a department of public health will easily satisfy the first requirement. The Federal Department of Health and Human Services has suggested in opinion letters that the second requirement may not apply when the research is intended to track the incidence and causation of diseases. Thus, if the State is gathering information only for research purposes, the program can probably make reports including patients' names, if the department agrees not to redisclose patients' names or identifying information except back to the program and not to identify any patient in a report.
 14. See Letter to Oklahoma State Department of Health from the Legal Adviser to the U.S. Alcohol, Drug Abuse, and Mental Health Administration, dated September 2, 1988, and Letter to the New York State Department of Health from the Acting General Counsel to the U.S. DHHS, dated May 17, 1989.
 15. The regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v. United States*, 541 F. Supp. 999 [D. Md. 1982]), the court ruled that the Federal confidentiality law prohibited any report.
 16. Federal confidentiality statutes and regulations strictly prohibit any investigation or prosecution of a patient based on information obtained from records unless the court order exception is used (42 U.S.C. §§290dd-2(2)(C) and 42 C.F.R. §2.12(d)(1)).
 17. If the patient is being sought because he or she has committed a crime on program premises or against program personnel, the program can point the patient out (see section IV.I.3).
 18. Two statutes (42 U.S.C. §241[d] and 21 U.S.C. §872[c]), both of which cover research into drug use, permit the Secretary of DHHS and the U.S. Attorney General, respectively, to authorize researchers to withhold the names and identities of research subjects. The statutes both state that the researcher "may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding" to identify the subjects of research for which such authorization was obtained. Such authorization is commonly called a "certificate of confidentiality." Whether or not research investigators have obtained an authorization from the Attorney General or the Secretary of DHHS, however, they must comply with the prohibitions on redisclosure discussed in this section of the chapter if they have been given access to patients' records in a federally assisted treatment program.
 19. These particular entities also may copy or remove records, but only if they agree in writing to maintain patient-identifying information in accordance with the regulations' security requirements (see §2.16), to destroy all patient-identifying information when the audit or evaluation is completed, and to redisclose patient information only (1) back to the program, (2) in accordance with a court order to investigate or prosecute the program (§2.66), or (3) to a government agency overseeing a Medicare or Medicaid audit or evaluation, §2.53(b).
 20. For information on how to deal with subpoenas, see *Confidentiality: A Guide to the Federal Laws and Regulations*, New York: Legal Action Center, 1991.
 21. If the information is being sought to investigate or prosecute a patient, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice is required (§2.66).
 22. If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court also must find that (1) the crime involved was extremely serious, such as an act causing or threatening to cause death or serious injury; (2) the records sought are likely to contain information of significance to the investigation or prosecution; (3) there is no other practical way to obtain the information; and (4) the public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients. When law enforcement personnel seek the order, the court also must find that the program had an opportunity to be represented by independent counsel. If the program is a government entity, it must be represented by independent counsel, §2.65(d).

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