

Arkansas Department of Human Services

Division of Aging, Adult and Behavioral Health
Services

Office of the Drug Director



Regional Alcohol and Drug Detoxification

Regional Alcohol and Drug Detoxification Manual

Office of the Drug Director

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Regional Alcohol and Drug Detoxification Program

The primary goal of the Regional Alcohol and Drug Detoxification (RADD) program is to provide quality detoxification treatment services, while managing limited allotted resources. Meeting the unique needs of Arkansans by insuring proper and timely placement in treatment is the desired outcome of this process.

The RADD manual is intended to be a guide for nurses, clinical staff, program administrators, and individuals that are involved in planning, evaluating, and providing alcohol and/or other detoxification services.

All providers of RADD services will adhere to the *Office of Alcohol and Drug Abuse Prevention (ADAP) rules of practice and procedure* and the *ADAP licensure standards for alcohol and other drug abuse treatment programs*.

Questions concerning the RADD program should be directed to the Arkansas Department of Human Services Division of Aging, Adult, and Behavioral Health Services Director of Treatment services or the RADD coordinator at (501) 686-9164. Questions regarding Admission and Data Management Information System (ADMIS) reporting should be directed to (501) 686-9164 as well.

RADD Training Objectives (As defined in ADAP rules of practice and procedure, 2009):

1. Identify responsibilities of RADD staff
 - Screening applicants
 - Evaluating presenting symptoms
 - Compiling an accurate substance abuse history
 - Taking vital signs
 - Nonviolently diffusing hostile situations
 - Providing CPR/First Aid
 - Documenting any occurrence relative to the detox process
2. Identify symptoms of alcohol/drug withdrawal and implications of those symptoms
3. Learn to take vital signs and know the implications of those signs
4. Prepare participants to score 80% (or above) on written examination required to obtain certification

Regional Detoxification Specialist Certification (RDS)

Regional Detoxification Specialists (RDS) are treatment professionals that have undergone a course of study to safely monitor clients who are in medical or observational detoxification facilities. To monitor clients in detox, you must be one of the following: Physician, Advanced Practice Registered Nurse, Registered Nurse, Licensed Practical Nurse, or RDS (Regional Detoxification Specialist).

RDS Certification includes valid and up-to-date certifications in First Aid and cardiopulmonary resuscitation (CPR), Nonviolent Physical Crisis Intervention (NPCI), and RADD (Regional Alcohol Drug and Detoxification) training.

If staff are not licensed medical professionals, or are without the previous trainings and certifications, they are not certified to monitor clients during the detoxification process.

RDS Responsibilities:

- Screening applicants
- Evaluating presenting symptoms
- Compiling an accurate substance abuse history
- Taking vital signs
- Nonviolently diffusing hostile situations
- Providing CPR/First Aid
- Documenting any occurrence relative to the detox process

RDS must recertify every 2 years by retaking the course provided by Division of Aging, Adult, and Behavioral Health Services (DAABHS) and successfully completing the post-test with a score of 80% or better.

All staff should feel comfortable taking vital signs and knowing the implications of those vital signs; evaluating signs and symptoms of withdrawal and implications of those signs and symptoms and be confident in knowledge of emergency procedures as defined in the facility policy and procedure manual.

Emergency Care Plan:

The program will maintain a written emergency care plan that will include the following:

- At least 3 staff members trained as Regional Detoxification Specialists
- The program does provide 24-hour availability of emergency services including adequate provision for handling special and difficult circumstance, when it is determined that an emergency exists
- The program maintains written agreements with ambulance services, doctors, hospitals, etc. to provide medical coverage for emergency situations at all times.
- The program maintains a list of the available services including phone numbers.

Chapter 1

Overview, Essential Concepts, and Definitions in Detoxification

Detoxification

Safe and effective withdrawal management can occur in a variety of environments that differ in the level of care and professional monitoring that they provide. Chapter 2 contains a review of the five levels of detoxification care outlined by the American Society of Addiction Medicine (ASAM). The objective of placing patients into the appropriate level of care is to ensure safety during detoxification in the least restrictive environment and promote long-term, successful recovery.

Definitions

The consensus panel for TIP 45 built on existing definitions of detoxification as a broad process with three essential components that may take place concurrently or as a series of steps: Evaluation, stabilization, and entry into treatment.

Evaluation entails testing for the presence of substances of abuse in the bloodstream, measuring their concentration, and screening for co-occurring mental and physical conditions. Evaluation also includes a comprehensive assessment of the patient's medical and physiological conditions, and social situation to help determine the appropriate level of treatment following detoxification. Essentially, the evaluation serves as the basis for the initial substance abuse treatment plan once the patient has been withdrawn successfully.

Stabilization includes the medical and psychosocial processes of assisting the patient through acute intoxication and withdrawal to the attainment of a medically stable, fully supported, substance-free state. This often is done with the assistance of medications, though in some approaches to detoxification no medication is used. Stabilization includes familiarizing patients with what to expect in the treatment milieu and their role in treatment and recovery.

Fostering the patient's entry into treatment involves preparing the patient for entry into substance abuse treatment by stressing the importance of following through with the complete substance abuse treatment continuum of care. For patients who have demonstrated a pattern of completing detoxification services and then failing to engage in substance abuse treatment, consideration of a written treatment contract may be advisable. This contract is not legally binding but is voluntary and can be utilized to remind patients of their goals at intake to treatment.

Detoxification (SAMHSA TIP 45, page 4)

Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. It denotes a clearing of toxins from the body of the patient who is acutely intoxicated and/or dependent on substances of abuse. Detoxification seeks to minimize the physical harm caused by the abuse of substances.

Supervised detoxification may prevent potentially life-threatening complications that might appear if the patient were left untreated.

At the same time, detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence because of hospitalization or legal involvement.

Treatment/rehabilitation, on the other hand, involves a constellation of ongoing therapeutic services ultimately intended to promote recovery for substance abuse patients.

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

The WCG makes an important distinction, however, in noting that “a detoxification program is not designed to resolve the long-standing psychological, social, and behavioral problems associated with alcohol and drug abuse” (McCorry et al. 2000a, p. 9).

Detoxification is not substance abuse treatment and rehabilitation but is the point of first contact with the treatment system and the first step to recovery.

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. 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 to function.

Drug Withdrawal

Sudden removal of alcohol or another drug of abuse from a physically dependent individual 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.”

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. On the other hand, heroin withdrawal produces an unpleasant mood (dysphoria), pain, anxiety, and over activity 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.

Tolerance and Withdrawal are the Hallmarks of Physiological Dependence

Determine the presence of tolerance or withdrawal, as documented in DSM-IV diagnostic criteria:

- A need for markedly increased amounts of alcohol to achieve intoxication or desired effect
- Markedly diminished effect with continued use of the same amount of alcohol

Withdrawal: (one of the following)

- The characteristic withdrawal syndrome for the substance (refer to DSM-IV for further details).
- The same for (or closely-related) substance is taken to relieve or avoid withdrawal symptoms.

For short acting drugs such as alcohol or heroin, the most severe signs and symptoms of withdrawal usually begin within hours of the individuals' 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.

Guiding principles in Detoxification and Substance Abuse Treatment (TIP 45)

Detoxification does not constitute substance abuse treatment but is one part of a continuum of care for substance related disorders.

The detoxification process consists of the following three sequential and essential components:

- Evaluation
- Stabilization
- Fostering patient readiness for and entry into treatment.

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

Detoxification can take place in a wide variety of settings and at several levels of intensity within these settings. Placement should be appropriate to the patient's needs.

Persons seeking detoxification should have access to the components of the detoxification process described above, no matter what the setting or the level of treatment intensity.

All persons requiring treatment for substance use disorders should receive treatment of the same quality and appropriate thoroughness and should be put into contact with a substance abuse treatment program

after detoxification, if they are not going to be engaged in a treatment services provided by the same program that provided them with detoxification services. There can be “no wrong door for treatment” for substance use disorders (CSAT 2000a).

Ultimately, insurance coverage for the full range of detoxification services is cost effective. If reimbursement systems do not provide payment for the complete detoxification process, patients may be released prematurely, leading to medically or socially unattended withdrawal. Ensuing medical complications ultimately drive up the overall cost of health care.

Patients seeking detoxification services have diverse cultural and ethnic backgrounds as well as unique health needs and life situations. Organizations that provide detoxification services need to ensure that they have standard practices in place to address cultural diversity. It also is essential that care providers possess the special clinical skills necessary to provide culturally competent comprehensive assessments. Detoxification program administrators have a duty to ensure that appropriate training is available to staff. (For more information on cultural competency training and specific competencies that clinicians need to be “culturally competent” see the forthcoming TIP Improving Cultural Competence in Substance Abuse Treatment.)

A successful detoxification process can be measured, in part, by whether an individual who is substance dependent enters, remains in, and is compliant with the treatment protocol of a substance abuse treatment/rehabilitation program after detoxification.

Chapter 2

Settings, Levels of Care, and Patient Placement

Adult Detoxification Placement Levels

The goal of placement is to find the *least restrictive* setting of care. “Least restrictive” refers to the patient’s civil rights and their right to choose of care. There are four specific themes of historical and clinical importance:

Patients should be treated in those settings that least interfere with their civil rights and freedom to participate in society.

Patients should be able to disagree with clinician recommendations for care. While this includes the right to refuse any care at all, it also includes the right to obtain care in a setting of their choice (if considerations of dangerousness and mental competency are satisfied). It implies a patient’s right to seek a higher or different level of care than that which the clinician has planned.

Patients should be informed participants in defining their care plan. Such planning should be done in collaboration with their healthcare providers.

Careful consideration of State laws and agency policies is required for patients who are unable to act in their own self-interests. Because the legal complexities of this issue will vary from State to State, the TIP 45 cannot provide definitive guidance.

The American Society of Addiction Medicine (ASAM) represents an effort to define how care settings may be matched to patient needs and special characteristics. The Patient Placement Criteria, Second Edition, revised defines six “assessment dimensions to be evaluated in making placement decisions” (ASAM 2001, p. 4). They are as follows:

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional, behavioral, or cognitive conditions and complications
- Readiness to change
- Relapse, continued use, or continued problem potential
- Recovery/living environments.

In addition to the above criteria, there have also been a second set of placement criteria created. These may be more important to our purpose of detox. As defined by American Society of Addiction Medicine in the Patient Placement Criteria, Second Edition, Revised. These 5 levels define the most broadly accepted standard of care for detoxification services.

Level I-D: Ambulatory Detoxification without extended onsite monitoring

i.e. physician’s office, home health care agency. This level of care is an organized outpatient service monitored at predetermined intervals.

Level II-D: Ambulatory Detoxification with extended onsite monitoring

i.e. day hospital service. This level of care is monitored by appropriately credentialed and licensed nurses.

Level III.2-D: Clinically Managed Residential Detoxification

i.e. non-medical or social detoxification setting. This level emphasizes peer and social support and is intended for patients whose intoxication and/or withdrawal is sufficient to warrant 24-hour support.

Level III.7-D: Medically Monitored Inpatient Detoxification

i.e. freestanding detoxification center. Unlike Level III.2.D, this level provides 24-hour medically supervised detoxification services.

Level IV-D: Medically managed intensive inpatient detoxification

i.e. psychiatric hospital inpatient center. This level provides 24-hour care in an acute care inpatient setting.

Matching patients to appropriate care represents a challenge to detoxification programs. Placement will depend in part on the substance of abuse. The consensus panel from TIP 45 suggests that for alcohol, sedative-hypnotic, and opioid withdrawal syndromes, hospitalization, or some form of 24-hour medical care is often the preferred setting for detoxification. The consensus panel also agreed on several guidelines for non-medical detoxification programs. It is desirable that all such programs have an alcohol and drug free environment as well as personnel who are familiar with the features of substance abuse withdrawal syndromes, have training in basic life support, and have access to an emergency medical system that can transport patients to emergency departments and other sites for clinical care.

For further information on patient placement, further guidelines are available in TIP 13, The role and current status of patient placement criteria in the treatment of substance use disorders.

The Evaluation Process

The Regional Detoxification Specialist (RDS) shall always be in control of the evaluation process. The goal of the evaluation is twofold: to reassure the person that you are concerned about his/her welfare and condition; and to gain as much insight as possible into the persons' physical and mental condition to make the proper referral. What you hear, see, and smell is important. Listen for clues about how the client feels and remain alert to the client's responses to gain insight into their condition.

The Withdrawal Risk Assessment form will be completed with vital signs, history of substance abuse on admission. Ensure you document all information to assure the client is referred to the appropriate level of care.

After your evaluation, the patient's options include admission to observational detox or referral for medical detox. Please see your institution specific forms and ensure you understand how to complete them. At minimum, you must document vital signs; client's history of substance abuse; symptoms reported by the client; signs you hear, see, smell or feel; and signs reported by the person who is accompanying the client.

Your safety is very important. If the client disrupts the environment by acting out, stop your evaluation process (remember you are always in control) and ask the client to leave, but assure them they may return when they can be more cooperative, and that contacting the police is an option to ensure your safety. The skill of diffusing hostile situations is very difficult and using the principles of non-violent crisis intervention (required to be an RDS) can be very effective.

Defusing Hostile Situations

The RDS should always be alert to the client's response to various things happening in the admission environment, such as their responses to questions, being examined, etc. If a situation starts presenting a hostile tone, the RDS should reassure the individual that they are there to help, and he/she needs the full cooperation of the individual to ensure services can be provided as soon as soon as possible. There should not be an atmosphere of confrontation. The RDS should never put him/herself in a situation of being hurt. If the situation deteriorates to the point where the evaluation is stopped, or the individual becomes non-cooperative, contacting the police should always be an option for a combative situation.

Standards of Care

RADD programs handle patients who are brought in by the police, by relatives, or are "involuntarily committed" to treatment by the courts. (Involuntary commitment is also known as "protective custody" and "emergency commitment.") This is in Act 10, Act 1268 of 1995 amended, see appendix.

Admission

For each new admission, re-admission, or transfer admission, the client must be interviewed. The interview must be documented. During the intake process, it is important to document that an effort

has been made to ensure the client understands policies and procedures, services available, costs, client rights and program rules. Also, upon admission, the risk assessment will be initiated, completed, and filed in the client record within 24 hours of admission. If the client's physical condition constitutes a medical emergency preventing completion of documentation, an explanation of the circumstances should be placed in the client record and the information obtained as soon as possible.

Types of Admission

Individuals presenting themselves for RADD program services will be evaluated by a Regional Detox Specialist. Admission to the RADD program includes: ACT 10 (ACT 1268 of 1995 Amended)-the voluntary and involuntary commitment law for substance abuse. (see appendix E).

Involuntary refers to court ordered admission; the court order gives the designated treatment facility permission to "treat and restrain" up to 21 days.

Involuntary clients cannot sign out of treatment, if they choose to leave they are in violation of their court order and law enforcement should be notified. The client should not be physically restrained or prevented from leaving the campus by staff; however, the client should be informed that law enforcement will be notified upon their exit.

Involuntary clients are entitled to the same care as involuntary clients and all care should meet professional standards.

Voluntary admissions include any person who believes themselves addicted to drugs or alcohol may apply for admission and be screened by RADD personnel.

Vital Signs

A complete set of vital signs must be obtained upon admission and at pre-determined intervals set by the facility, with vital signs being checked a minimum of every 6 hours. If vital signs are out of range, vital signs should be checked every 2 hours until they are in range, then the schedule can be adjusted to every 6 hours. Some programs have chosen to incorporate vital signs, wellness checks, fluids, etc. into documentation every 2 hours, which is appropriate.

The mandatory vital signs while in detoxification are body temperature, blood pressure, pulse rate, respiratory rate. It is recommended to check pulse oximetry as well. Each RADD training must include a hands on check off covering vital signs performed in the presence of the instructor; including a manual blood pressure check.

According to Medline Plus, accessed on 5/22/2019; the normal vital signs are as follows:

Vital signs reflect essential body functions, including your heartbeat, breathing rate, temperature, and blood pressure. Your health care provider may watch, measure, or monitor your vital signs to check your level of physical functioning.

Normal vital signs change with age, sex, weight, exercise capability, and overall health.

Normal vital sign ranges for the average healthy adult while resting are:

Blood pressure: 90/60 mm Hg to 120/80 mm Hg

Respirations: 12 to 18 breaths per minute

Pulse: 60 to 100 beats per minute

Temperature: 97.8°F to 99.1°F (36.5°C to 37.3°C); average 98.6°F (37°C)

Denial of Admission

Occasionally, clients may present that are not appropriate for treatment in a RADD facility. A client may not be denied admission for intoxication by drugs or alcohol. Per the Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs (3/1/2011); no clients under the age of 18 may be admitted. If a client is belligerent or combative, they should be asked to leave the interview and calm down and allowed to continue the assessment once able to cooperate.

Clients with any overriding medical problems should be referred to the appropriate medical facility for treatment prior to admission to any RADD program.

Examples of overriding medical problems include:

- Broken bones
- Bleeding wound (s), including nose bleeds
- Excessive bruising, especially on the face or head
- Seizure disorder
- Diabetes
- High blood pressure
- Chest pain
- Excessive vomiting (blood or blood tinged)
- Protruding abdomen (distended)
- Jaundice

The RDS will write a refusal note explaining the reason or reasons refused, alternative(s) suggested, and referral(s) made. The RDS will take care to ensure the applicant is referred to the appropriate service.

Symptoms and Signs of Conditions that require medical attention

- Change in mental status
- Increasing anxiety and panic

- Hallucinations
- Seizures
- Temperature greater than 100.4 degrees Fahrenheit (these clients should be considered potentially infectious)
- Significant increases and or decreases in blood pressure and heart rate
- Insomnia
- Abdominal pain
- Upper and lower gastrointestinal bleeding
- Changes in responsiveness of pupils
- Heightened deep tendon reflexes and ankle clonus, a reflex beating of the foot when pressed rostrally (i.e. toward the mouth of the patient, indicated profound central nervous system irritability and the potential for seizures)

Admission Priority

- Court ordered clients
- Arkansas Commitment Law
 - Act 10 (Act 1268 of 1995 as amended) –see appendix E
- Client with greatest clinical need
 - IV drug users and pregnant women first
- Clients from your catchment area
- Clients from other catchment areas in the state of Arkansas
- Clients from outside the state of Arkansas

Documentation

As the evaluation/examination process unfolds, appropriate documentation should take place. If it is not documented, it did not happen.

Document the initial evaluation on the Withdrawal Risk form so it can enhance the referral/treatment process. Always fully document client admissions, dispositions of the admissions (medical vs. observational), and rationale for client refusals. Follow up with a descriptive narrative of the client's disposition, basing the decision on: vital signs, presenting signs and symptoms, and substance use history.

Always consider the welfare of the client when reaching a referral decision. At this point, if a person wants to be admitted and the RDS finds it appropriate, the RDS will have the client sign a Voluntary Admission Agreement. The RDS will refer the client to one of two levels of service based on the evaluation, either medical or observational detoxification.

Medication

Upon admission, clients who bring prescribed medication to the facility should be allowed to continue it. Allowable medications include, but are not limited to:

- Heart medications
- High blood pressure medications
- Psychotropic drugs (used in treating psychiatric disorders)
- Diabetic medications
- Ulcer medications
- Breathing medications (tablets and inhalers)
- Seizure medications

Medications that should be scrutinized closely include sleeping pills, tranquilizers, diet pills, etc. The treatment facility should not discontinue prescribed medications without input from a physician or APRN/PA. Clients returning from detoxification in a medical unit should continue to take any medications prescribed at that facility. Also, medication taken at the facility should be documented in the RDS's notes. If any prescribed medication is discontinued, this should be reflected in the RDS notes (why, when, and physician/providers' input).

Medications should be counted on admission (including OTC medications) and logged. The patient will self-administer medications in observational detoxification.

Records

Upon admission to the Regional Alcohol and Drug Detoxification (RADD) Program, a chart will be compiled. The chart will include the following:

- Withdrawal Risk Assessment
- Commitment Papers (VOL or CCO-Act 10/1268)
- Release of Confidential Information Forms
- Condition of Admission Form
- Client's Personal Property form
- Vital Signs
- Regional Detoxification Specialist's Notes (Progress Notes)
- Stabilization /Treatment Plan
- Aftercare Plan
- Proof of Client's Identity

Referral Sources

Upon completion of the evaluation process, based upon vital signs, presenting signs and symptoms, and substance abuse history, the client will be referred to one of the following levels of service:

Clients in an acute phase of withdrawal will be referred to the appropriate medical facility for medical detoxification. Upon discharge from the medical facility, the client will be returned to the alcohol and other drug (AOD) treatment facility and placed in RADD services followed by continued care.

Clients who are in mild withdrawal will be placed in the observational level of the RADD program. Following discharge from observation, the client will be placed in RADD services followed by continued care.

Treatment

Observation includes periodic monitoring on a 24-hour/day basis of a client who is undergoing mild to moderate withdrawal in a residential/live-in setting. Monitoring will consist of taking the client's vital signs every two hours or more frequently if indicated, until results remain within the normal range for at least eight hours. A staff member that is trained and certified by the Division of Aging, Adult, and Behavioral Health Services (DAABHS) or medical personnel will take vital signs. The facility shall establish approved emergency medical procedures. These services shall be available should the client's condition deteriorate, and advanced medical care is required. Vital signs will be recorded on the vital sign sheet with any emergency comments. Once vital signs are within normal limits for eight consecutive hours, they will be taken no less than every six hours. There will be documentation in the client's case record verifying each vital sign taken during the client's stay in detoxification.

Stabilization

Staff, authorized by the program, will identify the client's short-term needs (based on withdrawal risk assessment and medical history) and develop an appropriate detoxification/stabilization plan. The plan will be signed by an RDS, LPN, LPTN, RN, APRN, or MD and the client, unless the client is unable to do so due to medical contraindications. If the client is unable to sign the plan, the staff will explain the circumstances in the client's record within 8 hours of admission. The program will implement the detoxification/stabilization plan and document the client's response to interventions in the progress notes. The program will also review, and if necessary, revise the detoxification/stabilization at a minimum of every 24-hour period. Should the client's needs change significantly within 24 hours, the plan will need to be revised earlier.

Aftercare

Prior to discharge, a continued plan of care will be developed. The aftercare plan is initiated to help in facilitating the ongoing process of treatment for an individual. The RDS and the client will sign the plan. The client's needs, established goals, and objectives or ways in which those needs will be met, are included in the aftercare plan. The plan will designate a staff person and date with which the client will follow through for review of aftercare status. The aftercare process should be started at the time of admission.

Legal and Ethical Issues for Detoxification Programs

Federal Law Protecting Patient's Right to Confidentiality (see appendix)

Federal laws (42 U.S.C. “290dd-2 (1992)” and federal regulations (C.F.R. Part 2), and the Legal Action Center’s Confidentiality and Communication 2003 guarantee the strict confidentiality of information about all persons receiving AOD abuse prevention and treatment services. They are designed to protect privacy rights and thereby attract individuals into treatment. Violating the regulations is punishable by a fine of up to \$500 for the first offense or up to \$5,000 for each subsequent offense.

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 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.

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Chapter 3

An Overview of Psychosocial and Biomedical Issues During Detoxification

Overarching Principles for Care During Detoxification Services

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

Detoxification is challenging, but Regional Detoxification Specialists (RDS) are equipped to provide safe and humane withdrawal from substances, and they are uniquely positioned to foster the patient’s entry into long term treatment and recovery. Clients presenting to detox are often in a crisis, and a therapeutic approach to their admission is often key to retaining the client in treatment. Research indicates that addressing key psychosocial issues during detoxification

“significantly increases the likelihood that the patient will experience a safe detoxification and go on to participate in substance abuse treatment. Staff members ability to respond to patient’s needs in a compassionate manner can make the difference between a return to substance abuse and the beginning of a new (and more positive) way of life.” (TIP 45)

Initial assessment can identify needs that the client has not actively articulated and assist in creating a comprehensive discharge plan of action with goals, objectives, and target dates. The items in a withdrawal risk assessment closely mirror the TIP 45’s identified “Initial Biomedical and Psychosocial Evaluation.” Looking at the client in a holistic manner is key, as well as knowing the local resources to assist with identified needs. The RDS will not be able to “fix” or “cure” the effects of addiction in a detoxification period but showing compassion and guidance for how to meet basic needs upon leaving detoxification will increase retention in treatment and equip clients to start the process of recovery.

Initial Biomedical and Psychosocial Evaluation Domains

Biomedical Domains

•General health history—

What is the patient's medical and surgical history?

Are there any psychiatric or medical conditions?

Are there known medication allergies?

Is there a history of seizures?

•Mental status—

Is the patient oriented, alert, cooperative?

Are thoughts coherent?

Are there signs of psychosis or destructive thoughts?

•General physical assessment with neurological exam—

This will ascertain the patient's general health
and identify any medical or psychiatric disorders of immediate concern.

•Temperature, pulse, blood pressure—

These are important indicators and should be monitored throughout detoxification.

•Patterns of substance abuse—

When did the patient last use?

What were the substances of abuse?

How much of these substances was used and how frequently?

•Urine toxicology screen for commonly abused substances.

•Past substance abuse treatments or detoxification—

This should include the course and number of
previous withdrawals, as well as any complications that may have occurred.

Psychosocial Domains

•Demographic features—

Gather information on gender, age, ethnicity, culture, language, and educational level.

•Living conditions—

Is the patient homeless or living in a shelter?

What is the living situation?

Are significant others in the home (and, if so, can they safely supervise)?

•Violence, suicide risk—

Is the patient aggressive, depressed, or hopeless?

Is there a history of violence?

•Transportation—

Does the patient have adequate means to get to appointments?

Do other arrangements need to be made?

•Financial situation—

Is the patient able to purchase medications and food?

Does the patient have adequate employment and income?

•Dependent children—

Is the patient able to care for children, provide adequate child care, and ensure the safety of children?

•Legal status—

Is the patient a legal resident?

Are there pending legal matters?

Is treatment court ordered?

•Physical, sensory, or cognitive disabilities—

Does the client have disabilities that require consideration?

Figure 3-1
Initial Biomedical and Psychosocial Evaluation Domains

Biomedical Domains
<ul style="list-style-type: none"> • <i>General health history</i>—What is the patient’s medical and surgical history? Are there any psychiatric or medical conditions? Are there known medication allergies? Is there a history of seizures? • <i>Mental status</i>—Is the patient oriented, alert, cooperative? Are thoughts coherent? Are there signs of psychosis or destructive thoughts? • <i>General physical assessment with neurological exam</i>—This will ascertain the patient’s general health and identify any medical or psychiatric disorders of immediate concern. • <i>Temperature, pulse, blood pressure</i>—These are important indicators and should be monitored throughout detoxification. • <i>Patterns of substance abuse</i>—When did the patient last use? What were the substances of abuse? How much of these substances was used and how frequently? • <i>Urine toxicology screen for commonly abused substances.</i> • <i>Past substance abuse treatments or detoxification</i>—This should include the course and number of previous withdrawals, as well as any complications that may have occurred.
Psychosocial Domains
<ul style="list-style-type: none"> • <i>Demographic features</i>—Gather information on gender, age, ethnicity, culture, language, and educational level. • <i>Living conditions</i>—Is the patient homeless or living in a shelter? What is the living situation? Are significant others in the home (and, if so, can they safely supervise)? • <i>Violence, suicide risk</i>—Is the patient aggressive, depressed, or hopeless? Is there a history of violence? • <i>Transportation</i>—Does the patient have adequate means to get to appointments? Do other arrangements need to be made? • <i>Financial situation</i>—Is the patient able to purchase medications and food? Does the patient have adequate employment and income? • <i>Dependent children</i>—Is the patient able to care for children, provide adequate child care, and ensure the safety of children? • <i>Legal status</i>—Is the patient a legal resident? Are there pending legal matters? Is treatment court ordered? • <i>Physical, sensory, or cognitive disabilities</i>—Does the client have disabilities that require consideration?

(TIP 45)

When assessing a client entering detoxification, they are often in personal and medical crisis. The process of withdrawal can worsen existing issues in the client, including emotional, psychological, or mental issues that were previously not addressed. To provide safe detoxification, medical issues should

be evaluated on admission and continually by RDS staff, and vital signs should be taken frequently as previously discussed. Expected signs, symptoms and withdrawal severity can be assumed from client interview and should be discussed, and each facility should have the ability to refer to medical or inpatient detoxification if indicated by severity of withdrawal expected.

If the following symptoms or signs are observed, the client should have immediate medical evaluation, either by in house staff or emergency medical services (EMS). The capabilities of the facility should be a consideration in response to emergency situations; for example, a medical detoxification facility may have resources to assess with a licensed nurse and obtain orders for medications to ease symptoms; where an observational facility will need to call EMS for further evaluation.

Seizures are of a special concern. On evaluation, seizure history should be assessed. All staff members who may contact the client need to be aware of signs and symptoms of impending seizures, including increased blood pressure, overactive reflexes, and high temperature and pulse. All staff should be trained in facility protocol of how to manage a seizure.

All staff should be familiar with medical disorders that are associated with drugs of abuse. Alcoholism often has effects on multiple body systems and can cause liver failure or confusion. Cocaine, through its actions of shrinking blood vessels (vasoconstriction) may cause a heart attack, stroke, spontaneous abortion, poor kidney function, and death of tissue that is not being adequately perfused (oxygen delivery is via the bloodstream). Heroin can cause decreased respirations and can stop breathing. Injecting drugs intravenously can cause multiple infections including HIV, hepatitis, sepsis, and skin abscesses.

Symptoms and Signs of Conditions That Require Medical Attention

- Change in mental status
- Increasing anxiety and panic
- Hallucinations
- Seizures
- Temperature greater than 100.4° F (these patients should be considered potentially infectious)
- Significant increases and/or decreases in blood pressure and heart rate
- Insomnia
- Abdominal pain
- Upper and lower gastrointestinal bleeding
- Changes in responsiveness of pupils

- Heightened deep tendon reflexes and ankle clonus, a reflex beating of the foot when pressed rostrally (i.e., toward the mouth of the patient), indicating profound central nervous system irritability and the potential for seizures

Universal Precautions

Standard or universal precautions should always be observed with all clients. Handwashing, wearing gloves, and avoiding any blood or body fluids should always be priority for Regional Detoxifications Specialists. Nonmedical detoxification staff should be trained to watch for the signs of common infectious diseases; including scabies and lice. Any injection sites should be carefully monitored for abscess formation; and clients should be seen by a medical provider for evaluation if abscess is suspected.

Suicide

According to the TIP 45, those who are users of multiple illicit substances are more likely to experience psychiatric disorders. Depression is common among those who abuse a combination of opiates, benzodiazepines, and or alcohol. In a study conducted by Marsden in 2000 of 1,075 clients; 29 percent reported suicidal ideation within a 3-month time period. A safe environment is key during detoxification to minimize opportunities for suicide attempts. Frequent safety checks should be implemented, and the frequency should be increased when signs of depression, shame, guilt, helplessness, worthlessness, and hopelessness are present. Locations that are not clearly visible should be free of items that might be used for suicide attempts. When feasible, clients at risk for suicide should be placed in areas that are easily monitored by staff. If this is not feasible, consideration should be given to transferring the patient for inpatient care with suicide precautions, most often provided by a 1:1 sitter who monitors the client at all times. Staff should avoid confrontation, judgement, and harsh words. Attempt to focus the client's thoughts on the treatable nature of substance use disorder and options available during and after detoxification to provide a meaningful recovery.

Aggression

As any detoxification employee is well aware of, clients may act out with aggression. As safety for all parties is our goal, an RDS may ask a client to leave if they become openly hostile or aggressive during the initial evaluation. Programs should have in place plans to promote staff and client safety, including protocols for response is required by local law enforcement agencies. Calling for help should always be an option in an RADD facility. In many cases, aggressive behaviors can be diffused through the principles of nonviolent crisis prevention and intervention. Physical restraint is not permitted in RADD programs.

Strategies for De-escalating Aggressive Behaviors

- Speak in a soft voice.
- Isolate the individual from loud noises or distractions.

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

Nutritional Concerns

Malnutrition is a major concern for clients suffering from addiction. Rationale for offering food and fluids at prescribed intervals, as well as offering juices rather than water is related to concern for malnutrition and gastrointestinal. The offering of juices is meant to combat the common electrolyte imbalances related to the detoxification process. Some clients suffering from gastrointestinal disturbances may only be able to tolerate clear fluids. Dehydration related to gastrointestinal distress may change blood chemistries, which can cause mental status changes, neurological or heart problems, and other dangerous conditions. Offering juices and monitoring for dehydration as well as excellent nutrition may combat these risks during detoxification.

Any client with diabetes should be carefully monitored, as they may suffer from high or low glucose during the detoxification process. At intake, assessment should include nutritional evaluation and any dietary considerations. Consideration of hydration and food allergies should also be assessed. According to the TIP 45 page 29;

“many drug addictions are associated with abnormal glucose (sugar) metabolism. This abnormality means that the body is unable to maintain a stable concentration of glucose in the blood. Abnormally high or low blood sugar levels easily can be confused with the signs and symptoms of alcohol intoxication or withdrawal; consequently, a check of blood glucose level is particularly important in patients with a history of blood sugar abnormalities. Hypoglycemia (low levels of blood sugar) in the person with a substance use disorder may lead to drastic mood changes. When blood glucose levels drop below a certain threshold, these patients usually feel depressed, anxious, or moody and may experience cravings for their drug of choice.”

Nutritional Deficits Associated with Specific Substances

RDS should be familiar with common nutritional deficits associated with specific substances. For example, opioids are known to decrease calcium absorption, and can increase cholesterol and potassium levels. Chronic alcohol dependence may result in multiple nutrient deficiencies including magnesium, protein, fat, zinc, calcium, iron, vitamins A and E, and water-soluble vitamins such as thiamine, folate, and vitamin B12.

Strategies for Engaging and Retaining Patients in Detoxification

Education

Intake should include information on the typical withdrawal process based on the particular drug of abuse. Providing information may minimize the fear and discomfort of detoxification. An open and honest approach to client education along with providing written materials may decrease the likelihood that a client will leave detoxification services prior to completion. If your program serves non-English-speaking clients, materials should be provided in the patient's language of choice. Materials should include drug effects, common withdrawal symptoms, and interventions to expect while in detoxification services.

Support Systems

Client advocates, often known as peer recovery support specialists, have a unique opportunity to make a difference in clients undergoing detoxification. As persons with lived experience in recovery, they can often reach clients and assist in making the connections that are so vital to recovery. Family can often support with housing, child care, etc. in some cases, but in some cases a person feels they have “nothing and no one” peer support is a wonderful option if offered by your facility. Seeing others who have successfully detoxed and are maintaining meaningful recovery can have a profound impact on sharing hope with clients. Any visitors to the program should be instructed about supporting the client, and 12 step or other support meetings should be attended if possible during and after detoxification.

While RDS staff are not counselors or clinicians, they can serve as a link to treatment and may form a therapeutic alliance with clients.

Clinician's Characteristics Most Important to the Therapeutic Alliance

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

Rehabilitation

On admission, the client should be evaluated and then re-evaluated every 24 hours for appropriate rehabilitation upon conclusion of detoxification services. Placement decisions are governed by numerous psychosocial factors. Individual client characteristics, environments, transportation, insurance coverage, etc. should be considered when recommending a treatment plan for rehabilitation.

Recommended Areas for Assessment to Determine Appropriate Rehabilitation Plans

Domain

Description

Medical Conditions and Complications

Infectious illnesses, chronic illnesses requiring intensive or specialized treatment, pregnancy, and chronic pain

Motivation/Readiness to Change

Degree to which the client acknowledges that substance use behaviors are a problem and is willing to confront them honestly

Physical, Sensory, or Mobility Limitations

Physical conditions that may require specially designed facilities or staffing

Relapse History and Potential

Historical relapse patterns, periods of abstinence, and predictors of abstinence; client awareness of relapse triggers and craving

Substance Abuse/Dependence

Frequency, amount, and duration of use; chronicity of problems; indicators of abuse or dependence

Developmental and Cognitive Issues

Ability to participate in confrontational treatment settings, and benefit from cognitive interventions and group therapy

Family and Social Support

Degree of support from family and significant others, substance-free friends, involvement in support groups

Co-Occurring Psychiatric Disorders

Other psychiatric symptoms that are likely to complicate the treatment of the substance use disorder and require treatment themselves, concerns about safety in certain settings (note that assessment for cooccurring disorders should include a determination of any psychiatric medications that the patient may be taking for the condition)

Dependent Children

Custody of dependent children or caring for noncustodial children and options for care of these children during rehabilitation

Trauma and Violence

Current domestic violence that affects the safety of the living environment, cooccurring posttraumatic stress disorder or trauma history that might complicate rehabilitation

Treatment History

Prior successful and unsuccessful rehabilitation experiences that might influence decision about type of setting indicated

Cultural Background

Cultural identity, issues, and strengths that might influence the decision to seek culturally specific rehabilitation programs, culturally driven strengths or obstacles that might dictate level of care or setting

Strengths and Resources

Unique strengths and resources of the client and his or her environment

Language

Language or speech issues that make it difficult to communicate or require an interpreter familiar with substance abuse

There are multiple settings for treatment just as there are multiple settings for detoxification. Knowledge of community resources, treatment settings, and maintenance activities are vital for successful treatment.

Examples of maintenance activities settings:

- Inpatient Programs
- Residential Treatment Programs
- Therapeutic Communities
- Transitional Residential Programs and Halfway Houses
- Partial Hospitalization and Day Treatment Programs
- Intensive Outpatient Programs
- Traditional Outpatient Services
- Recovery Maintenance Activities

As clients complete detoxification, whether they take the next step and enter treatment depends on several factors.

Strategies to promote initiation of treatment and maintenance activities include:

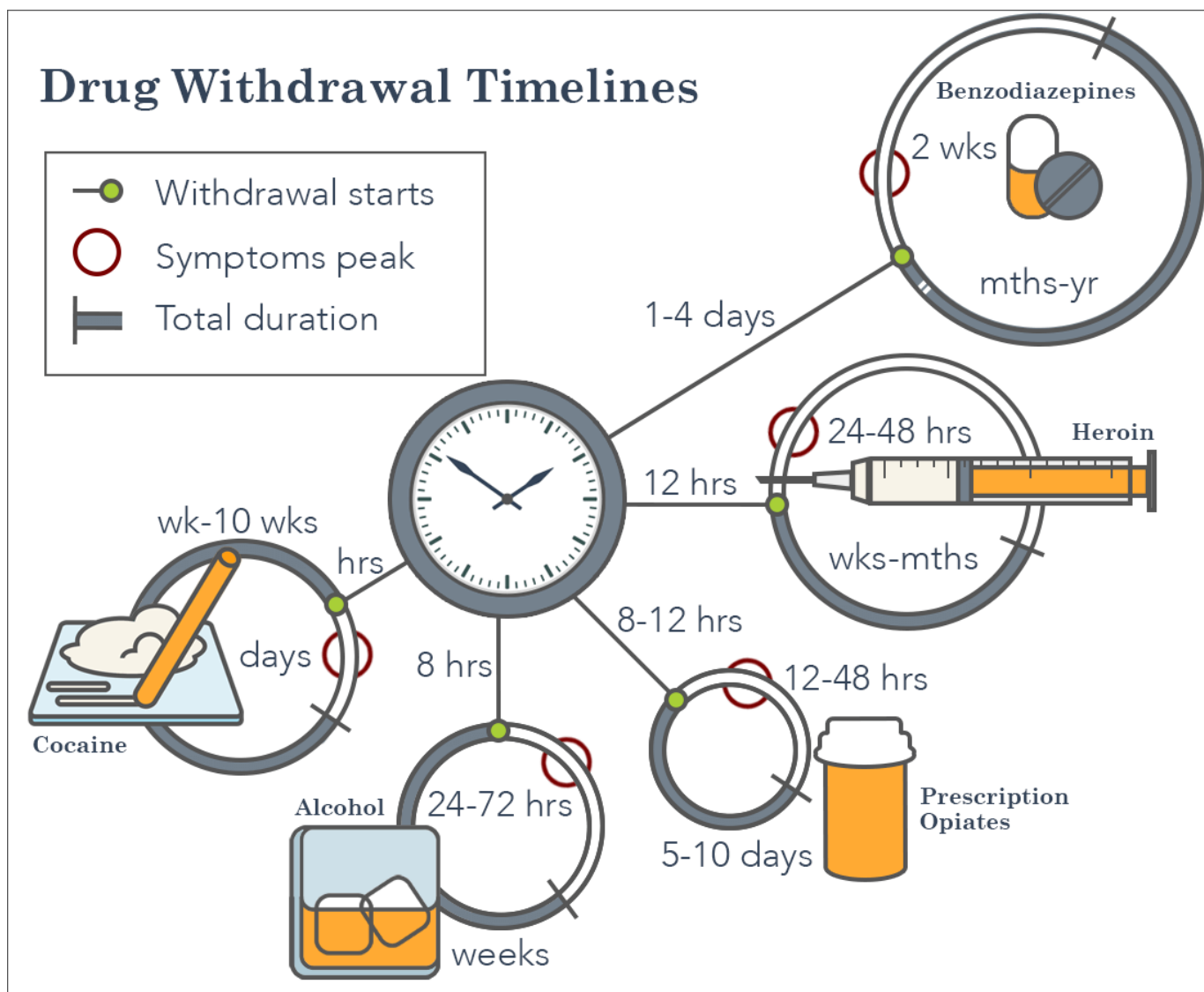
- Perform assessment of urgency for treatment
- Reduce time between initial call and appointment
- Call to reschedule missed appointments
- Provide information about what to expect at the first session
- Provide information about confidentiality
- Offer tangible incentives
- Engage the support of family members
- Introduce the client to the counselor who will deliver rehabilitation services
- Offer services that address basic needs, such as housing, employment, and childcare

Source: Carroll 1997; Fehr et al. 1991.

Chapter 4

Physical Detoxification Services for Withdrawal from Specific Substances

Drug Withdrawal Timelines



<https://americanaddictioncenters.org/>

Controlled Substances Act

Depress-ants



Depress-Ant® (depressant) drugs depress, or decrease thinking, feeling and behavior.

Alcohol

Opiates (Illicit or Licit)

Benzodiazepines/Barbiturates

Stimul-ants



Stim-U-Ant® (stimulant) drugs stimulate or increase thinking, feeling and behavior.

Cocaine

Amphetamine

Methamphetamine

Tobacco

Confus-ants



Confuse-Ant® drugs confuse or distort thinking, feeling and behavior.

Marijuana

MDMA or Ecstasy

LSD

Ketamine and PCP

Inhalants

The Controlled Substance Act

I. Controlled Substances Act DRUGS OF ABUSE I 2017 EDITION: A DEA Resource Guide

https://www.dea.gov/sites/default/files/2018-06/drug_of_abuse.pdf

CONTROLLING DRUGS OR OTHER SUBSTANCES THROUGH FORMAL SCHEDULING

The Controlled Substances Act (CSA) places all substances which were in some manner regulated under existing federal law into one of five schedules. This placement is based upon the substance's medical use, potential for abuse, and safety or dependence liability. The Act also provides a mechanism for substances to be controlled (added to or transferred between schedules) or decontrolled (removed from control). The procedure for these actions is found in Section 201 of the Act (21U.S.C. §811).

Proceedings to add, delete, or change the schedule of a drug or other substance may be initiated by the Drug Enforcement Administration (DEA), the Department of Health and Human Services (HHS), or by petition from any interested party, including:

- The manufacturer of a drug
- A medical society or association
- A pharmacy association
- A public interest group concerned with drug abuse
- A state or local government agency
- An individual citizen

When a petition is received by the DEA, the agency begins its own investigation of the drug. The DEA also may begin an investigation of a drug at any time based upon information received from law enforcement laboratories, state and local law enforcement and regulatory agencies, or other sources of information.

Once the DEA has collected the necessary data, the DEA Administrator, by authority of the Attorney General, requests from HHS a scientific and medical evaluation and recommendation as to whether the drug or other substance should be controlled or removed from control. This request is sent to the Assistant Secretary for Health of HHS.

The Assistant Secretary, by authority of the Secretary, compiles the information and transmits back to the DEA: a medical and scientific evaluation regarding the drug or other substance, a recommendation as to whether the drug should be controlled, and in what schedule it should be placed.

The medical and scientific evaluations are binding on the DEA with respect to scientific and medical matters and form a part of the scheduling decision.

Once the DEA has received the scientific and medical evaluation from HHS, the Administrator will evaluate all available data and make a final decision whether to propose that a drug or other substance should be removed or controlled and into which schedule it should be placed.

If a drug does not have a potential for abuse, it cannot be controlled. Although the term “potential for abuse” is not defined in the CSA, there is much discussion of the term in the legislative history of the Act. The following items are indicators that a drug or other substance has a potential for abuse:

- (1) There is evidence that individuals are taking the drug or other substance in amounts sufficient to create a hazard to their health or to the safety of other individuals or to the community.
- (2) There is significant diversion of the drug or other substance from legitimate drug channels.
- (3) Individuals are taking the drug or other substance on their own initiative rather than on the basis of medical advice from a practitioner.
- (4) The drug is a new drug so related in its action to a drug or other substance already listed as having a potential for abuse to make it likely that the drug will have the same potential for abuse as such drugs, thus making it reasonable to assume that there may be significant diversions from legitimate channels, significant use contrary to or without medical advice, or that it has a substantial capability of creating hazards to the health of the user or to the safety of the community. Of course, evidence of actual abuse of a substance is indicative that a drug has a potential for abuse.

In determining into which schedule a drug or other substance should be placed, or whether a substance should be decontrolled or rescheduled, certain factors are required to be considered. These factors are listed in Section 201 (c), [21 U.S.C. § 811 (c)] of the CSA as follows:

- (1) The drug’s actual or relative potential for abuse.
- (2) Scientific evidence of the drug’s pharmacological effect, if known. The state of knowledge with respect to the effects of a specific drug is, of course, a major consideration. For example, it is vital to know whether a drug has a hallucinogenic effect if it is to be controlled due to that effect. The best available knowledge of the pharmacological properties of a drug should be considered.
- (3) The state of current scientific knowledge regarding the substance. Criteria (2) and (3) are closely related. However, (2) is primarily concerned with pharmacological effects and (3) deals with all scientific knowledge with respect to the substance.
- (4) Its history and current pattern of abuse. To determine whether a drug should be controlled, it is important to know the pattern of abuse of that substance.
- (5) The scope, duration, and significance of abuse. In evaluating existing abuse, the DEA Administrator must know not only the pattern of abuse, but also whether the abuse is widespread.

(6)What, if any, risk there is to the public health. If a drug creates dangers to the public health, in addition to or because of its abuse potential, then these dangers must also be considered by the Administrator.

(7)The drug's psychic or physiological dependence liability. There must be an assessment of the extent to which a drug is physically addictive or psychologically habit forming.

(8)Whether the substance is an immediate precursor of a substance already controlled. The CSA allows inclusion of immediate precursors on this basis alone into the appropriate schedule and thus safeguards against possibilities of clandestine manufacture. After considering the above listed factors, the Administrator must make specific findings concerning the drug or other substance. This will determine into which schedule the drug or other substance will be placed. These schedules are established by the CSA. They are as follows:

Schedule I

- The drug or other substance has a high potential for abuse.
 - The drug or other substance has no currently accepted medical use in treatment in the United States.
 - There is a lack of accepted safety for use of the drug or other substance under medical supervision. •
- Examples of Schedule I substances include heroin, gamma hydroxybutyric acid (GHB), lysergic acid diethylamide (LSD), marijuana, and methaqualone.

Schedule II

- The drug or other substance has a high potential for abuse.
- The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- Abuse of the drug or other substance may lead to severe psychological or physical dependence.
- Examples of Schedule II substances include morphine, phencyclidine (PCP), cocaine, methadone, hydrocodone, fentanyl, and methamphetamine.

Schedule III

- The drug or other substance has less potential for abuse than the drugs or other substances in Schedules I and II.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.
- Anabolic steroids, codeine products with aspirin or Tylenol, and some barbiturates are examples of Schedule III substances.

Schedule IV

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- The drug or other substance has a currently accepted medical use in treatment in the United States. • Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.
- Examples of drugs included in Schedule IV are alprazolam, clonazepam, and diazepam.

Schedule V

- » The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- » The drug or other substance has a currently accepted medical use in treatment in the United States. » Abuse of the drug or other substances may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.
- » Cough medicines with codeine are examples of Schedule V drugs.

When the DEA Administrator has determined that a drug or other substance should be controlled, decontrolled, or rescheduled, a proposal to take action is published in the Federal Register. The proposal invites all interested persons to file comments with the DEA and may also request a hearing with the DEA. If no hearing is requested, the DEA will evaluate all comments received and publish a final order in the Federal Register, controlling the drug as proposed or with modifications based upon the written comments filed. This order will set the effective dates for imposing the various requirements of the CSA.

If a hearing is requested, the DEA will enter into discussions with the party or parties requesting a hearing in an attempt to narrow the issue for litigation. If necessary, a hearing will then be held before an Administrative Law Judge. The judge will take evidence on factual issues and hear arguments on legal questions regarding the control of the drug. Depending on the scope and complexity of the issues, the hearing may be brief or quite extensive. The Administrative Law Judge, at the close of the hearing, prepares findings of fact and conclusions of law and a recommended decision that is submitted to the DEA Administrator. The DEA Administrator will review these documents, as well as the underlying material, and prepare his/her own findings of fact and conclusions of law (which may or may not be the same as those drafted by the Administrative Law Judge). The DEA Administrator then publishes a final order in the Federal Register either scheduling the drug or other substance or declining to do so. Once the final order is published in the Federal Register, interested parties have 30 days to appeal to a U.S. Court of Appeals to challenge the order. Findings of fact by the Administrator are deemed conclusive if supported by “substantial evidence.” The order imposing controls is not stayed during the appeal, however, unless so ordered by the Court.

Depress-ants

Alcohol Intoxication and Withdrawal (TIP 45)

Intoxication Signs and Symptoms

The clinical presentation of intoxication from alcohol varies widely depending in part on blood alcohol level and level of previously developed tolerance.

At alcohol concentrations between 20mg percent and 80mg percent, loss of muscular coordination, changes in mood, personality alteration, and [increases in motor activity] begin.

At levels from 80 to 200mg percent, more progressive neurologic impairment occurs with ataxia (inability to coordinate muscular activity) and slurring of speech being prominent. A variety of cognitive functions also are impaired.

At blood alcohol levels between 200 and 300mg percent nausea and vomiting may occur, which along with sedation may place patients at grave risk for aspiration of stomach contents.

At levels greater than 300mg percent, hypothermia (low body temperature) with impairment of level of consciousness is likely except in all but the most tolerant individuals.

Coma begins to be seen at levels of 400 to 600mg percent, but this is variable, again depending on tolerance. Although exceptions are found, blood alcohol concentrations (BACs) between 600 and 800mg percent are fatal. At this point, respiratory, cardiovascular, and body temperature controls fail.

Since the elimination rate of alcohol from the body generally is 10 to 30mg percent per hour, the goals for the treatment of alcohol intoxication are to preserve respiration and cardiovascular function until alcohol levels fall into a safe range. Patients who are severely intoxicated and comatose as the result of alcohol use should be managed in the same manner as all comatose patients, with care taken in monitoring vital functions, protecting respiration, and observing aspiration, hypoglycemia, and thiamine deficiency. Screening for other drugs that may contribute to the coma, as well as other sources of coma induction, should be done. Agitation is best managed with interpersonal and nursing approaches rather than additional medications, which may only complicate and delay the elimination of the alcohol. (TIP 45)

Withdrawal Signs and Symptoms

The signs and symptoms of acute alcohol withdrawal generally start 6 to 24 hours after the patient takes his last drink.

The signs and symptoms may include the following:

- Restlessness, irritability, anxiety, agitation
- Anorexia (lack of appetite), nausea, vomiting
- Tremor (shakiness), elevated heart rate, increased blood pressure

- Insomnia, intense dreaming, nightmares
- Poor concentration, impaired memory and judgment
- Increased sensitivity to sound, light, and tactile sensations
- Hallucinations (auditory, visual, or tactile)
- Delusions, usually of paranoid or persecutory varieties
- Grand mal seizures (grand mal seizures represent a severe, generalized, abnormal electrical discharge of the major portions of the brain, resulting in loss of consciousness, brief cessation of breathing, and muscle rigidity followed by muscle jerking; a brief period of sleep, awakening later with some mild to even severe confusion, generally occurs)
- Hyperthermia (high fever)
- Delirium with disorientation regarding time, place, person, and situation; fluctuation in level of consciousness

Mild alcohol withdrawal generally consists of anxiety, irritability, difficulty sleeping, and decreased appetite.

Moderate alcohol withdrawal is defined more vaguely but represents some features of both mild and severe withdrawal.

Severe alcohol withdrawal usually is characterized by:

- obvious trembling of the hands and arms
- sweating
- elevation of pulse (above 100)
- blood pressure (greater than 140/90)
- nausea (sometimes with vomiting)
- hypersensitivity to noises (which seem louder than usual)
- light (which appears brighter than usual)
- Brief periods of hearing and seeing things that are not present (auditory and visual hallucinations) also may occur.
- A fever greater than 101° F also may be seen, though care should be taken to determine whether the fever is the result of an infection.

The use of a standardized clinical rating instrument for withdrawal such as the CIWA-AR is valuable because it guides the clinician through multiple domains of alcohol withdrawal and allows for semiquantitative assessment of nausea, tremor, autonomic hyperactivity, anxiety, agitation, perceptual disturbances, headache, and disorientation. Age, general health, nutritional factors, and possible cooccurring medical or psychiatric conditions all appear to play a role in increasing the severity of the symptoms of alcohol withdrawal.

Uncomplicated or mild to moderate withdrawal is characterized by:

- Restlessness

- Irritability
- anorexia (lack of appetite)
- tremor (shakiness)
- insomnia
- impaired cognitive functions
- mild perceptual changes.

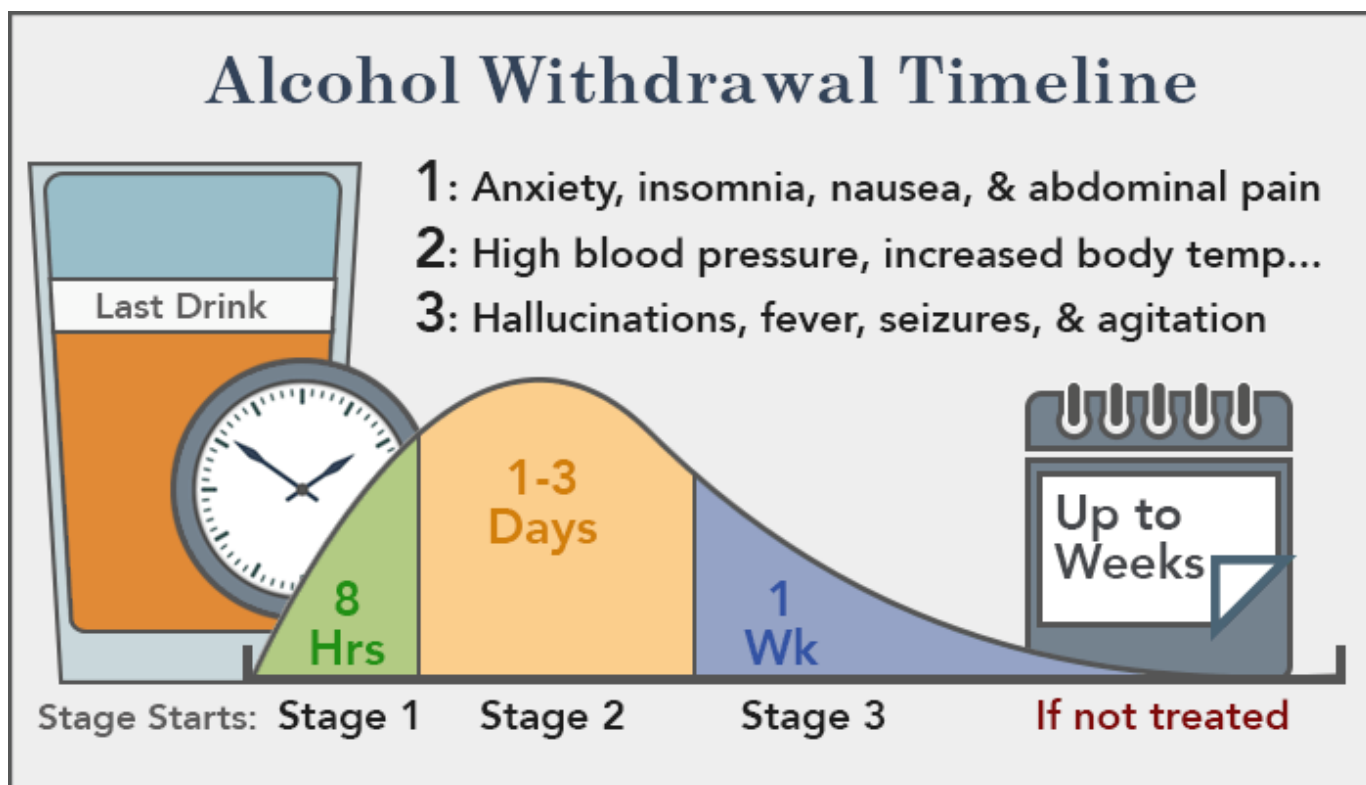
Complicated or severe medical withdrawal consists of one or more elements:

- delirium
- hallucinations
- delusions
- seizures
- disturbances of body temperature, pulse, and blood pressure.

Medical Complications of Alcohol Withdrawal: Possible Fatal Outcomes

Seizures; delirium tremens (severe delirium with trembling); and dysregulation of body temperature, pulse, and blood pressure are outcomes in severe alcohol dependence that can lead to fatal consequences. Other medical complications of alcohol withdrawal include infections, hypoglycemia, gastrointestinal (GI) bleeding, undetected trauma, hepatic failure, cardiomyopathy (dilation of the heart with ineffective pumping), pancreatitis (inflammation of the pancreas), and encephalopathy (generalized impaired brain functioning). The suspicion of impending complications or their appearance will require hospitalization of the client and possible intensive care unit level of management.

Mild to moderate alcohol withdrawal clients are appropriate for observational detoxification if the assessment does not reveal risk factors or concern for severe alcohol withdrawal. Moderate to severe alcohol withdrawal can qualify for medical detox or inpatient treatment depending on assessment. If any signs of complicated or severe medical withdrawal are seen, the client should be referred to medical or inpatient detoxification.



<https://americanaddictioncenters.org/withdrawal-timelines-treatments/alcohol>

Opioids (TIP 45)

“Opioids are highly addicting, and their chronic use leads to withdrawal symptoms that, although not medically dangerous, can be highly unpleasant and produce intense discomfort. All opioids (e.g., heroin, morphine, hydromorphone, oxycodone, codeine, and methadone) produce similar effects by interacting with endogenous (produced by the body itself) opioid receptors (that is, specific sites on cells where these substances bind to the cell). Opioid agonists stimulate these receptors and opioid antagonists block them, preventing their action.” (TIP 45)

Opioid Withdrawal Symptoms

All opioid agents produce similar withdrawal signs and symptoms. There is some variability in severity, time of onset, and duration of symptomatology, depending on the agent used, the duration of use, the daily dose, and the interval between doses.

For instance, heroin withdrawal typically begins 8 to 12 hours after the last heroin dose and subsides within a period of 3 to 5 days.

Methadone withdrawal typically begins 36 to 48 hours after the last dose, peaks after about 3 days, and gradually subsides over a period of 3 weeks or longer.

Physiological, genetic, and psychological factors can significantly affect intoxication and withdrawal severity.

Figure 4-4 Signs and Symptoms of Opioid Intoxication and Withdrawal	
Opioid Intoxication	Opioid Withdrawal
Signs Bradycardia (slow pulse) Hypotension (low blood pressure) Hypothermia (low body temperature) Sedation Meiosis (pinpoint pupils) Hypokinesia (slowed movement) Slurred speech Head nodding Symptoms Euphoria Analgesia (pain-killing effects) Calmness	Signs Tachycardia (fast pulse) Hypertension (high blood pressure) Hyperthermia (high body temperature) Insomnia Mydriasis (enlarged pupils) Hyperreflexia (abnormally heightened reflexes) Diaphoresis (sweating) Piloerection (gooseflesh) Increased respiratory rate Lacrimation (tearing), yawning Rhinorrhea (runny nose) Muscle spasms Symptoms Abdominal cramps, nausea, vomiting, diarrhea Bone and muscle pain Anxiety
<i>Source: Consensus Panelist Charles Dackis, M.D.</i>	

Opioid dependence, with IV use, can be associated with several medical complications including HIV/AIDS, viral hepatitis, STDs, and opportunistic infections. Testing for these conditions should be performed if the patient consents.

The first 24 hours in detoxification the client should be allowed to be on bed rest or reduced activity, but then may be able to participate in rehabilitative activities during detoxification. Multiple symptoms including night sweats, chills, decreased nutritional intake, diarrhea, gastrointestinal distress should all be monitored and medical consultation considered if vital signs are unstable. Dehydration is a real risk, and ways to counteract dehydration should be common practice as fluids should be offered every 2 hours. Injection sites should be monitored for signs or symptoms of infection and abscess. Fever and cough may also occur in the client detoxing from opioids.

There are several treatment and detox options for the removal of opioids from the body, and some may provide a more comprehensive model than others. Medical detox, for instance, encompasses both pharmacological and psychological treatment methodologies while under close supervision of both medical and mental health specialists in a safe and comforting residential setting, while standard detox may be performed in an outpatient basis.

Opiate withdrawal symptoms can be very uncomfortable, and medical detox may provide the safest and smoothest way to detox. Vital signs, such as blood pressure, respiration levels, body temperature, and heart rate, can all be closely monitored in a medical detox center that may utilize medications to regulate brain and body functions.

Mental health professionals can also evaluate and stabilize individuals during medical detox. While there is no specific timeline for detox, as everyone will likely experience withdrawal from opiates differently, medical detox usually lasts 5-7 days.

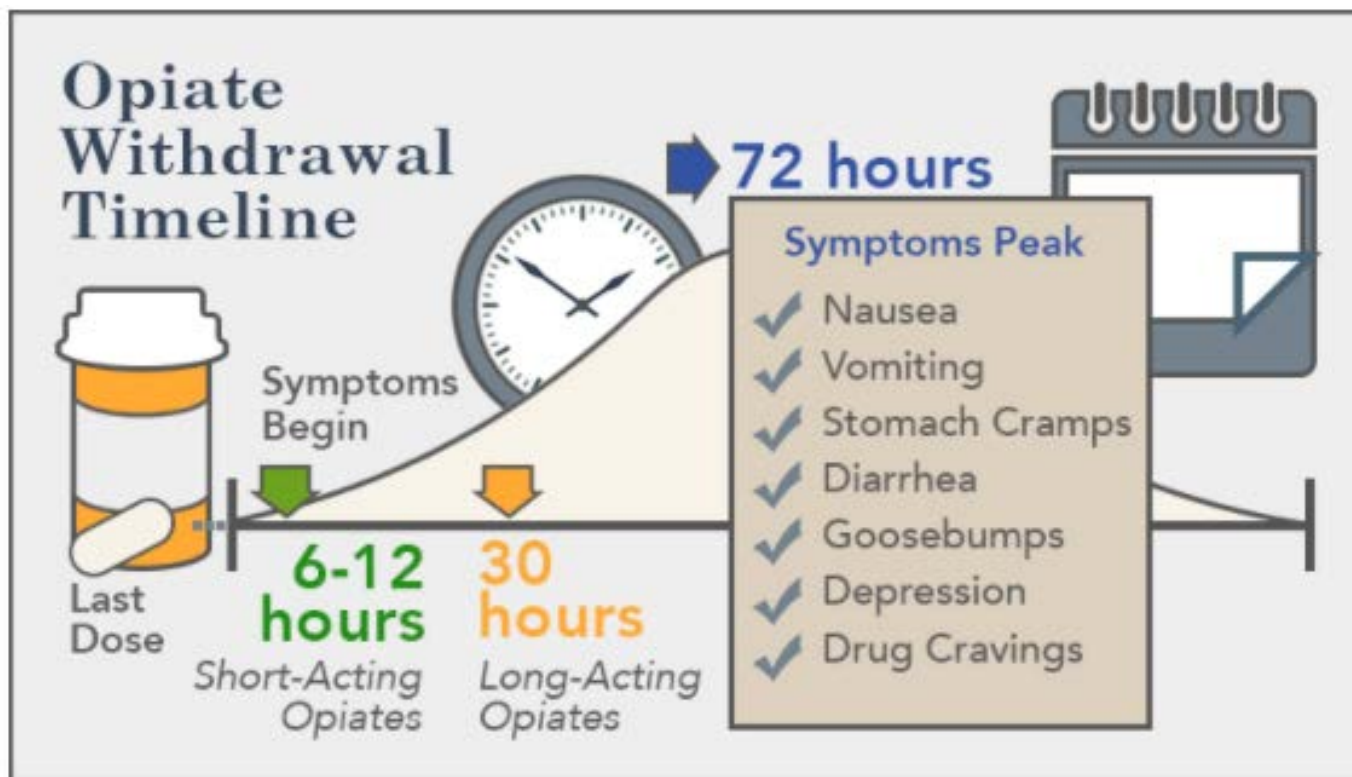
Opioid drugs should not be stopped suddenly, without physical and emotional support and supervision, as the side effects of withdrawal may be powerful and even have dangerous complications.

Medications, such as anticonvulsants, antidepressants, and other symptom-specific pharmaceuticals, may be useful during medical detox to control the more difficult withdrawal symptoms.

Medical professionals may help an individual wean off opioid drugs by slowly lowering, or tapering, the dosage during medical detox. This keeps the opioid receptors filled and prevents the onset of severe withdrawal symptoms. Drug cravings and withdrawal may be managed by replacing a short-acting opioid like heroin with a longer-acting one such as methadone.

Buprenorphine is a partial opioid agonist often used during opioid detox and dependency treatment as well, as it remains active in the body for longer than most opioids and requires a lower dosage. Partial agonists also do not usually create the same “high” as full agonists do, therefore making them less likely to be abused. Buprenorphine even stops being effective after a certain point, further acting as an abuse deterrent.

<https://americanaddictioncenters.org/withdrawal-timelines-treatments/opiate>



<https://americanaddictioncenters.org/withdrawal-timelines-treatments/opiate>

Benzodiazepines (<https://americanaddictioncenters.org/withdrawal-timelines-treatments>)

Benzodiazepines, often called “benzos” for short, make up a class of prescription drug used primarily to treat anxiety, panic disorders, and seizures. They may also be used as sleep aids or muscle relaxants. These drugs are considered central nervous system depressants that work to dampen the “fight or flight” reflex that may be hyperactive in someone suffering from heightened levels of anxiety or stress by activating the inhibitory neuron gamma amino-butyric acid, or GABA, which acts as a natural sedative.

This is when the brain is trying to regain its state of balance as GABA levels potentially drop, opening the door to heightened levels of anxiety and insomnia in the early stage of withdrawal.

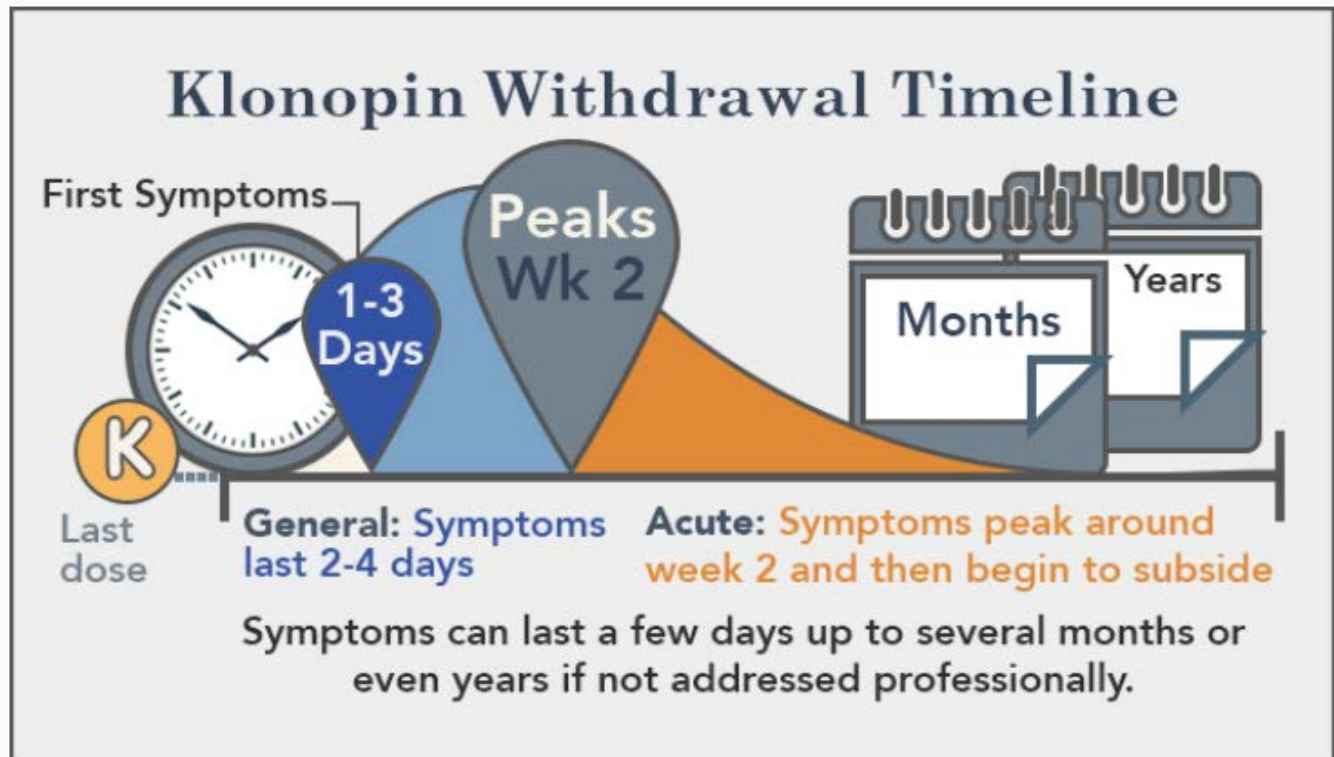
The bulk of withdrawal symptoms will be present during the acute withdrawal phase and may include:

- Tension
- Panic attacks
- Tremors
- Difficulty concentrating
- Short-term memory loss
- Anxiety
- Irritability
- Disturbed sleep
- Headache
- Heart palpitations
- Sweating
- Nausea
- Muscle pain and stiffness
- Hypertension
- Irregular heart rate

More serious side effects may also occur during benzo withdrawal, such as delirium, hallucinations, fever, and seizures. Benzodiazepine withdrawal can be life-threatening due to grand mal seizures that may result in coma or death in someone heavily dependent on benzodiazepines who stops taking them suddenly, the [*Journal of the Oklahoma State Medical Association*](#) states.

Anxiety and psychological withdrawal symptoms may continue for several months or even years in about 10 percent of those addicted to a benzodiazepine, [*ABC News*](#) reports. This is called “protracted withdrawal” and can be managed with therapy and mental health services.

A short-acting benzo, for example, will have the shortest half-life and faster onset of withdrawal than a long-acting benzodiazepine. Short-acting benzodiazepines include Halcion (triazolam) and Serax (oxazepam). Ativan (lorazepam) and Xanax (alprazolam) are intermediate-acting, and Valium (diazepam), [Klonopin \(clonazepam\)](#), and Librium (chlordiazepoxide) are long-acting, per [Primary Psychiatry](#). All three types of benzos produce similar withdrawal symptoms, and detox should be medically managed.



<https://americanaddictioncenters.org/withdrawal-timelines-treatments/clonazepam>

Figure 4-5
Benzodiazepines and Their Phenobarbital Withdrawal Equivalents

Generic name	Trade name	Therapeutic dose range (mg/day)	Dose equal to 30mg 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	Halcyon	0.125–0.50*	0.25	120
<p>* Usual hypnotic dose.</p> <p>** Phenobarbital withdrawal conversion equivalence is not the same as therapeutic dose equivalency. Withdrawal equivalence is the amount of the drug that 30mg of phenobarbital will substitute for and prevent serious high-dose withdrawal signs and symptoms.</p> <p>*** Not applicable.</p>				
<i>Source:</i> American Psychiatric Association (APA) 1990; Wesson and Smith 1985.				

Figure 4-6
Other Sedative-Hypnotics and Their Phenobarbital Withdrawal Equivalents

Generic name	Trade name(s)	Common therapeutic indication	Dose equal to 30mg 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					
bupirone	Buspar	sedative	15–60	***	***
chloral hydrate	Noctec, Somnos	hypnotic	250–1,000	500	0.06
ethchlorvynol	Placidyl	hypnotic	500–1,000	500	0.06
glutethimide	Doriden	hypnotic	250–500	250	0.12
meprobamate	Miltown, Equanil, Equagesic	sedative	1,200–1,600	1,200	0.025
methylprylon	Noludar	hypnotic	200–400	200	0.15
<p>* Butalbital usually is available in combination with opioid or non-opioid analgesics.</p> <p>** Phenobarbital withdrawal conversion equivalence is not the same as therapeutic dose equivalency. Withdrawal equivalence is the amount of the drug that 30mg of phenobarbital will substitute for and prevent serious high-dose withdrawal signs and symptoms.</p> <p>*** Not cross-tolerant with barbiturates.</p>					
<i>Source: APA 1990; Wesson and Smith 1985.</i>					

Medical complications of withdrawal from benzodiazepines include problems like those seen in alcohol withdrawal. Seizures are particularly worrisome and may occur without being preceded by other evidence of withdrawal. As in alcohol withdrawal, seizures and delirium represent the most extreme pathology seen.

Anecdotal reports appearing in the literature also have described distortions in taste, smell, and other perceptions.

Since many individuals who take benzodiazepines have underlying anxiety disorders, it often is difficult during periods of withdrawal to determine whether symptomatology is related to withdrawal or the emergence of panic attack symptoms.

Elderly patients who are being withdrawn from benzodiazepines are at risk for falls and myocardial infarctions. Delirium without marked autonomic hyperactivity (no elevations of pulse, blood pressure, or temperature) also may be seen in the elderly.

The management of benzodiazepine withdrawal is not recommended without medical supervision. All benzodiazepines should be tapered rather than stopped abruptly, regardless of dose or duration of use—unless it is a matter of use for only a few days (Ashton 2002). (TIP 45).

Stimul-ants

- Cocaine
- Amphetamine
- Methamphetamine
- Tobacco

Figure 4-7 Stimulant Withdrawal Symptoms	
<ul style="list-style-type: none">• Depression• Hypersomnia (or insomnia)• Fatigue• Anxiety• Irritability	<ul style="list-style-type: none">• Poor concentration• Psychomotor retardation• Increased appetite• Paranoia• Drug craving
<i>Source: Consensus Panelist Robert Malcolm, M.D.</i>	

Stimulant Withdrawal Symptoms (TIP 45)

Stimulants are associated with withdrawal symptoms that are different from those seen with opioid, alcohol, and sedative dependence (see Figure 4-7 above). While most clinicians believe that alcohol and heroin withdrawal should be treated aggressively with detoxification, there has been little emphasis on treating symptoms of stimulant withdrawal. No medications have been developed for this purpose. Stimulant withdrawal usually does not involve medical danger or intense patient discomfort. However, if stimulant withdrawal predicts poor outcome, it may be a reasonable target for clinical interventions.

An often overlooked but potentially lethal “medical danger” during stimulant withdrawal is the risk of a profound dysphoria (depression, negative thoughts and feelings) that may include suicidal ideas or attempts. While both cocaine and amphetamine users may experience depression during withdrawal, the period of depression experienced by amphetamine users is more prolonged and may be more intense. Amphetamine users should be monitored closely during detoxification for signs of suicidality and treated for depression if appropriate.

Symptoms often disappear after several days of stimulant abstinence but can persist for 3 to 4 weeks (Coffey et al. 2000). In addition, since individuals addicted to stimulants often fail to achieve abstinence, withdrawal symptoms can be a persistent component of active addiction. In addition, individuals addicted to stimulants may experience impairment in hedonic function (ability to experience pleasure) that has been ascribed to

stimulant induced disruptions of endogenous reward centers (Dackis and O'Brien 2002). Research on animals has found that exposure to high doses of methamphetamine results in changes to both the dopaminergic and serotonergic systems of the brain (Nordahl et al. 2005) and dopamine abnormalities among animals and humans who had been ingesting cocaine (Schuckit 2000).

Researchers have also observed abnormalities in regions of the brain that govern attention and memory in animals that were regularly administered methamphetamine (Nordahl et al. 2005).

Although cocaine withdrawal has traditionally been viewed as relatively mild (Satel et al. 1991; Weddington et al. 1990), evidence suggests that individuals dependent on cocaine with severe stimulant withdrawal are more likely to have a poor clinical outcome (Kampman et al. 2001a).

The level of withdrawal symptoms, therefore, may be clinically significant and should be monitored and recorded for future treatment (Kampman et al. 2001b). Kampman reported significantly higher dropout rates in individuals dependent on cocaine who scored high on the Cocaine Selective Severity Assessment (CSSA), a reliable and valid structured interview designed to capture cocaine withdrawal symptoms (Kampman et al. 1998).

Patients with high scores on the CSSA were five times more likely to leave treatment and four times more likely to resume cocaine use than those with low scores (Mulvaney et al. 1999). The CSSA is an easily administered 18-item questionnaire. Each item is a 7-point rating scale, so that a person can score several points on any given question. Scores more than 22 indicate the presence of significant cocaine withdrawal.

Medical Complications of Stimulant Withdrawal

As previously noted, stimulant withdrawal is not usually associated with medical complications during the withdrawal periods. However, patients with recent cocaine use can experience persistent cardiac complications, including prolonged QTc interval and vulnerability for arrhythmia and myocardial infarction (Chakko and Myerburg 1995).

QT is an interval of time that can be measured on an electrocardiogram (between the q wave and the t wave), while QTc is the relative (or “corrected”) QT interval. Some conditions and many drugs (LAAM, other opioids, and even antibiotics) can cause the interval to lengthen and this can result in cardiac rhythm disturbances. Anterior chest pain or cardiac symptoms should therefore be fully evaluated in these individuals.

Seizures also may be a complication of stimulant abuse and can occur during detoxification. Persistent headaches could represent a subdural, subarachnoid, or intracerebral bleed (bleeding in or around the brain) and should be appropriately evaluated.

It also should be emphasized that people who abuse stimulants usually become addicted to other substances, such as alcohol, sedatives, or opioids, and therefore can experience any of the complications ascribed to detoxification from these substances. Unreported use of other substances should be suspected and assessed with urine toxicology.

Patient Care and Comfort

Since stimulant withdrawal is not associated with severe physical symptoms, adjunctive medications are seldom required. These patients often are sleep deprived and might be unable to benefit from therapeutic activities during the first 24 to 36 hours of abstinence. They often are hungry and in need of large meal portions initially as their food intake may have been inadequate during active addiction.

Stimulant users also may be irritable and care should be taken to avoid needless confrontation during the initial withdrawal phase. Headaches often are reported and can be treated symptomatically. Persistent headaches should be evaluated, as cocaine can produce cerebrovascular disease. Similarly, chest pain of possible cardiac origin should be evaluated medically with electrocardiography, cardiac enzymes, and appropriate medical attention.

On occasion, patients undergoing withdrawal from cocaine or amphetamines report insomnia and may benefit from diphenhydramine (Benadryl) 50 to 100mg, trazodone (Desyrel) 75 to 200mg, or hydroxyzine (Vistaril) 25 to 50mg at bedtime. Benzodiazepines should be avoided unless required for concomitant alcohol or sedative detoxification. As stimulant withdrawal symptoms wane, patients are best treated with an active rehabilitative approach that combines entry into substance abuse treatment with support, education, and changes in lifestyle.

Other Immediate Concerns

Central nervous system stimulants exert most of their toxic effects through vasoconstriction (constriction of the blood vessels). Consequently, several medical conditions can arise from ischemia (lack of proper blood supply) or infarction (death of tissue as the result of lack of blood supply) because of stimulant use.

Myocardial (heart muscle) infarction and stroke are widely recognized complications of stimulant use. However, other problems such as spontaneous abortion, bowel necrosis (tissue death), and renal (kidney) infarction also have been reported from cocaine induced vasoconstriction.

Cardiac arrhythmias also are common. Other medical problems that are associated with stimulant dependence include dental disease, neuropsychiatric abnormalities, and movement disturbances/disorders.

Antidepressants, such as selective serotonin reuptake inhibitors, can be prescribed for the depression that often accompanies methamphetamine or other amphetamine withdrawal.

Tobacco/Nicotine (TIP 45)

In 1988, the U.S. Surgeon General's Report concluded that nicotine is the principal addictive agent in tobacco. Nicotine binds to nicotinic acetylcholine receptors in the brain and has the direct ability to stimulate the release of dopamine in the nucleus accumbens area. The nucleus accumbens has long been considered the "reward center" in the brain. This increase in dopamine is like what occurs when patients use stimulants and is felt to be an essential element in the reward process of addiction (Glover and Glover 2001).

As many as 90 percent of patients entering treatment for substance abuse are current nicotine users (Perine and Schare 1999). There has long been controversy in the field of addiction medicine as to how best to handle the problem of nicotine dependence in patients seeking treatment for other types of substance abuse. Traditionally, it has been argued that patients would find that trying to stop smoking while also contending with other (more pressing) addiction problems would be too difficult and distracting in early abstinence.

However, others argue that nicotine dependence is a lethal disease and that physicians have the responsibility to intervene in this addiction with the same aggressiveness they show toward other addictive substances. This prointervention position has received increasing attention from clinicians, since it is now understood that alcohol consumption is associated with increased nicotine usage (Henningfield et al. 1984).

Gulliver and colleagues (1995) have demonstrated that the urge to smoke is correlated with the urge to drink, and others have shown that continued nicotine dependence may be a relapse trigger for resumption of drinking (Stuyt 1997). The concern that smoking cessation may precipitate relapse to other substances of abuse has not been supported in the literature (Hughes 1995).

Treatment programs that have attempted to treat nicotine dependence in conjunction with other drugs of addiction have met with limited success (Bobo and Davis 1993; Burling et al. 1991; Hurt et al. 1994) and have generated increased interest in smoking cessation as a part of a patient's overall substance abuse treatment (Sees and Clark 1993). One study reported that forcing unmotivated patients (or patients who did not consider smoking a problem) to quit was countertherapeutic (Trudeau et al. 1995).

Moreover, it has traditionally been accepted that nicotine detoxification concurrent with detoxification from other substances makes the undertaking more difficult.

Several factors are involved including the following:

- (1) patient ambivalence and/or lack of interest in smoking cessation
- (2) physician ambivalence about the importance of smoking cessation early in treatment
- (3) staff's use of nicotine
- (4) staff's ambivalence about the importance of nicotine cessation early in treatment
- (5) easy availability of cigarettes from peers, family, visitors, staff, and at 12-Step meetings

- (6) lack of sufficient training and expertise on the part of physicians and staff in managing nicotine withdrawal
- (7) staff resistance to patient smoking cessation because withdrawal symptoms include irritability, anxiety, and depression, all of which can make patients more difficult to manage.

Withdrawal Symptoms Associated with Nicotine

The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision* (DSM-IV-TR) (APA 2000) notes that typically, a person in nicotine withdrawal will have four or more of the signs presented in Figure 4-9 (below), though some clinicians believe that three or more is sufficient to make the diagnosis of nicotine withdrawal.

Furthermore, it should be noted that symptoms vary in duration and intensity, with decreased heart rate and lightheadedness resolving in 48 hours, while increased appetite may remain present for weeks to months (Glover and Glover 2001).

Smokers who have severe craving during withdrawal are less likely to be successful in their attempt at quitting (Hughes and Hatsukami 1992). Depression during withdrawal also has been linked to relapse in smoking. (Covey et al. 1993).

Figure 4-9
DSM-IV-TR on Nicotine Withdrawal

- A. Daily use of nicotine for at least several weeks.
- B. Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by 4 or more of the following signs:
 - 1. Dysphoric or depressed mood
 - 2. Insomnia
 - 3. Irritability, frustration, or anger
 - 4. Anxiety
 - 5. Difficulty concentrating
 - 6. Restlessness
 - 7. Decreased heart rate
 - 8. Increased appetite or weight gain
- C. The symptoms of Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Source: APA 2000, pp. 244–245.

Figure 4-10**Items and Scoring for the Fagerstrom Test for Nicotine Dependence**

Questions	Answers	Points
1. How soon after you wake up do you smoke your first cigarette?	Within 5 minutes 6–30 minutes 31–60 minutes After 60 minutes	3 2 1 0
2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., in church, at the library, in the cinema, etc.)?	Yes No	1 0
3. Which cigarette would you hate most to give up?	The first thing in the morning All others	1 0
4. How many cigarettes/day do you smoke?	10 or less 11–20 21–30 31 or more	0 1 2 3
5. Do you smoke more frequently during the first hours of waking than during the rest of the day?	Yes No	1 2
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes No	1 0
Source: APA 1996.		

There are no major medical complications precipitated by nicotine withdrawal itself. However, patients frequently experience withdrawal symptoms that are uncomfortable. These symptoms can include increased coughing, a desire for sweets, and difficulty concentrating. Most smokers who attempt to quit do so without any formal nicotine cessation treatment. Some smokers can quit on their own, but others may require intervention in the form of behavioral treatment and/or pharmacotherapy.

Figure 4-14
The “5 A’s” for Brief Intervention

Ask about tobacco use. Identify and document tobacco use status for every patient at every visit.

Advise to quit. In a clear, strong, and personalized manner urge every tobacco user to quit.

Assess willingness to make a quit attempt. Is the tobacco user willing to make a quit attempt at this time?

Assist in quit attempt. For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit.

Arrange followup. Schedule followup contact, preferably within the first week after the quit date.

Source: Fiore et al. 2000a, p. 26.

Confus-ants

Marijuana

MDMA or Ecstasy

LSD

Ketamine and PCP

Inhalants

Marijuana withdrawal symptoms include irritability, anxiety, physical tension, and decreases in appetite and mood.

Marijuana and Other Drugs Containing THC (TIP 45)

Marijuana and hashish are the two substances containing THC commonly used today. The field of addiction medicine has given considerable attention to the question of whether there is a specific withdrawal syndrome associated with cessation from prolonged THC use. In the past, many have stated that there is no acute abstinence syndrome that develops in people who abruptly discontinue THC (CSAT 1995⁴). More recently this has been called into question and most experts now believe that a THC-specific withdrawal syndrome does occur in some patients who are heavy users (Budney et al. 2001), though cannabis withdrawal is not yet included in the APA's *Diagnostic and Statistical Manual of Mental Disorders*.

The THC abstinence syndrome usually starts within 24 hours of cessation. The amount of THC that one needs to ingest to experience withdrawal is unknown. It can be assumed, however, that heavier consumption is more likely to be associated with withdrawal symptoms.

The most frequently seen symptoms of THC withdrawal are:

- Anxiety
- restlessness and irritability
- sleep disturbance
- change in appetite (usually anorexia)

Other symptoms of withdrawal are less frequently seen and include:

- tremor,
- diaphoresis (sweating),
- tachycardia (elevated heart rate),
- GI disturbances, including nausea, vomiting, and diarrhea.

Cognitive difficulties including depression also have been reported and may persist but usually improve with time. There are no medical complications of withdrawal from THC, and medication is generally not required to manage withdrawal.

Marijuana withdrawal symptoms include irritability, anxiety, physical tension, and decreases in appetite and mood.

Clinicians may see a variety of the symptoms mentioned above, but these generally require no immediate medication during the detoxification period and usually are self-limiting. However, the clinician should be aware of the potential for more persistent problems.

The patient should be encouraged to maintain abstinence from THC as well as other addictive substances. Some patients will require a substance free, supportive environment to achieve and maintain abstinence. Clinicians should educate all patients about the effects of withdrawal, validate their complaints, and reassure them that their symptoms will likely improve with time. Symptomatic relief may be provided to increase the patient's comfort.

There are no clinical assessment instruments available that measure THC withdrawal. Both animal and human studies indicate that a withdrawal syndrome starts within 24 hours of cessation and may last for up to a week.

Hallucinogens

Hallucinogens are a broad group of substances that can produce sensory abnormalities and hallucinations. Most hallucinogens have some adrenergic effects as well. Hallucinogens also are referred to as psychedelics and psychomimetics. The more traditional hallucinogens such as lysergic acid diethylamide (LSD) are considered primarily serotonergic acting agents. Some of the other compounds include phenylethylamines which have hallucinogenic properties but act like amphetamines as well.

These drugs include mescaline and MDMA. Other hallucinogens are acetylcholine antagonists. These include belladonna, drugs such as benztropine used to treat parkinsonian symptoms, and many common over the counter antihistamines.

- Hallucinogen intoxication often consists of:
- Autonomic effects, sometimes nausea and vomiting
- Mild increases of heart rate, body temperature
- Slight elevations of systolic blood pressure
- Dizziness and dilated pupils may occur

The prominent effects during intoxication are sensory distortions with illusions and hallucinations. Visual distortions are more common than auditory or tactile ones. So-called “bad trips” may involve anxiety including panic attacks, paranoid reactions, anger, violence, and impulsivity. Either due to delusions or misperceptions, individuals may feel they can fly or have special powers, and thus injure themselves in falls or other accidents. Suicide attempts also can occur during “bad trips” and possible suicidal ideation should be carefully evaluated, even though it may be quite transient.

Withdrawal syndromes have not been reported with hallucinogens; however, considerable attention has been paid to residual effects such as delayed perceptual illusions with anxiety, “flashbacks,” residual psychotic symptoms, and long-term cognitive impairment. Controversies around these issues are not important in the clinical setting. The important thing is to determine whether residual symptoms are present and provide an appropriate environment and appropriate care for the individual who has them. Generally, staff of emergency

rooms, clinics that treat people who abuse substances, and social detoxification centers have individuals who are very familiar with “talking down” individuals with bad hallucinogenic trips.

Acute intoxication and bad trips usually can be managed with placement of the individual in a quiet, non-stimulating environment with immediate and direct supervision so that the patient does not cause harm to herself or to others.

Occasionally, a low dose of a shorter intermediate-acting benzodiazepine may be useful to control anxiety and promote sedation. Individuals with chronic depressive-like reactions may require antidepressant therapy. Individuals with residual psychotic symptoms are likely to require antipsychotic medications. On rare occasions, the use of a low dose, high-potency antipsychotic medication may be required orally or parenterally (any method other than the digestive tract, e.g., intravenously, subcutaneously, or intramuscularly). Assessment of residual psychiatric and cognitive symptoms should be made prior to treatment referral.

Ecstasy

MDMA, commonly known as ecstasy, was synthesized around the turn of the century and patented by Merck Pharmaceuticals in 1914 (Christophersen 2000; Parrot et al. 2000). There are several related compounds that are designated by their initials (MDMA, MDA, MDEA, DOM, 2CB, and DOT). Clinicians are likely to have to manage the complications of intoxication and overdose but not withdrawal.

Patients using MDMA or related compounds appear to be:

- hyperactive and hypervocal
- reporting heightened tactile and visual sensations
- frequently will use camphor on the skin in facial masks, gloves, and other clothing to heighten their tactile sensations
- light sticks are used to heighten visual experiences at raves

Hyperthermia, dehydration, water intoxication with low sodium, rhabdomyolysis (severe muscular injury and breakdown of muscle fibers), renal failure, cardiac arrhythmia, and coma have been reported

Ecstasy withdrawal symptoms include depression, confusion, anxiety, cravings, agitation, paranoia, insomnia, fatigue, difficulty concentrating, loss of appetite, memory problems and changes in self-perception.

MDMA has been proven to be toxic to serotonergic neurons in several animal studies. Heavy ecstasy users can have paranoid thinking, psychotic symptoms, obsessional thinking, and anxiety (Parrott et al. 2000). Impaired cognitive performance in heavy ecstasy users also has been identified (Gouzoulis-Mayfrank et al. 2000). Ecstasy users performed more poorly than control groups in complex attention, memory, and learning tasks. The duration or permanence of such effects has not yet been well studied.

Ketamine and PCP (Phencyclidine)

Ketamine and PCP (phencyclidine) were both developed in the 1950s as anesthetic agents for humans. Phencyclidine was briefly marketed for human anesthetic use but taken off the market because of an unusual high incidence of psychotic symptoms.

PCP remains in legitimate use for veterinarian anesthesia for large animals as does ketamine for small animals. Although both drugs were originally developed for intravenous use, they are now manufactured illicitly as oral drugs of abuse. PCP frequently is sold as LSD.

Some studies have found that ketamine and PCP act specifically at the MDMA/glutamate receptor as noncompetitive MDMA receptor antagonists. Research in animals indicates that both drugs are reinforcing, in that animals will press a bar to obtain doses of either drug. Furthermore, in these same animal models, abstinence syndromes have been observed.

Withdrawal symptoms in humans have included:

- Depression
- drug craving
- increased appetite
- hypersomnolence (excessive sleep)

In the clinical setting, syndromes of acute intoxication with hallucinations, delusions, agitation, and violence are the most pressing problems. A human laboratory study (Lahti et al. 2001) conducted a comparison of ketamine and placebo in normal volunteers never exposed to ketamine and to people with schizophrenia with a previous history of ketamine use. In both groups, ketamine produced a dose related, but brief, increase in psychotic symptoms. The magnitude of ketamine induced positive psychotic symptoms was similar for both groups, although the schizophrenia group had higher baseline scores.

In the clinical setting, ketamine and PCP use require management for the agitation and psychotic features produced during acute use. Occasionally, patients will have such large overdoses, intentionally or accidentally, that they will require airway management and ventilatory support for some hours. The behavioral management of the agitation and violence that may be seen is best managed in a controlled environment with limited stimuli and very close supervision. Occasionally, oral or parenteral uses of sedating medications such as benzodiazepines will be required. In extreme cases, restraints may be required for protection of the patient and staff.

Following acute management, assessment of persistent mood and cognitive effects must be made prior to any treatment attempts. The persistence of psychotic symptoms may represent an underlying psychiatric disorder that may require medication treatment.

There are no studies to guide the treatment of ketamine or PCP detoxification. The need to manage withdrawal symptoms from these drugs is unlikely, but if it should arise, benzodiazepines should be administered.

Inhalants/Solvents

Withdrawal Symptoms Associated with Inhalants/Solvents

The term “inhalants” is used to describe a large and varied group of psychoactive substances that all share the common characteristic of being inhaled for their effects. They are commonly found in household, industrial, and medical products. These drugs are used primarily by adolescents, although some, especially the nitrates, are used by adults as well (NIDA 2000). Figure 4-8 presents some of the more commonly abused inhalants.

Dependence on inhalants and subsequent withdrawal symptoms are both relatively uncommon phenomena (Balster 2003). There is no *specific* or characteristic withdrawal syndrome that would include all drugs in the inhalant class. Intoxication with the solvents, aerosols, and gases often produces a syndrome most like that of alcohol intoxication but lasting only 15 to 45 minutes (Miller and Gold 1990). Rarely, symptoms like sedative withdrawal have been described, including “fine tremors, irritability, anxiety, insomnia, tingling sensations, seizures and muscle cramps” (Miller and Gold 1990, p. 87). Toluene withdrawal has been reported to cause delirium tremens (Miller and Gold 1990). Longtime users also may exhibit weakness, weight loss, inattentive behavior, and depression (NIDA 2005). It has been reported that withdrawal symptoms can occur with as little as 3 months of regular usage (Ron 1986). When present, the withdrawal typically lasts 2 to 5 days (Evans and Raistrick 1987).

In addition to their short-term intoxicating affects, nitrates are used to enhance sexual pleasure by vasodilation (dilation of blood vessels) that produces a rush and sensation of warmth. There is no withdrawal syndrome that has been associated with nitrate abuse.

There are no specific assessment instruments available to measure inhalant withdrawal symptoms. A patient who presents with a history of inhalant use and symptoms of sedative like withdrawal should alert the clinician to the possibility of inhalant withdrawal. These patients require a complete history and physical exam. Additionally, a blood alcohol level and urine drug screen are helpful in the cases of suspected polydrug abuse.

Medical Complications of Withdrawal from Inhalants/Solvents

There are many medical complications associated with inhalant abuse and intoxication. Many of these complications are not the result of withdrawal but may still be seen when the patient presents to the clinician. Most inhalants produce some neurotoxicity with cognitive, motor, and sensory involvement. Additionally, damage to internal organs including the heart, lungs, kidneys, liver, pancreas, and bone marrow has been reported.

Management of Withdrawal Without Medications

It is crucial to provide the patient with an environment of safety that removes him from access to inhalants. This can pose a challenge due to the almost universal availability of these drugs in society. Many of the medical consequences of This can pose a challenge due to the almost universal availability of these drugs in society. Many of the medical consequences of inhalant usage will remit once the patient achieves abstinence (Balster 2003). The patient should be monitored for withdrawal symptoms and changes in mental status.

Most patients presenting for treatment of inhalant dependence will be adolescents. Ideally, they should be entered an age appropriate treatment program that meets their medical and psychosocial needs. Supportive

care, including helping them to get enough sleep and a well-balanced diet, usually will be enough to get patients safely through withdrawal (Frances and Miller 1998).

Patient Care and Comfort

For patients who have only been abusing inhalants, treatment of insomnia during withdrawal is not usually necessary. Sedative substitution during the period of detoxification may allow the patient to sleep. However, a period of post detoxification insomnia should be expected and usually can be treated by the recommendation of good sleep hygiene practices such as avoiding caffeine, daytime napping, and overstimulation in the evening.

If the patient can refrain from inhalant (and other substance) use and has no serious psychiatric or medical consequences, then outpatient treatment should be the first option. Inpatient or residential treatment should be used for those patients who cannot achieve abstinence or have serious cooccurring medical or psychiatric disorders. Hospitalized patients will need a thorough history and physical exam. Therapy to address denial, addiction, and pertinent psychosocial issues should be initiated as soon as possible during the hospitalization. Supportive care and abstinence will resolve most medical problems associated with chronic inhalant usage (Balster 2003).

Figure 4-8 (continued) Commonly Abused Inhalants/Solvents		
Solvents and gases	Nail polish remover	Acetone, ethyl acetate
	Paint remover	Toluene, methylene chloride, methanol acetone, ethyl acetate
	Paint thinner	Petroleum distillates, esters, acetone
	Correction fluid and thinner	Trichloroethylene, trichloroethane
	Fuel gas	Butane, isopropane
	Lighter	Butane, isopropane
	Fire extinguisher	Bromochlorodifluoromethane
Food products	Whipped cream	Nitrous oxide
	Whippets	Nitrous oxide
“Room odorizers”	Locker Room, Rush, Poppers	Isoamyl, isobutyl, isopropyl or butyl nitrate (now legal), cyclohexyl
Source: Balster 2003.		

Interventions

Interventions for detoxification from depressants, stimulants, and confusants are very similar. All with mild to moderate symptoms and acceptable scores on withdrawal risk assessments may be placed in observational detoxification. Vital signs should be checked regularly as recommended in chapter 3, bed rest should be encouraged, and pushing intake of fluids and juices to maintain hydration and electrolyte balance while undergoing detoxification are standard for all detoxification clients. Diet should be well balanced and frequent snacks offered but may not be well tolerated by the client. If the client cannot retain food or fluids, shows signs of dehydration, has abnormal vital signs, or any other changes in health status they should be referred for medical services. More specific interventions may be offered to clients according to facility policy.

Appendices

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Appendix C Screening and Assessment Instruments

Appendix D 42 CFR Part 2

Appendix E Act 10

Appendix F Sample Forms

Appendix G List of Current RADD providers

Appendix H RADD Grant

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Appendix J Course Resources for Instructors

Appendix A

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Appendix B

Common Drug Intoxication Signs and Withdrawal Symptoms

	Cocaine	Alcohol	Heroin	Cannabis (marijuana)
Intoxication				
Action	Stimulant	Sedative	Sedative, euphoriant, analgesic	Euphoriant, at high doses may induce hallucinations
Characteristics of intoxication	<input type="checkbox"/> BP, HR, temp, <input type="checkbox"/> energy, <input type="checkbox"/> paranoia, <input type="checkbox"/> fatigue, ↓ appetite, move bowels/ urinate	<ul style="list-style-type: none"> • Sedation, ↓respiration, • Depresses CNS system, can result in coma, death 	Drowsiness, “nodding,” euphoria (happy giddiness)	↓BP, <input type="checkbox"/> HR, ↓intraocular pressure (pressure in the eyes) conjunctival injection (reddening of the eyes)
Withdrawal				
Onset	Depends upon type of cocaine used: for crack will begin within hours of last use	24–48 hours after blood alcohol level drops	Within 24 hours of last use	Some debate about this, may be a few days
Duration	3–4 days	5–7 days	4–7 days	May last up to several weeks

	Cocaine	Alcohol	Heroin	Cannabis (marijuana)
Characteristics	Sleeplessness <i>or</i> excessive restless sleep, appetite increase, depression, paranoia, decreased energy	□BP, □HR, □temp, nausea/vomiting/diarrhea, seizures, delirium, death	Nausea, vomiting, diarrhea, goose bumps, runny nose, teary eyes, yawning	Irritability, appetite disturbance, sleep disturbance, nausea, concentration problems, nystagmus, diarrhea
Medical/psychiatric issues	Stroke, cardiovascular collapse, myocardial and other organ infarction, paranoia, violence, severe depression, suicide	Virtually every organ system is affected (e.g., cardiomyopathy, liver disease, esophageal and rectal varices); fetal alcohol syndrome and other problems with fetus	During withdrawal individual may become dehydrated	

Appendix C

Screening and Assessment Instruments

Section I: Screening and Assessment for Alcohol Abuse

Section II: Screening and Assessment for Alcohol and Other Drug Abuse

Section I: Screening and Assessment for Alcohol Abuse

This section of the appendix lists common screening and assessment instruments specifically used in cases where abuse of or dependence upon alcohol is in question.

The Alcohol Use Disorders Identification Test (AUDIT)

Purpose: The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health.

Clinical utility: The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement.

Groups with whom this instrument has been used: Adults, particularly primary care, emergency room, surgery, and psychiatric patients; DWI offenders; offenders in court, jail, and prison; enlisted men in the armed forces; workers receiving help from employee assistance programs and in industrial settings.

Norms: Yes, heavy drinkers and people with alcohol use disorders

Format: A 10-item screening questionnaire with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 on problems caused by alcohol.

Administration time: Two minutes

Scoring time: One minute

Computer scoring? No

Administrator training and qualifications: The AUDIT is administered by a health professional or paraprofessional. Training is required for administration. A detailed user's manual and a videotape training module explain proper administration, procedures, scoring, interpretation, and clinical management.

Fee for use: No

Available from: Department of Mental Health and Substance Dependence, World Health Organization, CH-1211 Geneva 27, Switzerland; request document WHO/MSD/MSB/01.6a.

Brief Michigan Alcoholism Screening Test (BMAST)

Purpose: Used to screen for alcoholism with a variety of populations.

Clinical utility: The BMAST can save clinicians time when integrated with instruments used to screen for other behavioral health problems (Pokorny et al. 1972).

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: Ten-item questionnaire; interview or paper-and-pencil

Administration time: Five minutes

Scoring time: Two to 3 minutes

Computer scoring? No

Administrator training and qualifications: No training required.

Fee for use: No

Available from: Can be downloaded from Project Cork Web site: <http://www.projectcork.org>

CAGE Questionnaire

Purpose: Used to detect alcoholism.

Clinical utility: The CAGE Questionnaire is a very useful bedside, clinical desk instrument and has become the favorite of many family practice and general internists and among nurses.

Groups with whom this instrument has been used: Adults and adolescents (over 16 years old)

Norms: Yes

Format: Very brief, relatively non-confrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present use.

Administration time: Less than 1 minute

Scoring time: Instantaneous

Computer scoring? No

Administrator training and qualifications: No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

Fee for use: No

Available from: Can be downloaded from Project Cork Web site: <http://www.projectcork.org>

Clinical Institute Withdrawal Assessment (CIWA-Ar)

Purpose: Converts DSM-III-R items into scores to track severity of withdrawal; measures severity of alcohol withdrawal.

Clinical utility: Aid to adjustment of care related to withdrawal severity.

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: A 10-item scale for clinical quantification of the severity of the alcohol withdrawal syndrome.

Administration time: Two minutes

Scoring time: Four to 5 minutes

Computer scoring? No

Administrator training and qualifications: Training is required; the CIWA-Ar can be administered by nurses, doctors, research associates, and detoxification unit workers.

Fee for use: No

Available from: Center for Substance Abuse Treatment. A Guide to Substance Abuse Services for Primary Care Clinicians. Treatment Improvement Protocol (TIP) Series 24. HHS Publication No. (SMA) 97-3139.

Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997.

Michigan Alcoholism Screening Test (MAST)

Purpose: Used to screen for alcoholism with a variety of populations.

Clinical utility: A 25-item questionnaire designed to provide a rapid and effective screen for lifetime alcohol-related problems and alcoholism.

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: Consists of 25 questions

Administration time: Ten minutes

Scoring time: Five minutes

Computer scoring? No

Administrator training and qualifications: No training required.

Fee for use: Fee for a copy, no fee for use

Available from: Can be downloaded from Project Cork Web site: <http://www.projectcork.org>

TWEAK

Purpose: Screens for heavy drinking and alcohol dependence in the past year in male and female samples of the general household population and hospital clinic outpatients (Chan et al. 1993).

Clinical utility: The TWEAK provides a quick and easy method of targeting outpatients and inpatients in need of more thorough assessments of their alcohol use patterns and problems to determine whether treatment is needed. The TWEAK has also been used to screen for periconceptional risk drinking among obstetric outpatients (Russell et al. 1994), which may improve pregnancy outcome among high-risk drinkers.

Groups with whom this instrument has been used: Adults

Norms: Yes

Format: Five items; pencil and paper self-administered, administered by interview, or computer self-administered.

Administration time: Less than 2 minutes

Scoring time: Approximately 1 minute

Computer scoring? No

Administrator training and qualifications: No training required.

Fee for use: No

Available from: Can be downloaded from Project Cork Web site: <http://www.projectcork.org>

Section II: Screening and Assessment for Alcohol and Other Drug Abuse

This section of the appendix lists common screening and assessment instruments used in cases where abuse of or dependence upon sub-stances (including alcohol) is in question.

Addiction Severity Index (ASI)

Purpose: The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time.

Clinical utility: The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Groups with whom this instrument has been used: Designed for adults of both sexes who are not intoxicated (on illicit drugs or alcohol) when interviewed. It is also available in Spanish.

Norms: The ASI has been used with males and females with substance use disorders in both inpatient and outpatient settings.

Format: Structured interview

Administration time: Fifty minutes to 1 hour

Scoring time: Five minutes for severity rating

Computer scoring? Yes

Administrator training and qualifications: A self-training packet is available as well as onsite training by experienced trainers.

Fee for use: No cost; minimal charges for photocopying and mailing may apply

Available from: A. Thomas McLellan, Ph.D. Building 7PVAMC University Avenue Philadelphia, PA 19104

Phone: (800) 238-2433

Cocaine Selective Severity Assessment (CSSA)

Purpose: Measures early cocaine abstinence signs and symptoms.

Clinical utility: The CSSA is able to predict a patient's response to treatment and could be used to identify patients at greater risk for treatment failure so that these patients could be targeted for additional interventions. This instrument could also be used to evaluate the effectiveness of medications intended to treat cocaine abstinence symptoms.

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: Eighteen items

Administration time: Less than 10 minutes

Scoring time: N/A

Computer scoring? No

Administrator training and qualifications: Requires little training; clinician-administered

Available from: Kampman, K.M., Volpicelli, J.R., McGinnis, D.E., Alterman, A.I., Weinrieb, R.M., D'Angelo, L., and Epperson, L.E. Reliability and validity of the Cocaine Selective Severity Assessment. *Addictive Behaviors* 23(4):449–461, 1998.

Objective Opiate Withdrawal Scale (OOWS)

Purpose: Used to record symptoms of opiate withdrawal.

Clinical utility: Allows staff to share information about a client's withdrawal, especially objective signs observed by staff.

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: Thirteen manifestations of withdrawal; observer scores

Computer scoring? No

Administrator training and qualifications: Staff must be familiar with withdrawal signs (e.g., registered nurse, physician) or trained.

Available from: Handelsman, L., Cochrane, K.J., Aronson, M.J., Ness, R., Rubinstein, K.J., and Kanof, P.D. Two new rating scales for opiate withdrawal. *American Journal of Alcohol Abuse*. 13:293–308, 1987.

Structured Clinical Interview for DSMIV Disorders (SCID)

Purpose: Obtains Axis I and II diagnoses using the DSMIV diagnostic criteria for enabling the interviewer to either rule out or to establish a diagnosis of “drug abuse” or “drug dependence” and/or “alcohol abuse” or “alcohol dependence.”

Clinical utility: A psychiatric interview

Groups with whom this instrument has been used: Psychiatric, medical, or community based normal adults.

Norms: No Format: A psychiatric interview form in which diagnosis can be made by the examiner asking a series of approximately 10 questions of a client.

Administration time: Administration of Axis I and Axis II batteries may require more than 2 hours each for patients with multiple diagnoses. The Psychoactive Substance Use Disorders module may be administered by itself in 30 to 60 minutes.

Scoring time: Approximately 10 minutes

Computer scoring? No. Diagnosis can be made by the examiner after the interview.

Administrator training and qualifications: Designed for use by a trained clinical evaluator at the master's or doctoral level, although in research settings it has been used by bachelor's level technicians with extensive training.

Fee for use: Yes

Available from: American Psychiatric Publishing, Inc. 1400 K Street, N.W. Washington, DC 20005

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

Purpose: Designed to assess client motivation to change drinking or drug related behavior. Consists of five scales: precontemplation, contemplation, determination, action, and maintenance. Separate versions are available for alcohol and illicit drug use.

Clinical utility: The SOCRATES can assist clinicians with necessary information about client motivation for change, an important predictor of treatment compliance and outcome, and aid in treatment planning.

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: Forty items; paper and pencil

Administration time: Five minutes

Computer scoring? No

Administrator training and qualifications: No training required.

Fee for use: No

Available from: Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 35. HHS Publication No. (SMA) 993354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Subjective Opiate Withdrawal Scale (SOWS)

Purpose: Used to record client's impressions or complaints of opiate withdrawal symptoms.

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: Sixteen item questionnaire; interview or paper and pencil

Computer scoring? No

Available from: Handelsman, L., Cochrane, K.J., Aronson, M.J., Ness, R., Rubinstein, K.J., and Kanof, P.D. Two new rating scales for opiate withdrawal. *American Journal of Alcohol Abuse*. 13:293–308, 1987.

University of Rhode Island Change Assessment (URICA)

Purpose: The URICA operationally defines four theoretical stages of change (precontemplation, contemplation, action, and maintenance), each assessed by eight items.

Clinical utility: Assessment of stages of change/readiness construct can be used as a predictor, and for treatment matching and determining outcome variables.

Groups with whom this instrument has been used: Both inpatient and outpatient adults

Norms: Yes, for an outpatient alcoholism treatment population

Format: The URICA is a 32-item inventory designed to assess an individual's stage of change located along a theorized continuum of change.

Administration time: Five to 10 minutes to complete

Scoring time: Four to 5 minutes

Computer scoring? Yes, using computer scannable forms

Administrator training and qualifications: N/A

Fee for use: No—the instrument is in the public domain

Available from: Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 35. HHS Publication No. (SMA) 993354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Appendix D

42 CFR Part 2

Title 42: Public Health

PART 2—CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

Contents

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- §2.53 Audit and evaluation.

Subpart E—Court Orders Authorizing Disclosure and Use

- §2.61 Legal effect of order.
 - §2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.
 - §2.63 Confidential communications.
 - §2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.
 - §2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.
 - §2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a part 2 program or the person holding the records.
 - §2.67 Orders authorizing the use of undercover agents and informants to investigate employees or agents of a part 2 program in connection with a criminal matter.
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AUTHORITY: 42 U.S.C. 290dd-2.

SOURCE: 82 FR 6115, Jan. 18, 2017, unless otherwise noted.

Subpart A—Introduction

§2.1 Statutory authority for confidentiality of substance use disorder patient records.

Title 42, United States Code, Section 290dd-2(g) authorizes the Secretary to prescribe regulations. Such regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this statute, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

§2.2 Purpose and effect.

(a) *Purpose.* Pursuant to 42 U.S.C. 290dd-2(g), the regulations in this part impose restrictions upon the disclosure and use of substance use disorder patient records which are maintained in connection with the performance of any part 2 program. The regulations in this part include the following subparts:

(1) Subpart B of this part: General Provisions, including definitions, applicability, and general restrictions;

(2) Subpart C of this part: Disclosures with Patient Consent, including disclosures which require patient consent and the consent form requirements;

(3) Subpart D of this part: Disclosures without Patient Consent, including disclosures which do not require patient consent or an authorizing court order; and

(4) Subpart E of this part: Court Orders Authorizing Disclosure and Use, including disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders.

(b) *Effect.* (1) The regulations in this part prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) The regulations in this part are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable by reason of the availability of their patient record than an individual with a substance use disorder who does not seek treatment.

(3) Because there is a criminal penalty for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers v. United States*, 327 U.S. 614, 621-22, 66 S. Ct. 705, 707-08 (1946)).

§2.3 Criminal penalty for violation.

Under 42 U.S.C. 290dd-2(f), any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined in accordance with Title 18 of the U.S. Code.

§2.4 Reports of violations.

(a) The report of any violation of the regulations in this part may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of the regulations in this part by an opioid treatment program may be directed to the United States Attorney for the judicial district in which the violation occurs as well as to the Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight.

Subpart B—General Provisions

§2.11 Definitions.

For purposes of the regulations in this part:

Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for withdrawal management or maintenance treatment for the purpose of avoiding an individual's concurrent enrollment in more than one treatment program.

Diagnosis means any reference to an individual's substance use disorder or to a condition which is identified as having been caused by that substance use disorder which is made for the purpose of treatment or referral for treatment.

Disclose means to communicate any information identifying a patient as being or having been diagnosed with a substance use disorder, having or having had a substance use disorder, or being or having been referred for treatment of a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person.

Federally assisted—see §2.12(b).

Informant means an individual:

(1) Who is a patient or employee of a part 2 program or who becomes a patient or employee of a part 2 program at the request of a law enforcement agency or official; and

(2) Who at the request of a law enforcement agency or official observes one or more patients or employees of the part 2 program for the purpose of reporting the information obtained to the law enforcement agency or official.

Maintenance treatment means long-term pharmacotherapy for individuals with substance use disorders that reduces the pathological pursuit of reward and/or relief and supports remission of substance use disorder-related symptoms.

Member program means a withdrawal management or maintenance treatment program which reports patient identifying information to a central registry and which is in the same state as that central registry or is in a state that participates in data sharing with the central registry of the program in question.

Minor, as used in the regulations in this part, means an individual who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, the age of 18 years.

Part 2 program means a federally assisted program (federally assisted as defined in §2.12(b) and program as defined in this section). See §2.12(e)(1) for examples.

Part 2 program director means:

(1) In the case of a part 2 program that is an individual, that individual.

(2) In the case of a part 2 program that is an entity, the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer of the part 2 program.

Patient means any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a part 2 program. *Patient* includes any individual who, after arrest on a criminal charge, is identified as an individual with a substance use disorder in order to determine that individual's eligibility to participate in a part 2 program. This definition includes both current and former patients.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient, as defined in this section, can be determined with reasonable accuracy either directly or by reference to other information. The term does not include a number assigned to a patient by a part 2 program, for internal use only by the part 2 program, if that number does not consist of or contain numbers (such as a social security, or driver's license number) that could be used to identify a patient with reasonable accuracy from sources external to the part 2 program.

Person means an individual, partnership, corporation, federal, state or local government agency, or any other legal entity, (also referred to as "individual or entity").

Program means:

(1) An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or

(2) An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or

(3) Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.

Qualified service organization means an individual or entity who:

(1) Provides services to a part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(2) Has entered into a written agreement with a part 2 program under which that individual or entity:

(i) Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the part 2 program, it is fully bound by the regulations in this part; and

(ii) If necessary, will resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by the regulations in this part.

Records means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts). For the purpose of the regulations in this part, records include both paper and electronic records.

Substance use disorder means a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal. For the purposes of the regulations in this part, this definition does not include tobacco or caffeine use.

Third-party payer means an individual or entity who pays and/or agrees to pay for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of the patient's family or on the basis of the patient's eligibility for federal, state, or local governmental benefits.

Treating provider relationship means that, regardless of whether there has been an actual in-person encounter:

(1) A patient is, agrees to, or is legally required to be diagnosed, evaluated, and/or treated, or agrees to accept consultation, for any condition by an individual or entity, and;

(2) The individual or entity undertakes or agrees to undertake diagnosis, evaluation, and/or treatment of the patient, or consultation with the patient, for any condition.

Treatment means the care of a patient suffering from a substance use disorder, a condition which is identified as having been caused by the substance use disorder, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means any federal, state, or local law enforcement agency or official who enrolls in or becomes an employee of a part 2 program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

Withdrawal management means the use of pharmacotherapies to treat or attenuate the problematic signs and symptoms arising when heavy and/or prolonged substance use is reduced or discontinued.

§2.12 Applicability.

(a) *General*—(1) *Restrictions on disclosure.* The restrictions on disclosure in the regulations in this part apply to any information, whether or not recorded, which:

(i) Would identify a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person; and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date; for the purpose of treating a substance use disorder, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290dd-2(c)) applies to any information, whether or not recorded, which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date; for the purpose of treating a substance use disorder, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* A program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (2) of this section relating to the Department of Veterans Affairs and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Participating provider in the Medicare program;

(ii) Authorization to conduct maintenance treatment or withdrawal management; or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of substance use disorders;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of federal financial assistance in any form, including financial assistance which does not directly pay for the substance use disorder diagnosis, treatment, or referral for treatment; or

(ii) Conducted by a state or local government unit which, through general or special revenue sharing or other forms of assistance, receives federal funds which could be (but are not necessarily) spent for the substance use disorder program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions—* (1) *Department of Veterans Affairs.* These regulations do not apply to information on substance use disorder patients maintained in connection with the Department of Veterans Affairs' provision of hospital care, nursing home care, domiciliary care, and medical services under Title 38, U.S.C. Those records are governed by 38 U.S.C. 7332 and regulations issued under that authority by the Secretary of Veterans Affairs.

(2) *Armed Forces.* The regulations in this part apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Department of Veterans Affairs furnishing health care to veterans.

(3) *Communication within a part 2 program or between a part 2 program and an entity having direct administrative control over that part 2 program.* The restrictions on disclosure in the regulations in this part 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 patients with substance use disorders if the communications are:

(i) Within a part 2 program; or

(ii) Between a part 2 program and an entity that has direct administrative control over the program.

(4) *Qualified service organizations.* The restrictions on disclosure in the regulations in this part do not apply to communications between a part 2 program and a qualified service organization of information needed by the qualified service organization to provide services to the program.

(5) *Crimes on part 2 program premises or against part 2 program personnel.* The restrictions on disclosure and use in the regulations in this part do not apply to communications from part 2 program personnel to law enforcement agencies or officials which:

(i) Are directly related to a patient's commission of a crime on the premises of the part 2 program or against part 2 program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* The restrictions on disclosure and use in the regulations in this part do not apply to the reporting under state law of incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, the restrictions continue to apply to the

original substance use disorder patient records maintained by the part 2 program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information—* (1) *Restriction on use of information.* The restriction on the use of any information subject to the regulations in this part to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a part 2 program, regardless of the status of the person obtaining the information or whether the information was obtained in accordance with the regulations in this part. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see §2.17) or through patient access (see §2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—*(i) *Third-party payers, administrative entities, and others.* The restrictions on disclosure in the regulations in this part apply to:

(A) Third-party payers with regard to records disclosed to them by part 2 programs or under §2.31(a)(4)(iii)(A);

(B) Entities having direct administrative control over part 2 programs with regard to information that is subject to the regulations in this part communicated to them by the part 2 program under paragraph (c)(3) of this section; and

(C) Individuals or entities who receive patient records directly from a part 2 program or other lawful holder of patient identifying information and who are notified of the prohibition on re-disclosure in accordance with §2.32.

(ii) [Reserved]

(e) *Explanation of applicability—*(1) *Coverage.* These regulations cover any information (including information on referral and intake) about patients receiving diagnosis, treatment, or referral for treatment for a substance use disorder created by a part 2 program. Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide substance use disorder diagnosis, treatment, or referral for treatment. However, the regulations in this part would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of substance use disorder diagnosis, treatment, or referral for treatment and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.

(2) *Federal assistance to program required.* If a patient's substance use disorder diagnosis, treatment, or referral for treatment is not provided by a part 2 program, that patient's record is not covered by the regulations in this part. Thus, it is possible for an individual patient to benefit from federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in paragraph (b) of this section. For example, if a federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by the regulations in this part unless the program itself received federal assistance as defined by paragraph (b) of this section.

(3) *Information to which restrictions are applicable.* Whether a restriction applies to use or disclosure affects the type of information which may be disclosed. The restrictions on disclosure apply to any

information which would identify a patient as having or having had a substance use disorder. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the part 2 program for the purpose of diagnosis, treatment, or referral for treatment of patients with substance use disorders. (Note that restrictions on use and disclosure apply to recipients of information under paragraph (d) of this section.)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as having or having had a substance use disorder which is initially prepared by a part 2 provider in connection with the treatment or referral for treatment of a patient with a substance use disorder. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by the regulations in this part. The following are not covered by the regulations in this part:

(i) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement agencies or officials; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved does not have a substance use disorder (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

§2.13 Confidentiality restrictions and safeguards.

(a) *General.* The patient records subject to the regulations in this part may be disclosed or used only as permitted by the regulations in this part and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any federal, state, or local authority. Any disclosure made under the regulations in this part must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in the regulations in this part apply whether or not the part 2 program or other lawful holder of the patient identifying information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement agency or official or other government official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by the regulations in this part.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a health care facility or component of a health care facility which is publicly identified as a place where only substance use disorder diagnosis, treatment, or referral for treatment is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of this part or if an authorizing court order is entered in accordance with subpart E of this part. The regulations permit acknowledgement of the presence of an identified patient in a health care facility or part of a health care facility if the health care facility is not publicly identified as only a substance use disorder diagnosis, treatment, or referral for treatment facility, and if the acknowledgement does not reveal that the patient has a substance use disorder.

(2) Any answer to a request for a disclosure of patient records which is not permissible under the regulations in this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a substance use disorder. An inquiring party may be provided a copy of the regulations in this part and advised that they restrict the disclosure of substance use disorder patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.

(d) *List of disclosures.* Upon request, patients who have consented to disclose their patient identifying information using a general designation pursuant to §2.31(a)(4)(iii)(B)(3) must be provided a list of entities to which their information has been disclosed pursuant to the general designation.

(1) Under this paragraph (d), patient requests:

(i) Must be made in writing; and

(ii) Are limited to disclosures made within the past two years;

(2) Under this paragraph (d), the entity named on the consent form that discloses information pursuant to a patient's general designation (the entity that serves as an intermediary, as described in §2.31(a)(4)(iii)(B)) must:

(i) Respond in 30 or fewer days of receipt of the written request; and

(ii) Provide, for each disclosure, the name(s) of the entity(-ies) to which the disclosure was made, the date of the disclosure, and a brief description of the patient identifying information disclosed.

(3) The part 2 program is not responsible for compliance with this paragraph (d); the entity that serves as an intermediary, as described in §2.31(a)(4)(iii)(B), is responsible for compliance with the list of disclosures requirement.

§2.14 Minor patients.

(a) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable state law to apply for and obtain substance use disorder treatment, any written consent for disclosure authorized under subpart C of this part may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a part 2 program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a state or local law requiring the program to furnish the service irrespective of ability to pay.

(b) *State law requiring parental consent to treatment.* (1) Where state law requires consent of a parent, guardian, or other individual for a minor to obtain treatment for a substance use disorder, any written consent for disclosure authorized under subpart C of this part must be given by both the minor and their parent, guardian, or other individual authorized under state law to act in the minor's behalf.

(2) Where state law requires parental consent to treatment, the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of this part; or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the part 2 program director under paragraph (c) of this section.

(c) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a substantial threat to the life or physical well-being of the minor applicant or any other individual may be

disclosed to the parent, guardian, or other individual authorized under state law to act in the minor's behalf if the part 2 program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of this part to their parent, guardian, or other individual authorized under state law to act in the minor's behalf; and

(2) The minor applicant's situation poses a substantial threat to the life or physical well-being of the minor applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf.

§2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors*—(1) *Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage their own affairs, any consent which is required under the regulations in this part may be given by the guardian or other individual authorized under state law to act in the patient's behalf.

(2) *No adjudication of incompetency.* In the case of a patient, other than a minor or one who has been adjudicated incompetent, that for any period suffers from a medical condition that prevents knowing or effective action on their own behalf, the part 2 program director may exercise the right of the patient to consent to a disclosure under subpart C of this part for the sole purpose of obtaining payment for services from a third-party payer.

(b) *Deceased patients*—(1) *Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as having a substance use disorder is subject to the regulations in this part. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable state law. If there is no such applicable state law appointment, the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 251, Jan. 3, 2018]

§2.16 Security for records.

(a) The part 2 program or other lawful holder of patient identifying information must have in place formal policies and procedures to reasonably protect against unauthorized uses and disclosures of patient identifying information and to protect against reasonably anticipated threats or hazards to the security of patient identifying information. These formal policies and procedures must address:

(1) Paper records, including:

(i) Transferring and removing such records;

(ii) Destroying such records, including sanitizing the hard copy media associated with the paper printouts, to render the patient identifying information non-retrievable;

(iii) Maintaining such records in a secure room, locked file cabinet, safe, or other similar container, or storage facility when not in use;

(iv) Using and accessing workstations, secure rooms, locked file cabinets, safes, or other similar containers, and storage facilities that use or store such information; and

(v) Rendering patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (e.g., removing direct identifiers).

(2) Electronic records, including:

(i) Creating, receiving, maintaining, and transmitting such records;

(ii) Destroying such records, including sanitizing the electronic media on which such records are stored, to render the patient identifying information non-retrievable;

(iii) Using and accessing electronic records or other electronic media containing patient identifying information; and

(iv) Rendering the patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (e.g., removing direct identifiers).

(b) [Reserved]

§2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under §2.67, no part 2 program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a part 2 program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

§2.18 Restrictions on the use of identification cards.

No person may require any patient to carry in their immediate possession while away from the part 2 program premises any card or other object which would identify the patient as having a substance use disorder. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a part 2 program.

§2.19 Disposition of records by discontinued programs.

(a) *General.* If a part 2 program discontinues operations or is taken over or acquired by another program, it must remove patient identifying information from its records or destroy its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under §2.16, unless:

(1) The patient who is the subject of the records gives written consent (meeting the requirements of §2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the part 2 program.

(b) *Special procedure where retention period required by law.* If paragraph (a)(2) of this section applies:

(1) Records, which are paper, must be:

(i) Sealed in envelopes or other containers labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]";

(A) All hard copy media from which the paper records were produced, such as printer and facsimile ribbons, drums, etc., must be sanitized to render the data non-retrievable; and

(B) [Reserved]

(ii) Held under the restrictions of the regulations in this part by a responsible person who must, as soon as practicable after the end of the required retention period specified on the label, destroy the records and sanitize any associated hard copy media to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under §2.16.

(2) Records, which are electronic, must be:

(i) Transferred to a portable electronic device with implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or key and implemented access controls for the confidential process or key; or

(ii) Transferred, along with a backup copy, to separate electronic media, so that both the records and the backup copy have implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or key and implemented access controls for the confidential process or key; and

(iii) Within one year of the discontinuation or acquisition of the program, all electronic media on which the patient records or patient identifying information resided prior to being transferred to the device specified in (i) above or the original and backup electronic media specified in (ii) above, including email and other electronic communications, must be sanitized to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under §2.16; and

(iv) The portable electronic device or the original and backup electronic media must be:

(A) Sealed in a container along with any equipment needed to read or access the information, and labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date];" and

(B) Held under the restrictions of the regulations in this part by a responsible person who must store the container in a manner that will protect the information (e.g., climate controlled environment); and

(v) The responsible person must be included on the access control list and be provided a means for decrypting the data. The responsible person must store the decryption tools on a device or at a location separate from the data they are used to encrypt or decrypt; and

(vi) As soon as practicable after the end of the required retention period specified on the label, the portable electronic device or the original and backup electronic media must be sanitized to render the patient identifying information non-retrievable consistent with the policies established under §2.16.

§2.20 Relationship to state laws.

The statute authorizing the regulations in this part (42 U.S.C. 290dd-2) does not preempt the field of law which they cover to the exclusion of all state laws in that field. If a disclosure permitted under the regulations in this part is prohibited under state law, neither the regulations in this part nor the authorizing statute may be construed to authorize any violation of that state law. However, no state law may either authorize or compel any disclosure prohibited by the regulations in this part.

§2.21 Relationship to federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by the regulations in this part and by administrative action taken under section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR part 1316); or section 301(d) of the Public Health Service Act (42 U.S.C. 241(d) and the implementing regulations at 42 CFR part 2a). These research privilege statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under subpart E of this part of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes.

§2.22 Notice to patients of federal confidentiality requirements.

(a) *Notice required.* At the time of admission to a part 2 program or, in the case that a patient does not have capacity upon admission to understand his or her medical status, as soon thereafter as the patient attains such capacity, each part 2 program shall:

(1) Communicate to the patient that federal law and regulations protect the confidentiality of substance use disorder patient records; and

(2) Give to the patient a summary in writing of the federal law and regulations.

(b) *Required elements of written summary.* The written summary of the federal law and regulations must include:

(1) A general description of the limited circumstances under which a part 2 program may acknowledge that an individual is present or disclose outside the part 2 program information identifying a patient as having or having had a substance use disorder;

(2) A statement that violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to appropriate authorities consistent with §2.4, along with contact information;

(3) A statement that information related to a patient's commission of a crime on the premises of the part 2 program or against personnel of the part 2 program is not protected;

(4) A statement that reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected; and

(5) A citation to the federal law and regulations.

(c) *Program options.* The part 2 program must devise a notice to comply with the requirement to provide the patient with a summary in writing of the federal law and regulations. In this written summary, the part 2 program also may include information concerning state law and any of the part 2 program's policies that are not inconsistent with state and federal law on the subject of confidentiality of substance use disorder patient records.

§2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a part 2 program from giving a patient access to their own records, including the opportunity to inspect and copy any records that the part 2 program maintains about the patient. The part 2 program is not required to obtain a patient's written consent or other authorization under the regulations in this part in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of this information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under §2.12(d)(1).

Subpart C—Disclosures With Patient Consent

§2.31 Consent requirements.

(a) *Required elements for written consent.* A written consent to a disclosure under the regulations in this part may be paper or electronic and must include:

(1) The name of the patient.

(2) The specific name(s) or general designation(s) of the part 2 program(s), entity(ies), or individual(s) permitted to make the disclosure.

(3) How much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed.

(4)(i) The name(s) of the individual(s) to whom a disclosure is to be made; or

(ii) *Entities with a treating provider relationship with the patient.* If the recipient entity has a treating provider relationship with the patient whose information is being disclosed, such as a hospital, a health care clinic, or a private practice, the name of that entity; or

(iii) *Entities without a treating provider relationship with the patient.*

(A) If the recipient entity does not have a treating provider relationship with the patient whose information is being disclosed and is a third-party payer, the name of the entity; or

(B) If the recipient entity does not have a treating provider relationship with the patient whose information is being disclosed and is not covered by paragraph (a)(4)(iii)(A) of this section, such as an entity that facilitates the exchange of health information or a research institution, the name(s) of the entity(-ies); and

(1) The name(s) of an individual participant(s); or

(2) The name(s) of an entity participant(s) that has a treating provider relationship with the patient whose information is being disclosed; or

(3) A general designation of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed.

(i) When using a general designation, a statement must be included on the consent form that the patient (or other individual authorized to sign in lieu of the patient), confirms their understanding that, upon their request and consistent with this part, they must be provided a list of entities to which their information has been disclosed pursuant to the general designation (see §2.13(d)).

(ii) [Reserved]

(5) The purpose of the disclosure. In accordance with §2.13(a), the disclosure must be limited to that information which is necessary to carry out the stated purpose.

(6) A statement that the consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer

(7) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided.

(8) The signature of the patient and, when required for a patient who is a minor, the signature of an individual authorized to give consent under §2.14; or, when required for a patient who is incompetent or deceased, the signature of an individual authorized to sign under §2.15. Electronic signatures are permitted to the extent that they are not prohibited by any applicable law.

(9) The date on which the consent is signed.

(b) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through reasonable diligence could be known, by the individual or entity holding the records to be materially false.

§2.32 Prohibition on re-disclosure.

(a) *Notice to accompany disclosure.* Each disclosure made with the patient's written consent must be accompanied by one of the following written statements:

(1) This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65; or

(2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

(b) [Reserved]

[83 FR 251, Jan. 3, 2018]

§2.33 Disclosures permitted with written consent.

(a) If a patient consents to a disclosure of their records under §2.31, a part 2 program may disclose those records in accordance with that consent to any person or category of persons identified or generally designated in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§2.34 and 2.35, respectively.

(b) If a patient consents to a disclosure of their records under §2.31 for payment and/or health care operations activities, a lawful holder who receives such records under the terms of the written consent may further disclose those records as may be necessary for its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder. Disclosures to contractors, subcontractors, and legal representatives to carry out other purposes such as substance use disorder patient diagnosis, treatment, or referral for treatment are not permitted under this section. In accordance with §2.13(a), disclosures under this section must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

(c) Lawful holders who wish to disclose patient identifying information pursuant to paragraph (b) of this section must have in place a written contract or comparable legal instrument with the contractor or voluntary legal representative, which provides that the contractor, subcontractor, or voluntary legal representative is fully bound by the provisions of part 2 upon receipt of the patient identifying information.

In making any such disclosures, the lawful holder must furnish such recipients with the notice required under §2.32; require such recipients to implement appropriate safeguards to prevent unauthorized uses and disclosures; and require such recipients to report any unauthorized uses, disclosures, or breaches of patient identifying information to the lawful holder. The lawful holder may only disclose information to the contractor or subcontractor or voluntary legal representative that is necessary for the contractor or subcontractor or voluntary legal representative to perform its duties under the contract or comparable legal instrument. Contracts may not permit a contractor or subcontractor or voluntary legal representative to re-disclose information to a third party unless that third party is a contract agent of the contractor or subcontractor, helping them provide services described in the contract, and only as long as the agent only further discloses the information back to the contractor or lawful holder from which the information originated.

[83 FR 251, Jan. 3, 2018]

§2.34 Disclosures to prevent multiple enrollments.

(a) *Restrictions on disclosure.* A part 2 program, as defined in §2.11, may disclose patient records to a central registry or to any withdrawal management or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment;

(ii) The type or dosage of the drug is changed; or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information;

(ii) Type and dosage of the drug; and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of §2.31, except that:

(i) The consent must list the name and address of each central registry and each known withdrawal management or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any withdrawal management or maintenance treatment program established within 200 miles of the program, but does not need to individually name all programs.

(b) *Use of information limited to prevention of multiple enrollments.* A central registry and any withdrawal management or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under subpart E of this part.

(c) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose:

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollments.

(d) *Permitted disclosure by a withdrawal management or maintenance treatment program to prevent a multiple enrollment.* A withdrawal management or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollments.

§2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A part 2 program may disclose information about a patient to those individuals within the criminal justice system who have made participation in the part 2 program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or post-trial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of §2.31 (except paragraph (a)(6) of this section which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the part 2 program, the patient, and the individual(s) within the criminal justice system who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on re-disclosure and use.* An individual within the criminal justice system who receives patient information under this section may re-disclose and use it only to carry out that individual's

official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 251, Jan. 3, 2018]

Subpart D—Disclosures Without Patient Consent

§2.51 Medical emergencies.

(a) *General rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained.

(b) *Special rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the part 2 program shall document, in writing, the disclosure in the patient's records, including:

- (1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;
- (2) The name of the individual making the disclosure;
- (3) The date and time of the disclosure; and
- (4) The nature of the emergency (or error, if the report was to FDA).

§2.52 Research.

(a) Notwithstanding other provisions of this part, including paragraph (b)(2) of this section, patient identifying information may be disclosed by the part 2 program or other lawful holder of part 2 data, for the purpose of conducting scientific research if the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer or their designee makes a determination that the recipient of the patient identifying information:

- (1) If a HIPAA-covered entity or business associate, has obtained and documented authorization from the patient, or a waiver or alteration of authorization, consistent with the HIPAA Privacy Rule at 45 CFR 164.508 or 164.512(i), as applicable; or
- (2) If subject to the HHS regulations regarding the protection of human subjects (45 CFR part 46), either provides documentation that the researcher is in compliance with the requirements of the HHS regulations, including the requirements related to informed consent or a waiver of consent (45 CFR 46.111 and 46.116) or that the research qualifies for exemption under the HHS regulations (45 CFR 46.101(b) and any successor regulations; or

(3) If both a HIPAA covered entity or business associate and subject to the HHS regulations regarding the protection of human subjects, has met the requirements of paragraphs (a)(1) and (2) of this section; and

(4) If neither a HIPAA covered entity or business associate or subject to the HHS regulations regarding the protection of human subjects, this section does not apply.

(b) Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section:

(1) Is fully bound by the regulations in this part and, if necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by the regulations in this part.

(2) Must not re-disclose patient identifying information except back to the individual or entity from whom that patient identifying information was obtained or as permitted under paragraph (c) of this section.

(3) May include part 2 data in research reports only in aggregate form in which patient identifying information has been rendered non-identifiable such that the information cannot be re-identified and serve as an unauthorized means to identify a patient, directly or indirectly, as having or having had a substance use disorder.

(4) Must maintain and destroy patient identifying information in accordance with the security policies and procedures established under §2.16.

(5) Must retain records in compliance with applicable federal, state, and local record retention laws.

(c) *Data linkages*—(1) *Researchers*. Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section that requests linkages to data sets from a data repository(-ies) holding patient identifying information must:

(i) Have the request reviewed and approved by an Institutional Review Board (IRB) registered with the Department of Health and Human Services, Office for Human Research Protections in accordance with 45 CFR part 46 to ensure that patient privacy is considered and the need for identifiable data is justified. Upon request, the researcher may be required to provide evidence of the IRB approval of the research project that contains the data linkage component.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not provided to law enforcement agencies or officials.

(2) *Data repositories*. For purposes of this section, a data repository is fully bound by the provisions of part 2 upon receipt of the patient identifying data and must:

(i) After providing the researcher with the linked data, destroy or delete the linked data from its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under §2.16 Security for records.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not provided to law enforcement agencies or officials.

(2) Except as provided in paragraph (c) of this section, a researcher may not redisclose patient identifying information for data linkages purposes.

§2.53 Audit and evaluation.

(a) *Records not copied or removed.* If patient records are not downloaded, copied or removed from the premises of a part 2 program or other lawful holder, or forwarded electronically to another electronic system or device, patient identifying information, as defined in §2.11, may be disclosed in the course of a review of records on the premises of a part 2 program or other lawful holder to any individual or entity who agrees in writing to comply with the limitations on re-disclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to a part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder;

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a utilization or quality control review, or such individual's or entity's or quality improvement organization's contractors, subcontractors, or legal representatives.

(2) Is determined by the part 2 program or other lawful holder to be qualified to conduct an audit or evaluation of the part 2 program or other lawful holder.

(b) *Copying, removing, downloading, or forwarding patient records.* Records containing patient identifying information, as defined in §2.11, may be copied or removed from the premises of a part 2 program or other lawful holder or downloaded or forwarded to another electronic system or device from the part 2 program's or other lawful holder's electronic records by any individual or entity who:

(1) Agrees in writing to:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under §2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to the part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder; or

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a utilization or quality control review, or such individual's or entity's or quality improvement organization's contractors, subcontractors, or legal representatives.

(c) *Medicare, Medicaid, Children's Health Insurance Program (CHIP), or related audit or evaluation.* (1) Patient identifying information, as defined in §2.11, may be disclosed under paragraph (c) of this section to any individual or entity for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation, including an audit or evaluation necessary to meet the requirements for a Centers for Medicare & Medicaid Services (CMS)-regulated accountable care organization (CMS-regulated ACO) or similar CMS-regulated organization (including a CMS-regulated Qualified Entity (QE)), if the individual or entity agrees in writing to comply with the following:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under §2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section.

(2) A Medicare, Medicaid, or CHIP audit or evaluation under this section includes a civil or administrative investigation of a part 2 program by any federal, state, or local government agency with oversight responsibilities for Medicare, Medicaid, or CHIP and includes administrative enforcement, against the part 2 program by the government agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(3) An audit or evaluation necessary to meet the requirements for a CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must be conducted in accordance with the following:

(i) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must:

(A) Have in place administrative and/or clinical systems; and

(B) Have in place a leadership and management structure, including a governing body and chief executive officer with responsibility for oversight of the organization's management and for ensuring compliance with and adherence to the terms and conditions of the Participation Agreement or similar documentation with CMS; and

(ii) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must have a signed Participation Agreement or similar documentation with CMS, which provides that the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE):

(A) Is subject to periodic evaluations by CMS or its agents, or is required by CMS to evaluate participants in the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) relative to CMS-defined or approved quality and/or cost measures;

(B) Must designate an executive who has the authority to legally bind the organization to ensure compliance with 42 U.S.C. 290dd-2 and this part and the terms and conditions of the Participation Agreement in order to receive patient identifying information from CMS or its agents;

(C) Agrees to comply with all applicable provisions of 42 U.S.C. 290dd-2 and this part;

(D) Must ensure that any audit or evaluation involving patient identifying information occurs in a confidential and controlled setting approved by the designated executive;

(E) Must ensure that any communications or reports or other documents resulting from an audit or evaluation under this section do not allow for the direct or indirect identification (e.g., through the use of codes) of a patient as having or having had a substance use disorder; and

(F) Must establish policies and procedures to protect the confidentiality of the patient identifying information consistent with this part, the terms and conditions of the Participation Agreement, and the requirements set forth in paragraph (c)(1) of this section.

(4) Program, as defined in §2.11, includes an employee of, or provider of medical services under the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(2) of this section.

(5) If a disclosure to an individual or entity is authorized under this section for a Medicare, Medicaid, or CHIP audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(2) of this section, the individual or entity may further disclose the patient identifying information that is received for such purposes to its contractor(s), subcontractor(s), or legal representative(s), to carry out the audit or evaluation, and a quality improvement organization which obtains such information under paragraph (a) or (b) of this section may disclose the information to that individual or entity (or, to such individual's or entity's contractors, subcontractors, or legal representatives, but only for the purposes of this section).

(6) The provisions of this paragraph do not authorize the part 2 program, the federal, state, or local government agency, or any other individual or entity to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the audit or evaluation as specified in paragraph (c) of this section.

(d) Limitations on disclosure and use. Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the part 2 program or other lawful holder from which it was obtained and may be used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under §2.66.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 252, Jan. 3, 2018]

Subpart E—Court Orders Authorizing Disclosure and Use

§2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290dd-2 and the regulations in this part. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under the regulations in this part.

(b) *Examples.* (1) A person holding records subject to the regulations in this part receives a subpoena for those records. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under the regulations in this part.

(2) An authorizing court order is entered under the regulations in this part, but the person holding the records does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure.

Upon the entry of a valid subpoena or other compulsory process the person holding the records must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of the regulations in this part.

§2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under the regulations in this part may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under §2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§2.63 Confidential communications.

(a) A court order under the regulations in this part may authorize disclosure of confidential communications made by a patient to a part 2 program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime allegedly committed by the patient, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

§2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which the applicant asserts that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given written consent (meeting the requirements of the regulations in this part) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be provided:

(1) Adequate notice in a manner which does not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in §2.64(d).

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of the regulations in this part. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to investigate or prosecute a patient in connection with a criminal proceeding may be applied for by the person holding the records or by any law enforcement or prosecutorial officials who are responsible for conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under §2.66 is sought in addition to an order under this section, the person holding the records must be provided:

(1) Adequate notice (in a manner which will not disclose patient identifying information to other persons) of an application by a law enforcement agency or official;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in §2.65(d); and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a law enforcement agency or official.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the part 2 program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a law enforcement agency or official, that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within federal, state, or local government has in fact been represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of the extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment of only that public interest and need found by the court.

§2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a part 2 program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to investigate or prosecute a part 2 program or the person holding the records (or employees or agents of that part 2 program or person holding the records) in connection with a criminal or administrative matter may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a part 2 program or the person holding the records (or agents or employees of the part 2 program or person holding the records) in which the applicant asserts that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has provided written consent (meeting the requirements of §2.31) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the part 2 program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with §2.66(c).

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of §2.64.

(d) *Limitations on disclosure and use of patient identifying information.* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient in connection with a criminal matter, or be used as the basis for an application for an order under §2.65.

§2.67 Orders authorizing the use of undercover agents and informants to investigate employees or agents of a part 2 program in connection with a criminal matter.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a part 2 program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the part 2 program are engaged in criminal misconduct.

(b) *Notice.* The part 2 program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with §2.67(c)), unless the application asserts that:

(1) The part 2 program director is involved in the suspected criminal activities to be investigated by the undercover agent or informant; or

(2) The part 2 program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents of the program who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find all of the following:

(1) There is reason to believe that an employee or agent of the part 2 program is engaged in criminal activity;

(2) Other ways of obtaining evidence of the suspected criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the part 2 program outweigh the potential injury to patients of the part 2 program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a part 2 program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to investigate or prosecute employees or agents of the part 2 program in connection with the suspected criminal activity; and

(4) Include any other measures which are appropriate to limit any potential disruption of the part 2 program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed in a part 2 program under this section may be used to investigate or prosecute any patient in connection with a criminal matter or as the basis for an application for an order under §2.65.

Appendix E

Act 10

0209951506.mih664

As Engrossed: 3/15/95

1 **State of Arkansas**

2 **80th General Assembly** **A Bill** **ACT 1268 OF 1995**

3 **Regular Session, 1995 HOUSE BILL 1673**

4 **By: Representative Goodwin**

5

6

7 **For An Act To Be Entitled**

8 "AN ACT TO AMEND VARIOUS SECTIONS OF ARKANSAS CODE TITLE
9 20, CHAPTER 64, SUBCHAPTER 8 CONCERNING VOLUNTARY
10 ADMISSIONS AND INVOLUNTARY COMMITMENT OF PERSONS ADDICTED
11 TO ALCOHOL OR OTHER DRUGS; AND FOR OTHER PURPOSES."

12

13

14 **Subtitle**

15 "AN ACT CONCERNING VOLUNTARY ADMISSIONS
16 AND INVOLUNTARY COMMITMENT OF PERSONS
17 ADDICTED TO ALCOHOL OR OTHER DRUGS."

18

19

20 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

21

22 SECTION 1. Arkansas Code 20-64-801 is amended to read as follows:

23 "20-64-801. Definitions.

24 As used in this subchapter:

25 (1) Administrator refers to the chief administrative officer or
26 executive director of any *private or public* facility or program designated as
27 a receiving facility or program by the bureau;

28 (2) Bureau refers to the Bureau of Alcohol and Drug Abuse Prevention
29 of the Department of Health;

30 (3) Detention refers to any confinement of a person against his
31 wishes and begins either:

32 (A) When a person is involuntarily brought to a receiving
33 facility or program; or

34 (B) When the person appears for the initial hearing; or

35 (C) When a person on a voluntary admission is in a receiving

36 facility or program pursuant to § 20-64-810;

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As Engrossed: 3/15/95

2

1
2 (4) Evaluation means an assessment prepared by a *receiving facility*
3 to include a description of the existence and extent of the person's addiction
4 to alcohol or drugs;

5 (5) Gravely disabled refers to a person who, if allowed to remain at
6 liberty, is substantially likely, by reason of addiction to alcohol or other
7 drugs, to physically harm himself or others as a result of inability to make a
8 rational decision to receive medication or treatment, as evidenced by:

9 (A) Inability to provide for his own food, clothes, medication,
10 medical care, or shelter; or

11 (B) Placement of others in a reasonable fear of violent behavior
12 or serious physical harm to them; or

13 (C) An inability to avoid or protect himself from severe
14 impairment or injury without treatment;

15 (6) Homicidal refers to a person who is addicted to alcohol or drugs
16 and poses a significant risk of physical harm to others as manifested by
17 recent overt behavior evidencing homicidal or other violent assaultive
18 tendencies;

19 (7) Person shall mean a citizen of the State of Arkansas who is
20 eighteen (18) years of age or older;

21 (8) Receiving facility or program refers to a residential, inpatient,
22 or outpatient treatment facility or program which is designated within each
23 geographical area of the state by the bureau to accept the responsibility for
24 care, custody, and treatment of persons voluntarily admitted or involuntarily
25 committed to such facility or program;

26 (9) Suicidal refers to a person who is addicted to alcohol or other
27 drugs and by reason thereof poses a substantial risk to himself as manifested
28 by evidence of, threats of, or attempts at suicide, or serious self-inflicted
29 bodily harm, or by evidence of other behavior or thoughts that create a grave
30 and imminent risk to his physical condition."

31

32 SECTION 2. Arkansas Code 20-64-803 is amended to read as follows:

33 "20-64-803. Civil immunity.

34 The prosecuting attorney, prosecutor coordinator, law enforcement
35 officers, employees of the bureau, and employees of designated receiving

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As Engrossed: 3/15/95

3

1 facilities and programs shall be immune from civil liability for performance
2 of duties imposed by this subchapter."

3

4 SECTION 3. Arkansas Code 20-64-805 is amended to read as follows:

5 "20-64-805. Inspections - Procedures.

6 (a) To assure compliance with this subchapter, the bureau, through its
7 authorized agents, may visit or investigate any receiving program or facility
8 to which persons are admitted or committed under this subchapter.

9 (b) The bureau shall promulgate written procedures to implement this
10 subchapter on or before July 1, 1995. Such provisions shall:

11 (1) Designate receiving facilities and programs within prescribed
12 geographical areas of the state for purposes of voluntary admissions or
13 involuntary commitments under this subchapter; and

14 (2) Establish ongoing mechanisms, guidelines, and regulations for
15 review and refinement of the treatment programs offered in the receiving
16 facilities and programs for alcohol and other drug abuse throughout this
17 state."

18

19 SECTION 4. Arkansas Code 20-64-810 is amended to read as follows:

20 "20-64-810. Voluntary admissions.

21 Any person who believes himself to be addicted to alcohol or other drugs
22 may apply to the administrator or his designee of a receiving facility or
23 program for admission. If the administrator or his designee shall be
24 satisfied after examination of the applicant that he is in need of treatment
25 and will be benefited thereby, the applicant may be received and cared for in
26 the receiving facility or program for such a period of time as the
27 administrator or his designee shall deem necessary for the recovery and
28 improvement of said person, provided that said person agrees at all times to
29 remain in the receiving facility or program."

30

31 SECTION 5. Arkansas Code 20-64-812 (a) is amended to read as follows:

32 "(a) Treatment staff shall immediately inform the prosecuting attorney
33 of the county where the treatment facility or program is located if, in the
34 opinion of the treatment staff, a person who voluntarily admitted himself
35 meets the criteria for involuntary commitment set forth in this subchapter and

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As Engrossed: 3/15/95

4

1 such person has absented himself from the receiving facility or program. The
2 prosecuting attorney shall initiate an involuntary commitment under this
3 subchapter against such person. Statements made by the prosecuting attorney
4 in furtherance of the petition shall not be deemed to be a disclosure.
5 Statements made by treating staff to the prosecuting attorney shall be treated
6 as confidential and the prosecuting attorney shall remain subject to the
7 confidentiality requirements as set forth in state and federal law and
8 regulation."

9

10 SECTION 6. Arkansas Code 20-64-815 is amended to read as follows:

11 "20-64-815. Petition for involuntary commitment.

12 (a) Any person having any reason to believe that a person is homicidal,
13 suicidal, or gravely disabled may file a petition with the clerk of the
14 probate court of the county in which the person alleged to be addicted to
15 alcohol or other drugs resides or is detained, and be represented by the
16 prosecuting attorney or any other licensed attorney within the State of
17 Arkansas.

18 (b) The petition for involuntary commitment shall:

19 (1) State whether the person is believed to be homicidal,
20 suicidal, or gravely disabled;

21 (2) Describe the conduct, clinical signs, and symptoms upon which
22 the petition is based. Such descriptions shall be limited to facts within the
23 petitioner's personal knowledge;

24 (3) Contain the names and addresses of any witnesses having
25 knowledge relevant to the allegations contained in the petition;

26 (4) Contain a specific prayer for commitment of the person to an
27 appropriate designated receiving facility or program including residential
28 inpatient or outpatient treatment for his or her addiction to alcohol or other
29 drugs.

30 (c) Personal service of the petition shall be made in accordance with
31 the Arkansas Rules of Civil Procedure and shall include:

32 (1) Notice of the date, time, and place of hearing;

33 (2) A notice that if the person shall fail to appear, the court
34 shall issue an order directing a law enforcement officer to place the person
35 in custody for the purpose of a hearing, unless the court finds that the

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5

1 person is unable to appear by reason of physical infirmity or the appearance
2 would be detrimental to his health, well-being, or treatment."

3

4 SECTION 7. Arkansas Code 20-64-816 is amended to read as follows:

5 "20-64-816. Petition for immediate detention.

6 (a) Any person filing a petition for involuntary commitment may append
7 thereto a petition for immediate detention.

8 (b) The request for immediate detention shall be verified and shall:

9 (1) State with particularity facts personally known to the
10 affiant which establish reasonable cause to believe the person is in imminent
11 danger of death or serious bodily harm;

12 (2) State whether the person is currently detained in a
13 designated receiving facility or program;

14 (3) Contain a specific prayer that the person be immediately
15 detained at a designated receiving facility or program pending a hearing.

16 (c) If, based on the petition for involuntary commitment and request
17 for immediate confinement, the judge finds a reasonable cause to believe the
18 person meets the criteria set forth in this subchapter for involuntary
19 commitment and that the person is in imminent danger of death or serious
20 bodily harm, the court may grant the request and order a law enforcement
21 officer to place the person in immediate detention at *the Benton*
22 *Detoxification Service Center* or a designated receiving facility or program
23 for treatment pending a hearing to be scheduled and conducted pursuant to §
24 20-64-821.

25 (d) Personal service of the petition and order of immediate detention
26 must be made by a law enforcement officer who shall, at the time of service,
27 take the person into custody and immediately deliver such person to the *Benton*
28 *Detoxification Service Center* or *designated receiving facility or program*."

29

30 SECTION 8. Arkansas Code 20-64-830 is amended to read as follows:

31 "20-64-830. Liability for treatment - Rules.

32 (a) Any person legally obligated to support a person in treatment from
33 a receiving facility or program shall pay to such facility or program an
34 amount to be fixed by such facility or program as cost for treatment. Such
35 amounts shall be a debt of the obligor.

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6

1 (b) The Bureau of Alcohol and Drug Abuse Prevention of the Department of
2 Health shall promulgate rules specifying the amounts to be fixed as costs and
3 establishing procedures for implementation of this section. Such rules shall
4 set forth costs by reference to the income and assets of the obligor."

5

6 SECTION 9. All provisions of this act of a general and permanent
7 nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas
8 Code Revision Commission shall incorporate the same in the Code.

9

10 SECTION 10. If any provision of this act or the application thereof to
11 any person or circumstance is held invalid, such invalidity shall not affect
12 other provisions or applications of the act which can be given effect without
13 the invalid provision or application, and to this end the provisions of this
14 act are declared to be severable.

15

16 SECTION 11. All laws and parts of laws in conflict with this act are
17 hereby repealed.

18

19 /s/Rep. Goodwin

20

21 APPROVED: 4-13-95

22

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7

Appendix F

Sample forms

REGIONAL ALCOHOL AND DRUG DETOXIFICATION PROGRAM
ADMISSIONS AND REFUSALS

FACILITY: _____

NAME	DATE	DISPOSITION	RDS	REFERRAL

REGIONAL ALCOHOL AND DRUG DETOXIFICATION PROGRAM
VOLUNTARY ADMISSION AGREEMENT

FACILITY: _____
IN THE MATTER OF THE VOLUNTARY ADMISSION OF

VOLUNTARY ADMISSION AGREEMENT

WHEREAS, alcoholism and drug addiction are illnesses, and are problems affecting the general welfare and economy of the State, and

WHEREAS, I, _____, realize that I am an alcoholic/drug abuser and in need of treatment for alcoholism/drug abuse, I wish to admit myself to _____
_____ for treatment of alcoholism/drug abuse for a period of not more than twenty-one (21) days. I wish to further state that this voluntary admission agreement is binding and was entered into with full understanding of its meaning.

I further state that there are no charges pending against me in any court under the laws of the State of Arkansas.

Signed this day of 20____.

WITNESS _____

WITNESS _____

CONDITIONS OF ADMISSION

1. I agree to participate in all aspects of the program. If I leave the program prior to completion or if I am given a disciplinary discharge, I understand I will not be eligible for readmission for one (1) year.
2. Any alcohol/drug use or verbal/physical abuse will result in immediate discharge.
3. I understand all my possessions will be searched upon admission and subject to search at any time while in the program. Any drugs or alcohol found during said search will be seized.
4. I understand that any illegal drugs or any item possessed in violation of the criminal laws of the United States or the State of Arkansas will be seized and delivered to law enforcement officials.
5. I will have no visitors while I am a client in this program.
6. If I become homicidal, suicidal or gravely disabled and leave the premises, I authorize the Director of the facility, or his/her designee, to contact the proper authorities or persons with the intent that no harm occurs to myself or others.
7. I hereby authorize the facility Director, or his appointed representative, to assist me in receiving adequate medical attention whenever the facility staff becomes aware that medical treatment may be necessary. For this service, the facility will not be held medically, legally or financially responsible.

I knowingly and voluntarily consent to the above terms and conditions. Each item has been read by me, has been explained to me, and is understood by me. No one has attempted to force me to sign this document and no threats of any kind have been made to me by any person employed by or acting under the direction of this facility.

Client Signature

Date

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 CFR 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)

Signature of Participant

Date

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:
CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, hereby consent to
(Name of defendant)

communication between _____ and
(treatment program)

(court, probation, parole, and/or other referring agency)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack at treatment sessions, my cooperation with the treatment program, prognosis, and

I understand that this consent will remain in effect and cannot be revoked by me until:

there has been a formal and effective termination or revocation of my release from
confinement, probation, or parole, or other proceeding under which I was
mandated into treatment, or

(other time when consent can be revoked)

(other expiration of consent)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may disclose it only in connection with their official duties.

Signature

Date

Personal Property Inventory

DATE: _____

I hereby agree to assume full responsibility upon admission for my personal property.

I understand that _____ cannot be responsible
(facility)
for my personal property during my stay in the facility. I further understand that all items left in the facility at the time of my discharge will be disposed of as the facility staff sees fit.

Signature of Client: _____

Witness: _____

Date: _____

The amount of money I had when I came to this facility was: \$ _____ .

The following is a list of items I had in my possession when I came to this facility:

Signature of Client: _____

Witness: _____

Date: _____

Name: _____

DOB: _____

Facility: _____

Admission Vital Signs: Temperature _____ Pulse _____ Resp _____ B/P _____ Pulse Ox _____

VITAL SIGNS Log Page _____ of _____

[illegible]

Name: _____

DOB: _____

Facility: _____

Regional Detoxification Specialist Notes Page _____ of _____

[illegible]

Demographics/Financial Assessment

Name (Last, First, Middle)		Race/Sex		Phone #	
Street Address		City	County	DOB	Age
SS#		Marital Status	Correspondent/Next of Kin	Phone #	
Date of Admission	Time of Admission		Type of Admission (circle one) Voluntary Court Order Medical Emergency		
_____First Admission _____Readmission					
_____Date of Last Discharge _____# of Prior Admissions					
Monthly Income (list sources)			Amount		
			Total Amount		
Health Insurance:					

STABILIZATION PLANS

No.	PROBLEM (Medical, Behavioral, ED/Voc Financial, Occupational/ Lifestyle, Functional Skills, Family)	GOAL (must be specific)	INTERVENTIONS OBJECTIVE & METHOD (must be measurable and include Frequency)	STAFF & TARGET DATE
1.	Impaired safety due to _____. Withdrawal manifested by _____. _____.	Patient will experience safe withdrawal from _____.	Monitor vital signs every two hours until stable for eight hours, then every six hours for the duration of detoxification. Offer food and fluids every two hours Ensure adequate safety, rest, and nutrition.	To be completed by 5/27/2019 JDS 5/24/2019
2.	Impaired Safety due to _____. Withdrawal manifest by (list symptoms). This can be tailored to the specific symptoms manifested.	Patient will verbalize understanding of relationship between symptoms and addiction. Patient will verbalize understanding of need for sobriety after discharge.	Chemical Dependency consult prior to discharge Make follow up appointment with counselor Provide meeting schedule and set up peer to meet patient at meeting.	

STABLIZATION PLAN
(Detoxification Plan)

Problem #	PROBLEM (Medical, Behavioral, Ed/ Voc Financial, Occupational/ Lifestyle, Functional Skills, Family)	Goal (must be specific)	Objectives (must be measurable and include frequency)	Target Date	Staff and Client Initials

Client Signature _____

RDS Signature _____

**Discharge/Rehabilitation Plan
(Aftercare Plan)**

Client Name: _____

Date Plan Initiated: _____
Initiated By: _____

This is started on admission and updated as more patient information is obtained.

Patient will verbalize understanding of need for sobriety after discharge. Patient will have received a meeting schedule.

Patient will follow through with _____ on (date) _____ to review status.

Patient will follow through with _____ on (date) _____ to review status.

Patient will follow through with _____ on (date) _____ to review status.

Patient will follow through with _____ on (date) _____ to review status.

Best Practice is to provide a discharge packet for clients which may include A.A. meeting schedules (or NA/ CA), Al-Anon meeting schedules for their “significant others”; information handouts (available at no cost from A.A.), listings of alcohol and drug mental health resources and treatment facilities (in and out-patient).

Date Initiated _____

Client Signature _____ Date _____

RDS Signature _____ Date _____

DISCHARGE PLAN
(Aftercare Plan)

Client Name _____

Client Need	Established Goal	Objective	Target Date

Date Initiated _____

Client Signature _____ Date _____

RDS Signature _____ Date _____

REGIONAL ALCOHOL AND DRUG
DETOXIFICATION
WITHDRAWAL RISK ASSESSMENT

General and Contact Information

Name: _____

Address: _____

City State Zip Code Phone

Number: (_____) _____

Race: (Circle one) White Black/ African-American Hispanic

Native American/ Indian Asian/Pacific Islander Other

Sex: (Circle one) Male Female Date of Birth: ____/____/____

In case of emergency, contact:

Name _____

Phone Number _____ Relationship _____

Date of Admission: ____/____/____

Time of Admission: ____:____ AM PM

Type of Admission: Voluntary Court Order

Vital Signs at Initial Intake:

Blood pressure ____/____

Pulse_____bpm

Respirations _____

Temperature _____

Substance Abuse History

Current substance (s) abused:_____

Length of use:_____

Amount used daily:_____

Amount used last:_____

Time of last use:_____:____AM PM

Method of use: (Circle one) Oral IV (inject) Inhale (smoke) Nasal (snort) Other

Prior Detox/Treatments: _____Yes_____No

If yes, how many prior admissions and where were the admissions:

How many prior admissions/treatments were completed?

Family History

Does anyone in the client's immediate (blood) family have or has anyone had a substance abuse problem?

_____Yes_____No

Have there been any deaths or departures (divorces, separations, displacements of children, etc.) from the family institutions?_____Yes _____No

Social History

Marital Status: (Circle one) Single Married Divorced Widowed Separated

Any children? _____ Yes _____ No List age (s) _____

Who has parenting rights/responsibilities? _____

Have you moved at any time in the past year? _____ Yes _____ No

Legal History

Does the client have a valid driver's license? _____ Yes _____ No

Has the client ever been arrested? _____ Yes _____ No

If so, for what? (List year and reason)

Educational History

Did client complete high school and obtain a diploma? _____ Yes _____ No

If not, what was the highest grade completed? _____ Has client attended college or vocational technical school?

Does client have any desire or plan of continued or future education?

Yes No

Occupational History

Employment Status: Employed Unemployed Occupation: _____

Monthly Family Income: \$ _____

Has the client ever been terminated or disciplined as a result of substance abuse?

_____ Yes _____ No

Medical History

Does the client have any medical problems? _____ Yes _____ No (Please describe)

Is the client currently taking any medications? _____ Yes _____ No

(Please list)

Did the client present with any medications in his/her possession? _____ Yes _____ No

Current health status: __Poor__Fair__Good

Does the client currently have any overriding health problems ? _____ Yes _____ No

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

Psychological and Behavioral History

Has the client ever been diagnosed and/or treated for any psychological or emotional problems? _____ Yes _____ No

If yes, please list diagnosis and year and whether client was an outpatient or inpatient.

What medications were prescribed to the client for the psychological/emotional problem? Please list name(s) of medications and length of use.

Outcome of Evaluation

This client is assessed as being in: (Circle one)

_____Mild Withdrawal _____Moderate Withdrawal _____Severe Withdrawal

Client admitted to:

_____Observational Detox	_____Residential Treatment
--------------------------	----------------------------

_____ Denied Admission (List reason)

Reason for Denial:_____Under 18 years of age

_____ Client is belligerent or combative

_____ Client has overriding medical problems

List problem(s)_____

_____ Other _____

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ Date: _____ Time: _____ (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 very 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 mild 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/or person

Total **CIWA-Ar** Score _____

Rater's Initials _____

Maximum Possible Score 67

The CIWA-Ar is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

Retrieved from:

https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf

June 3, 2019

GENERAL AND CONTACT INFORMATION

SCREENING LOCATION: _____

DATE /TIME OF ADMISSION: _____

TYPE OF ADMISSION: _____

REASON FOR ADMISSION _____

CLIENT NAME: _____ GENDER: _____ RACE: _____

DOB: _____ SSN: _____

MEDICAID #: _____ MEDICARE#: _____

OTHER INSURANCE:

NAME: _____ ADDRESS: _____

POLICY #: _____ CLIENT STREET ADDRESS: _____
CITY: _____ STATE: _____

ZIP: _____ APARTMENT NUMBER: _____

COUNTY: _____

HOME PHONE: _____

WORK PHONE: _____

OTHER PHONE: _____

REFERRED BY: _____ TITLE/PHONE: _____

REFERRAL AGENCY: _____

EMERGENCY CONTACT: NAME: _____

RELATIONSHIP: _____ PHONE: _____

BEHAVIORAL MANAGEABILITY

- Client does not appear to be assaultive or threatening to a degree that cannot be managed by this DETOX facility.

Go to next section.

- Client appears assaultive or threatening to a degree that cannot be managed by this DETOX facility.
Explain nature of behavior and actions taken below. Include names, agencies, phone numbers, and titles of persons notified for client referral. Also, if applicable, include name and title of person who took client into custody and note the time of occurrence. You must sign, date and put your credentials as staff member completing this section.

SUBSTANCE USE
Client is currently in a Methadone Maintenance Program. • Yes • No

If yes, Name of clinic_____ Amount_____ Last Dose_____

End interview at this time and notify nurse on call.

USAGE PATTERN IN LAST 30 DAYS (STARTING WITH DRUG OF CHOICE)

SUBSTANCE	AMOUNT/LAST USE	FREQUENCY	METHOD	YEAR OF FIRST USE

MOTIVATION FOR TREATMENT

What brought you here today?

Why now?

What difficulties/worries have you had in relation to your drinking and/or drug use?

In what ways do you think that you or other people have been affected by your drinking and/or drug use?

What do you think will happen if you don't do something about your drinking and/or drug use?

DRUG USE ASSESSMENT

Have you ever overdosed? _____ Yes _____ No

Did you intend to harm yourself? _____ Yes _____ No

How many times have you overdosed? _____ Within the last 90 days? _____ How many times was alcohol involved? _____

Which drugs were involved?

Have you ever had seizures as a result of withdrawal?

If yes to any of the above, when did the last episode occur? _____

Have you ever injected? _____ If so, how long have you been injecting? _____

Age of first IV drug use? _____

Where do you inject? _____

How often per day/week? _____

Any abscesses/bruises/problems from injecting? _____ (i.e. overdosing)? _____

Do you share needles? _____ Have you ever shared? _____

How many times in the last 4 weeks?

ALCOHOL USE ASSESSMENT

How often do you drink alcohol? _____ Over the last 7 days, how many drinks (units) would you say you've had? _____ Where do you usually drink? _____ With

whom? _____ How long have you been drinking this way? _____ Your age when you first started drinking? _____

How much do you spend on alcohol/month? _____ What are your concerns about this? _____

Have you ever had an episode of Delirium Tremens? Yes No

How long can you remain dry without discomfort? (check client for physical withdrawal symptoms)

PREVIOUS TREATMENT

Have you ever been admitted for any detoxification services and/or treatment services in the past? Yes No

If yes, which facility and what date(s)?

How many DETOX services and/or treatments have you completed? _____

How many DETOX services and/or treatments did you leave prior to completion? _____

What were the reasons for leaving treatment?

Have you had any significant periods of abstinence? Yes No If yes, how long? _____

How did you manage this?

LEGAL HISTORY

Do you have a driver's License? _____ Yes _____ No

Do you have previous convictions or legal problems? _____ Yes _____ No

Are any of your legal problems related to drug use and/or drinking?
_____ Yes _____ No What is the nature and date(s) of the offense
(s)?

Do you have any legal issues pending? Yes No

- Probation/Parole
- Court case pending
- Drug Court
- Community Sentence
- Fines pending
- Court ordered treatment

What is your attitude toward current/past offenses?

FAMILY/SOCIAL HISTORY

GENOGRAM

Divorced/Separated

• Male O Female
..... Co-habiting

= = Married
X Deceased

##

Do you live alone? _____ Yes _____ No, I live with _____

How many children do you have? _____ Children's ages _____ Do you
have custody? _____ Yes _____ No Who will be caring for the children while you are in
treatment? _____

Is there a family history of alcohol/drug use? _____ Yes _____ No

Explain:

What was it like growing up in your family?

Were there any significant events, traumas that occurred in your childhood that may be important to know about?

Have there been any deaths or departures (divorces, separations, displacements of children etc.) from the family? _____Yes _____No If yes, were any related to alcohol/drug use? _____Yes _____No

Do you engage in unprotected sex? _____Yes _____No If so, How often do you change partners?

Relationship Status: _____ Duration? _____

Any problems? (Domestic violence)_____

Does your partner/significant other use alcohol/drugs?

_____ Yes _____No

Have you moved any time in the past year? _____Yes

_____No

Have you found yourself not wanting to participate or enjoying social activities you liked in the past?

_____Yes _____No

Has the way you participate in or enjoy social activities changed?

_____Yes _____No

Do you have social support networks/friendships? _____Yes

_____No

EDUCATION/EMPLOYMENT HISTORY

What was the highest grade you completed in school? _____ College degree? _____

Are you currently employed? _____ If so, where? _____ How long? _____

If you are not employed, how do you pay your bills? _____

MEDICAL HISTORY

If female, are you pregnant? _____ Yes _____ No If yes, how many months? _____

Do you currently have any physical illnesses or emotional/medical problems that affect your life? _____ Yes _____ No If yes, please describe. _____

Are you currently taking any prescribed or over the counter medications (include any herbal remedies)? _____ Yes _____ NO

MEDICATION	DOSAGE	FREQUENCY	TIME OF LAST

How would you describe your current health status? _____ (poor, fair, good, excellent)

Does the client have any untreated injuries or health problems? (Overriding medical problems)

_____ Yes _____ No

- Change in mental status

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

IF YES, REFER TO MEDICAL FACILITY

FOOD AND DRUG ALLERGIES ____Yes ____No

I AM ALLERGIC TO:	MY REACTION TO THIS SUBSTANCE IS:

PREVIOUS TESTING

Have you been tested for:

HIV/AIDS ____Yes____No

Hepatitis B ____Yes ____No

Hepatitis C ____Yes ____No

Gamma GT____Yes ____No

Tuberculosis____Yes ____No

Are you interested in being tested? ____Yes ____No

PSYCHOLOGICAL AND BEHAVIORAL HISTORY

Do you currently have any emotional problems or concerns? ____Yes ____No

Have you ever been treated for any type of psychological or emotional problems?
____Yes ____No (If yes, please list the diagnoses, year diagnosed and whether
treatment was inpatient or outpatient)

Have you ever attempted ____Yes ____No If yes, how many times____
suicide?

Are you currently suicidal or have you had suicidal thoughts ____Yes ____No
recently?

Explain:

Have you ever deliberately self-harmed? ____Yes ____No

Have you ever tried to harm or kill anyone else? ____Yes ____No

Do you currently have thoughts of wanting to harm or kill others? ____Yes ____No

Explain:

What are your expectations and goals of treatment?

Immediate advice given, concerns addressed, referrals to other support services (mental or medical health),
urine/ toxicology tests taken, etc.

Client's mental state at time of interview (i.e. calm/cooperative, hostile, anxious, alert, drowsy, speech clear/slurred, thought patterns, evidence of psychotic symptomology, orientation, insight:

SUMMARY

This client is assessed as having:

NO WITHDRAWAL (No signs or symptoms of current intoxication or withdrawal)

MILD WITHDRAWAL (Mild or transient signs or symptoms with no impending threat to health and no history or evidence of potential significant medical complications).

MODERATE WITHDRAWAL (moderate signs of symptoms representing a threat to health but manageable through support, observation, reassurance, daily medical monitoring and management on an ambulatory basis with self-administration of fluids, foods, food supplements and prescribed medications).

SEVERE WITHDRAWAL (Presenting signs and symptoms represent a serious threat to health or life which can only be managed in an acute care facility, or there is evidence of significant medical complications requiring hospital assessment/treatment or acute inpatient management and monitoring). REFER CLIENT TO MEDICAL FACILITY.

- ☐ Consider referral to Medical detox
- ☐ Appropriate for Observational Detox
- ☐ Refer for psychiatric assessment
- ☐ Refer for medical assessment

RADD ASSESSMENT

Date ___/___/___ Time:___:___AM PM Location:_____

Name: _____ Last
First
Middle

SSN: _____ DOB:___/___/___ Male Female

Street Address: _____

City: _____ State/Zip: _____

County: _____ Phone #: () _____

List any document copied for Confirmation of Identity : _____

African- American American Indian/Alaska Native Asian/Pacific

Islander Caucasian Hispanic Multi-Racial

Allergies:

Referred for assessment of withdrawal risk by: _____

If not referred for withdrawal risk assessment, the applicant is not appropriate for Regional Alcohol and Drug Detoxification Services. **STOP!** Make appropriate referral(s) and specify alternative(s) offered to applicant:

If court referral, is Court Order present? _____

Comments: _____

Staff Signature

SUBSTANCE USE HISTORY

<i>Enter number in box to indicate order of use preference.</i> Substance	First Use	Amount Last Use	Last 30-Day Pattern of Use Include route, amount, frequency, longest abstinence
Alcohol (any use)			
Amphetamines			
Cannabis			
Cocaine			
Heroin/other opiates			
Barbiturates			
Sedatives/hypnotics/tranquilizer			
Hallucinogens			
Caffeine			
Nicotine (tobacco)			

Is applicant currently on Methadone Maintenance Program: Yes No
 Amount: _____ Last Dose: _____

Name of Clinic _____

If yes, **STOP!** and follow policy and procedure for your facility.

*Have you taken any other substances within the last 48 hours that you have not been asked about?

RISK ASSESSMENT

- YES NO Do you have chills or fever now?
- YES NO Are you having any stomach pain?
- YES NO Are you having any chest pain?
- YES NO Are you having any head pain?
- YES NO Have you had trouble breathing in the past three days?
- YES NO Have you fallen or been injured in a fight or accident in the past week?
- YES NO Have you hit/been hit on the head or lost consciousness in the past week?
- YES NO Have you had any bleeding from the rectum, black stools, vomiting with blood in it, or what looks like coffee grounds within the last week?
- YES NO Have you had any seizures, or awakened on the floor or the ground without knowing how you got there?
- YES NO Have you had any heart problems? *If on medication, applicant must bring supply.*
- YES NO Have you had any problems with high blood pressure? *If on medication, applicant must bring own supply.*
- YES NO Have you been told you have diabetes? *If on medication, applicant must bring supply.*
- YES NO Are you having thoughts or urges to kill yourself at this time?
- YES NO Do you have a plan for how you would kill yourself?
- YES NO Are you having thoughts about killing someone else?
- YES NO Are you currently hearing voices or seeing things that you know are not there?
- YES NO Applicant is threatening or aggressive to a degree that cannot be managed in this facility?

If ANY indicators are marked "YES,"

Applicant must have medical and/or psychiatric clearance prior to admission, or currently be under the care of a physician for stated condition.

Applicant must currently have applicable medications with them at admission.

Applicant must be currently on those medications.

If applicant does meet criteria...**STOP**...make appropriate referral(s); specify alternative(s) offered to applicant.

Time ____:____ AM PM
:

Date: _____

Staff Signature

Staff Title

APPENDIX 1

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____/____:____	
Reason for this assessment: _____	
Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: <i>over last 1/2 hour</i> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: <i>over past 1/2 hour not accounted for by room temperature or patient activity.</i> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	Tremor: <i>observation of outstretched hands</i> 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: <i>Observation during assessment</i> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	Yawning: <i>Observation during assessment</i> 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches: <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing: <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<div style="text-align: right;">Total Score _____</div> <div style="text-align: center;">The total score is the sum of all 11 items</div> Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Physical and/or Psychiatric Indicators for Determination of Detoxification Level

Attempts at Detox: _____

Have you ever experienced any of the following symptoms when you attempted to stop using?

(Circle any that apply)

1-Restlessness	1-Irritability	1-Anxiety	1-Anorexia
1-Nausea	1-Vomiting	1-Diarrhea	1-Constipation
1-Muscle Cramps	1-Headache	1-Craving	
2-Tremors	2-↑ heart rate	2-↑ blood pressure	1- Difficulty sleeping
2-Profound sweating		2-Impaired concentration	
2-Impaired judgment	2-Intense nightmares	3-Delirium	2-↑ temperature
3-Delusions (usually paranoid)	2-Sensitivity to sound	Time Place Situation	2- Impaired memory
	3-Grand Mal Seizures		3-Hallucinations Tactile Visual Auditory

Note

0-9...Observation
in Social Detox

10-19...Social
Detox with
Medical Support

20 &
higher...
Medical
Detox

Other: _____

Yes	No	Have you had any problems, other than those listed above, when you have tried detoxification in the past?
Yes	No	Are you vomiting up juice, broth or water when you drink now?
Yes	No	Do you think there is any chance you may be pregnant?
Yes	No	Have you been told by a health professional that you have tuberculosis?
Yes	No	Have you been told by a health professional that you have hepatitis?
Yes	No	Have you been told by a health professional that you are HIV positive or have AIDS?
Yes	No	Have you been told by a health professional that you have liver problems?
Yes	No	Have you taken Antabuse (Librium) in the last 48 hours? (“Yes” does not disqualify applicant)
Yes	No	Do you have trouble standing or walking?
Yes	No	Do you feel someone wants to hurt you?
Yes	No	Do you carry a gun, knife or other weapon to protect yourself?
Yes	No	Does it bother you if people get close to you or touch you?

If ANY indicators are marked “YES,” and/or history of withdrawal symptoms with a ‘2’ or ‘3’ applicant is not appropriate for Observational Services.

Current Medications: (Include over-the-counter and prescription medications)

Drug: _____ Dose: _____

Frequency: _____ Last Taken: _____ Rx#: _____

Drug: _____ Dose: _____

Frequency: _____ Last Taken: _____ Rx#: _____

Drug: _____ Dose: _____

Frequency: _____ Last Taken: _____ Rx#: _____

Drug: _____ Dose: _____

Frequency: _____ Last Taken: _____ Rx#: _____

Drug: _____ Dose: _____

Frequency: _____ Last Taken: _____ Rx#: _____

Did applicant bring adequate supply of above medications? _____

Yes No Are you allergic to any food or medication?

Yes No Have you been hospitalized in the past year for any reason? Have you ever had surgery?

Yes No Have you had thought of hurting or killing yourself? (If “yes,” how often do you have thoughts of killing yourself?)

_____ Rarely have thoughts
 _____ Sometimes have thoughts – not now
 _____ Often have thoughts – not now

Yes No Have you ever received care in a psychiatric hospital or from a psychiatrist?

Yes No Are you currently under the care of a mental health professional?

If “yes”:

Who? _____

Where? _____

How long? _____

Yes No Have you been to the emergency room for any problem in the
past year? Past and present legal problems: _____

Staff Signature

Date

Time

Withdrawal Risk Screening Rating

Risk Rating of “1”: No symptoms or signs of current intoxications or withdrawal

Risk Rating of “2”: Mild or transient signs of symptoms. No impending threat to health and no history of evidence of potential significant medical complications.

Risk Rating of “3”: Moderate signs or symptoms representing a threat of health but manageable through support, observation, reassurance, daily medical monitoring and management on an ambulatory basis, and self-administration of fluids, foods, food supplements and prescribed medications.

Risk Rating of “4”: Signs and symptoms representing a serious threat to health or life which can only be managed in an acute care facility, or evidence of significant medical complications requiring hospital assessment/treatment or acute inpatient management and monitoring.

Preliminary diagnosis of risk will be made by Physician and/or physicians’ agent and documented. Risk Level Rating Assigned by:

Name of person completing this section: _____

Signature: _____

Date:_____/_____/_____ Time:__:_____AM PM

Sobering Services/Ambulatory Detoxification Level of Care

II. All persons entering this level of care must be diagnosed by DSM criteria for psychoactive substance disorder and have a Nickens Withdraw Risk Scale Rating of less than “4” as documented by telephone medical personal order of preliminary admitting patient condition. None of the designated exclusion criteria in the section above apply. Persons entering treatment at this level of care must be in a state of current intoxication or at risk of withdrawal due to the ingestion of any of the following substances:

- Alcohol
- Amphetamines
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Opioids
- Phencyclidine
- Sedatives, hypnotic or anxiolytics
- Other type (specified)

Disposition

- ☐ Admit to Sobering Center for just observation
- ☐ Admit to Sobering Center with recommendation for medical team assessment within 24 hours
- ☐ Admit to Sobering Center with recommendation for mental health staff assessment within 24 hours
- ☐ Referred for psychiatric inpatient care to: _____
- ☐ Referred for inpatient detoxification to: _____
- ☐ Referred to medical inpatient (non-detox) to: _____
- ☐ Other referral/disposition: _____

Name of person completing this section: _____

Signature: _____

Date: ____/____/____ Time: __:____ AM PM

Appendix G

List of RADD programs May 2019

RADD Provider List

Quapaw House

812 Mountain Pine Road

Hot Springs, AR 71913

New Beginnings

412 York St

Warren, AR 71671

Freedom House

400 Lake Front Dr

Russellville, AR 72802

Quapaw House Little Rock

7600 Enmar Road

Little Rock, AR 72209

Decision Point

602 North Walton Blvd

Bentonville, AR

Gateway House

3900 Armour Av

Fort Smith, AR 72904

Harbor House

3900 Armour Ave

Fort Smith, AR 72904

NEARRC

6009 C W Post Road

Jonesboro, AR 72401

Serenity Park

2801 W Roosevelt Rd

Little Rock, AR 72204

Spencer Recovery

154 Huntsville

Eureka Springs AR 72632

Appendix H

RADD Grant Document

Regional Alcohol and Drug Detoxification (RADD) Grant

Funding has been provided for certain programs to provide detoxification's services to indigent individuals as regulated under the Substance Abuse Commitment Law. The RADD Program consist of two (2) levels of detoxification services: (1) Medical Detoxification and (2) Observation. An individual presenting for detoxification will be evaluated by a Regional Detoxification Specialist (RDS). The RADD evaluation is a process to assist in the evaluation and placement in the appropriate level of service and may include the administration of standardized screening or assessment instruments. At a minimum the following information will be gathered: (1) vital signs, (2) presenting symptoms, (3) substance abuse history, and (4) social/economic history. The program must designate at least three (3) staff members to be trained by the Bureau of Alcohol and Drug Abuse Prevention (BADAP) as RDS.

Based upon the RADD evaluation a determination of the appropriate level of service will be made. Those in the acute phase will be referred to the appropriate medical facility for medical detox or those in mild withdrawal will be placed into the observation level at the treatment program. Following discharge from either level of service the client will be placed in residential treatment followed by the development of a continued care plan.

Programs receiving funds for detoxification services are required to accept clients court ordered under the Substance Abuse Commitment for immediate detention. Those clients who become hostile, disruptive, a threat to leave treatment early and those actively experiencing mental health problems in lieu of placement in mental health can be transferred to the Wilbur Mills Treatment Center (WMTC) if space is available. WMTC has been funded to provide five (5) secure beds to meet this need. It is the responsibility of WMTC to set up procedure for referral with other BADAP funded treatment providers for this special service.

Those programs receiving RADD Grants must provide the following information:

1. Describe the specific population(s) you are proposing to serve in terms of characteristics and needs that influence program design. **Note: We are not looking for general demographic data about your region in this section of the application.**

2. State a minimum of (2) two program goals and objectives for this award period. Goals are broad statements of program purpose. Objectives state the precise and measurable results for a specified period that establishes the program's criteria for success. Objectives should be attainable and realistic, identify only one result, and be measurable. Each objective should be linked to a particular goal. Objectives must include outcome measures that identify the observable behavior changes that the service recipients will demonstrate after participation in the program.
3.
 - a) Describe the key strategies, program elements, and activities you will use to achieve the desired objectives, including strategies for reaching and engaging your target population. Include what services will be provided, and where, when and by whom they will be provided.
 - b) Describe how families are involved in the program, as applicable. Include what family services are to be provided, when, where, and by whom, and what outcomes will be achieved through family involvement.
 - c) Explain why you chose this approach and how it can be effective toward the target population, including any outcome studies or research related to a similar target population and/or program design.
4.
 - a) Describe the staffing structure and enclose an organizational chart of the proposed program. If the program will use consultants, include them in the staffing chart and in the items below.
 - b) Describe the experience and training that staffs (and consultants) have or new hires will be expected to have, including experience and training specific to the target population and the program design. Enclose job descriptions (or consultant agreements) for positions directly related to program services.
 - c) If people have already been assigned to any of the positions, include a summary of each person's experience and training that shows that each person is best qualified and trained to provide quality services to the target population.
5. Briefly describe the organization's experience with the target population and the proposed services, and identify the specific results achieved.
6.
 - a) Identify critical milestones, including target dates. Existing programs should focus on changes to be implemented. (Do not give a detailed

- implementation plan. Milestones define only the key accomplishments or threshold points that must be achieved if the program is to be successful).
- b) What resources will have to be acquired before new services can be delivered and how long will it take to acquire them.
 - c) What problems are likely during implementation or later in the award period and how will you avoid or deal with them.
7. a) Describe resources and services available in your area and how you will use them to support your program (as applicable). Include copies of written letters of agreement if applicable. Letters of agreement that establishes terms, services, and limitations of the agreement.
- b) Describe how you have worked with other service providers in the past to maximize resources and create an effective service delivery network.
8. Describe efforts made to win broad community support and give examples of how the community is involved in the program and has demonstrated support. Letters of support are not acceptable.
9. Describe how you will document and evaluate progress towards meeting objectives, including applicable performance measures. Identify both routinely collected sources of data and proposed data sources, and the frequency with which they are collected.
10. a) Describe how self-evaluation data and findings from any other quality assurance activities will be integrated into program management to improve performance on an ongoing basis.
- b) Describe how the organization has used the results of evaluation and other quality assurance activities. Describe any program changes you have made in the past three years or intend to make during the award period and explain why.

Appendix I

Program Administration Manual

RADD Program Administration Manual

Table of Contents

History

Criteria

Organization

Policy and Procedure

- Course Overview

- Record management

- Instructor training and records

- Obtaining certificates

- Course failure

Course Information

- General information

- Equipment

- Paperwork

- Teaching strategies

- Student assessment

- Instructor training potential

History

Regional Alcohol and other Drug Detoxification (RADD) is a program that was created by a grant in the late 1990s. The goal of the program is to give safe detoxification from alcohol and other drugs under the supervision of a regional detox specialist (RDS) that has completed training from Arkansas DHS (department of human services). The required trainings include RADD certification, CPI (nonviolent crisis intervention) or similar course, and CPR (cardio pulmonary resuscitation)/First Aid.

The RADD program is guided by the Arkansas Department of Human Services Division of Provider Services and Quality Assurance (DPSQA) Licensure Standards and Rules.

RADD training is defined by the office of the Drug Director in the Division of Aging, Adult, and Behavioral Health Services within Arkansas Department of Human Services.

Certificates for RADD, RDS, and RADD trainers will be processed by the DAABHS RADD coordinator.

A log of training will be kept by DAABHS to ensure persons observing detoxification are properly trained and validated as Regional Detoxification Specialists.

The RADD manual will be updated periodically by the RADD coordinator and will mirror the Substance Abuse Mental Health Service Associations' (SAMHSA) standards for detoxification (TIP 45).

Criteria

The RADD program coordinator reports to Arkansas DHS Division of Aging, Adult, and Behavioral Health Services, treatment services. To qualify to serve as the RADD coordinator, the employee must demonstrate expertise in treatment or medical profession. This person will report to the Arkansas Treatment Director.

To be a RADD instructor, a person must be a licensed nurse or physician. This ensures the vital sign and client evaluation portions of the course are taught according to industry standard.

To take a RADD course, an individual should be employed by a treatment center that performs medical or observational detoxification services.

Organization

Ideally, each facility should have a RADD instructor that can provide RADD training to individuals who will work with clients in detoxification.

RADD instructors report to the RADD coordinator for the State of Arkansas.

The RADD program coordinator reports to Arkansas DHS Division of Aging, Adult, and Behavioral Health Services, Arkansas Treatment Director. Certificates will be cosigned by either the treatment director or the state opioid treatment authority (SOTA).

The Arkansas Treatment Director reports to the Single State Authority, or Arkansas Drug Director.

Duties of the RADD coordinator

The RADD coordinator will keep a comprehensive database of all completed training, create certificates as appropriate, and issue certificates for RADD and RDS within 7-10 days of request by RADD instructors.

Certificate requests may be mailed or emailed to the RADD coordinator and should use the designated form. Location of the RDS trained staff is vital for certificate creation and should be specified by the RADD instructor.

Any instructor issues should be reported to the RADD coordinator. If he or she cannot resolve the issue, the treatment director will evaluate the situation and make the final decision in accordance with the Licensure Standards. Chain of command will be followed as stated in Organization.

The RADD coordinator is to complete site visits quarterly of all RADD programs.

The RADD coordinator is to keep the RADD manual current and provide training for RADD instructors as needed. The RADD manual should be posted on the DHS website and OneDrive for instructors to obtain securely.

The RADD coordinator will facilitate courses for programs that do not have a credentialed RADD trainer on staff. Requests for courses should be submitted by email to the RADD coordinator and copied to the treatment director. For courses requiring significant travel, the RADD coordinator may request to facilitate the course in Little Rock at Mid-South School of Social Work's training facility at Plaza West.

The RADD coordinator will provide copies of the training database to the Division of Provider Services and Quality Assurance as requested for facility licensure purposes. The RADD coordinator will work with the DPSQA staff to validate RADD and RDS certificates as requested.

Policy and Procedure

Course Overview

The RADD course is designed to train a person without formal medical or nursing training to safely observe a client who has voluntarily or involuntarily been placed into observational detoxification. The necessary skills include observation, taking and interpretation of vital signs, evaluation of level of withdrawal, and knowledge of emergency procedures.

Record management

Once a course has been completed, record of the course (written exams with scoring) and a request sheet should be submitted to the RADD coordinator at DAABHS. The RADD coordinator at DAABHS will maintain a comprehensive database of all participants trained in RADD, as well as dates that certifications are obtained for CPI and CPR. The RADD coordinator will assign numbers for RADD and RDS certificates and be able to validate certificates if need be. The required documentation from instructors can be emailed, mailed, or dropped off in person to the DAABHS office.

Instructor training and records

Instructor training shall be held as needed. Instructors must be RADD certified but are not required to be an RDS; as they already have medical and or nursing training professionally. Instructor certificates are valid for 3 years. Instructors should maintain their own records and collect evaluations to improve their instruction. The RADD coordinator should be notified of all scheduled classes and maintain a master list as other facilities may not have a RADD coordinator and may need to have an employee drop in to another course.

Obtaining certificates

Certificates will be created within 7-10 business days of receipt of required documentation. They will be mailed to the facility or can be picked up at DAABHS office. RADD certificates must have all signatures to be valid and must be signed by instructor prior to distribution to individuals.

Course failure

In the event a participant fails a course, they may retake the course from another instructor or the same instructor if desired. However, if the participant fails a course twice, their supervisor should be notified and their ability to serve as an RDS should be evaluated by the organization. The RADD coordinator can be consulted for course of action and should be notified of any course failures.

Course Information

General information

The RADD course is a bi annual, 6-hour long course that includes general information about the RADD program, legal implications, duties of RADD certified staff, how to become an RDS, and how to obtain and interpret vital signs. Documentation is heavily emphasized. Each participant should complete a hands on check off of vital signs on another participant or instructor for the course including pulse, respirations, blood pressure. Temperature check off is not necessary and can be verbalized.

Equipment

Each course should have equipment available to take vital signs. A manual blood pressure cuff, stethoscope, automatic blood pressure cuff, and pulse oximeter are recommended for the skills portion of class. A manual blood pressure cuff and stethoscope are required for check off. A course cannot be completed without hands on check off.

Paperwork

Each course should have a sign in sheet, power point handouts, class set of RADD books, agenda, evaluation, written test, and RADD certificate request form.

Teaching strategies

Power point is recommended to be utilized at all courses. Each instructor can modify the power point but may not delete slides created by the RADD coordinator. An interactive approach to teaching is recommended, with asking each participant questions and encouraging storytelling and personal experiences by staff and students. Take breaks when needed, encourage students to participate in class.

Student assessment

Each student should be taught how to take vital signs then observed taking the vital signs of another student. Each student must take the written exam with closed book, closed notes. If students have test anxiety, allow them to re attempt questions that were partially answered or not answered. Please allow adequate time for testing. If students need special accommodations, please consult with RADD coordinator if questions arise.

Instructor training potential

If a licensed nurse is in RADD training and shows potential to be an instructor, please contact the RADD coordinator to set up training.

Appendix J

Course Resources

Agenda

Sign in Sheet

Power point

Vital Signs Check off Sheet

Exam

Exam Key

Evaluation