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Substance Abuse Among Hospitalized Patients: Five Interventions to Enhance Care and Reduce Risk

It is estimated that between 17 and 25 percent of medical inpatients are considered "risky drinkers," who may undergo alcohol withdrawal syndrome while in the hospital.[1] Many more patients suffer from addiction to both illicit and prescription drugs.

The ongoing physical and mental suffering stemming from chronic chemical dependence – including immunodeficiency disorders, impaired organ performance, depression, anxiety and trauma-related injuries – presents both clinical and practical challenges to healthcare professionals entrusted with these patients' care. In addition, the metabolic imbalances and mood instability associated with addiction can complicate care by precipitating aggression and loss of control. For these reasons, substance abuse often produces a cycle of frequent and protracted hospitalizations.

To reduce the incidence of seizures, suicidal ideation and other life-threatening conditions, many healthcare organizations have established special units for the treatment of medical inpatients with alcohol and/or drug dependencies. Within these settings, hospitalists who possess advanced training in the treatment of addiction are available to provide consultative and supportive care.

Not every hospital is able to offer these specialized services to drug-dependent patients. However, all healthcare organizations can implement effective policies, procedures and risk control techniques designed to enhance treatment and support, prevent patients from harming themselves or others during difficult withdrawal periods, promote better long-term outcomes and minimize allegations of negligent care.

This edition of *Vantage Point*® offers practical interventions to help acute care providers better assess, treat and protect inpatients with known dependencies. By adopting a comprehensive intake process, soliciting psychiatric input, carefully managing withdrawal symptoms, and offering a secure and closely monitored environment, providers can safely stabilize acutely ill patients and support their efforts to achieve recovery.

1 See Finn, K. and Greenwald, J., "Hospitalists and Alcohol Withdrawal: Yes, Give Benzodiazepines but Is That the Whole Story?" in *Journal of Hospital Medicine*, October 2011, Volume 6:8, pp. 435–37. An abstract is available at **http://onlinelibrary.wiley.com/doi/10.1002/jhm.v6.8/issuetoc**.

1. UTILIZE A COMMON LANGUAGE FOR ALCOHOL AND DRUG USE.

Treatment terminology can vary among medical practitioners, potentially causing confusion for clinical staff and resulting in improper and stigmatizing "labeling" of patients within clinical documentation (e.g., categorizing occasional users as "drug addicts"). Effective care of dependent patients requires consistent utilization of a universally understood diagnostic vocabulary for levels of alcohol/drug use and their associated signs and symptoms. Such terms as *use*, *misuse*, *abuse* and *dependence* should be defined in writing. (In general, *use* and *misuse* denote a lower level of dependence, whereas *abuse* and *addiction* are formal diagnostic categories.) For a comprehensive list of alcohol and drug use terms and definitions, visit the World Health Organization at **http://www.who.int/substance_abuse/terminology/who_lexicon/en/**.

Written protocol also should formalize the criteria for determining when substance-abusing patients who present to emergency departments or clinics for acute care should be admitted to an inpatient unit. According to the patient placement criteria promulgated by the American Society of Addiction Medicine (ASAM), inpatient admission may be necessary to appropriately assess, monitor and treat the following conditions:

- *severe respiratory depression* following a possible drug overdose, which cannot be adequately and safely treated in an ambulatory setting
- *active withdrawal states,* in which the patient is at risk for a severe or complicated reaction (e.g., an individual dependent on multiple substances or with a history of delirium tremens)
- *acute or chronic general medical conditions* (such as severe cardiac disease), which make detoxification in a less restrictive setting unsafe
- *marked psychiatric comorbidities,* such as suicidal thoughts or acute psychosis, indicating that patients are a potential danger to themselves
- *aggressive behaviors,* which may render patients hazardous to others

To learn more about the ASAM placement criteria, visit **http://www.asam.org/publications/patient-placement-criteria/ppc-2r**.

2. STANDARDIZE THE INTAKE ASSESSMENT PROCESS.

All patients should be screened upon admission for alcohol and drug dependence, with responses documented in the patient care record. Reliable and relatively easy-to-use screening tools – such as the CAGE (an acronym for Cut down, Annoyed, Guilty and Eye-opener) questionnaire for alcohol use and CAGE-AID for drug use – can be adapted for any acute or emergency setting. (See the sidebar on page 4 for more information.)

Patients who respond affirmatively to two or more CAGE or CAGE-AID questions can then be further assessed, utilizing more comprehensive instruments that focus on the history, pattern, and physical and behavioral effects of abuse. This process can help avert potentially harmful secondary conditions, such as withdrawal syndrome, metabolic imbalances and cognitive disturbances. The University of Washington's Alcohol & Drug Abuse Institute maintains a database of clinical screening and assessment instruments, which can be accessed at **http://lib.adai.washington.edu/instruments/**.

The initial goal of intake assessment is to ascertain the substance or substances that have been most recently consumed and determine whether the current level of intoxication is in a waxing or waning state. In addition, the following information should be obtained from patients:

- time elapsed since the most recent use
- quantity of substance that has been consumed
- amount of substance remaining in the system
- frequency, mode and duration of substance use
- environmental and behavioral conditions and stressors that trigger use
- physical and behavioral manifestations and consequences of use
- length of use and escalation over time
- genetic predisposition to addiction
- risk of a dangerous withdrawal reaction

All clinical documentation pertaining to alcohol and/or drug abuse screening and evaluation should be recorded in the area of the patient care record designated for medical history and assessments.

3. ESTABLISH A TREATMENT PLAN IN CONSULTATION WITH RELEVANT SPECIALISTS.

Following screening and assessment, the next step is to develop and implement an interdisciplinary care and treatment plan. While some inpatients require intensive support, such as emergency detoxification and stabilization, others may require only medication or behavioral health interventions. If substance use is chronic and an extended hospital stay is anticipated, consider arranging a consultation with a psychiatrist, who can examine the patient for any coexisting psychiatric illnesses and determine the optimal course of therapy.

To ensure a consensus on interventions, psychiatric consults should occur in collaboration with professionals from other disciplines, such as internal medicine, nursing, case management and social services. Beyond the initial consultation, behavioral health professionals serve an important role in coordinating long-term care, including individual and family counseling and other community-based social services. The Academy of Psychosomatic Medicine offers comprehensive guidelines for psychiatric consultation in the general medical setting, which are available at **http://www.apm.org/prac-gui/psy39-s8.shtml**.

The discharge readiness tool on pages 5-7 addresses some of the post-care recuperation and rehabilitation challenges faced by chemically dependent patients. It lists planning strategies to ensure that such patients are discharged with appropriate and timely follow-up, which can help them begin the process of confronting and eventually overcoming their pattern of abuse.

Appropriate and timely follow-up can help chemically dependent patients begin the process of confronting and eventually overcoming their pattern of abuse.

4. MAINTAIN A SECURE TREATMENT ENVIRONMENT.

Individuals with alcohol use disorder, opioid dependence or mixed drug use have a suicide rate substantially higher than that of the general population.[2] Because withdrawal is associated with anxiety, altered mental states and impaired impulse control, patients require a safe, monitored and low-stimulus environment where they can receive reassurance and reorientation.

Patients who present with serious underlying mental health conditions should be considered for initial placement in a secure inpatient setting. Many states permit healthcare organizations to admit patients to a secure unit on a "conditional voluntary" status. This means that patients can be discharged or transferred only after they (or a guardian or agency) submit a written request, and a specified period (usually three days) elapses. As with any decision concerning commitment of patients to inpatient treatment units, consult with legal counsel for specific jurisdictional regulations and requirements.

For patients who do not require a restrictive setting, but still may pose some degree of risk, consider implementing the following protective measures:

- *Assign rooms near the central nursing station* when patients exhibit poor impulse control and judgment, and may be at risk of leaving the unit.
- *Restrict "open-door" policies*, which permit visitors to move freely in and out of patients' rooms.
- *Monitor deliveries to patients and their rooms*, in order to intercept possible exchanges of drugs or other contraband.
- *Evaluate suicide risk and implement appropriate precautions*, keeping in mind that patient acuity will vary over the course of treatment.
- *If necessary, secure a written physician order for physical restraint use*, documenting skin assessments and the patient's response to the restraints on an hourly basis.

2 See Schneider, B., "Substance Use Disorders and Risk for Completed Suicide," in *Archives of Suicide Research*, 2009, Volume 13:4, pp. 303-16. Abstract available at **http://www.ncbi.nlm.nih.gov/pubmed/19813108**.

5. BE PREPARED FOR MEDICAL EMERGENCIES.

Not all individuals who are admitted with a history of substance misuse or abuse will develop withdrawal symptoms. However, cessation after a period of heavy and/or prolonged use may induce acute withdrawal, potentially causing tachycardia, hypertension and/or seizure. In the most severe cases, delirium tremens can lead to cardiovascular collapse.

Nursing staff should screen identified high-risk patients for the possible onset of withdrawal reaction. The following screening instruments, which take only minutes to complete and can be formatted for use with electronic healthcare record systems, are designed to help clinicians detect patients requiring closer observation and care:

- Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (AUDIT-PC), at **http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf**
- Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar), at **http://www.chce.research.va.gov/apps/PAWS/pdfs/CIWA-Ar.pdf**
- Riker Sedation-Agitation Scale (SAS), (an arousal/sedation tool for heavily sedated, intubated or unresponsive patients), at **http://www.mc.vanderbilt.edu/icudelirium/docs/SAS.pdf**
- Withdrawal Assessment Tool Version 1 (WAT-1), at **http://www.restorenetwork.org/pages/WAT%20V1%202Mar08.pdf**

Treatment of withdrawal symptoms is typically guided by established clinical pathways, including proven and effective assessment tools. For patients in the grip of moderate to severe withdrawal, the priority is to reduce central nervous system irritability and restore homeostasis.[3] Patients in acute withdrawal states require frequent assessment and documentation of vital signs, airway patency, hydration status, and indicators of cardiac and/or respiratory distress. Ensure that staff have documented training in life support, as well as ready access to necessary equipment and supplies. In addition, provide dietary and pharmacy consults as indicated to address nutritional and metabolic deficiencies.

Chemically dependent individuals are among the most vulnerable of inpatients. Many present to a hospital lacking family support, stable employment, suitable housing, adequate health insurance or other essentials. While healthcare organizations cannot remedy all of these ills, they *can* provide safe and effective inpatient care, characterized by consistency, collaboration and sensitivity to patient needs. In addition, they can ensure that after-care measures, as outlined on pages 5-7, address patients' physical, psychological and social deficits, thereby smoothing the transition and lessening the potential for relapse and hospital readmission.

The CAGE Questionnaires: Screening Patients for Substance Abuse

The CAGE (alcohol) and CAGE-AID (drug) screening tools are popular in the primary care setting because they are concise, easy to remember and proven effective for detecting a range of substance issues, such as hazardous use, binge tendencies and dependence. They consist of four pointed questions:

CAGE QUESTIONS FOR ALCOHOL USE

*C-Have you ever felt you should **cut down** on your drinking?*
*A-Have people **annoyed** you by criticizing your drinking?*
*G-Have you ever felt bad or **guilty** about your drinking?*
*E-Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**eye-opener**)?*

CAGE QUESTIONS ADAPTED FOR DRUG USE (CAGE-AID)

*C-Have you ever felt you ought to **cut down** on your drug use?*
*A-Have people **annoyed** you by criticizing your drug use?*
*G-Have you felt bad or **guilty** about your drug use?*
*E-Have you ever used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**eye-opener**)?*

*For more information, visit **http://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/CAGE%20Substance%20Screening%20Tool.pdf**.*

3 To learn more about the benefits of withdrawal pathways and how they help foster consistent care for chemically dependent patients, see Repper-DeLisi, J. et al., "Successful Implementation of Alcohol-withdrawal Pathway in a General Hospital," in *Psychosomatics*, July-August 2008, Volume 49:4, pp. 292-299. (Available for purchase to non-members at **http://www.sciencedirect.com/science/article/pii/S0033318208709125**.)

Discharge Readiness Tool: Planning After-care for Dependent Patients

Discharge planning is of critical importance for patients with substance abuse issues, as fragmented and inadequate follow-up can quickly undo any health gains achieved during hospitalization. This tool is designed to help providers identify patients' post-care needs and prepare them for safe discharge and ongoing counseling, thus avoiding an all-too-common cycle of addictive episodes, treatment and relapse.

Patient name: _____ Admitting diagnosis: _____

Admission date: _____ Anticipated discharge date: _____

Attending physician/contact number: _____

Consulting physician(s)/contact number(s): _____

History of chemical dependence:

Substance(s) of choice: _____

Length of use: _____

Past rehabilitation attempts: _____

INITIATIVE	COMPLIANCE STATUS	COMMENTS	DATE ACHIEVED
INTAKE ASSESSMENT			
A discharge team is assembled, including a social worker, nurse, treating physician, pharmacist and dietician.			
A mental status assessment is conducted to determine the patient's ability to understand treatment options, necessary follow-up measures and discharge plans.			
Past attempts at rehabilitation are documented, including relapse dates and obstacles to sobriety.			
The patient is asked about current resources and needs in such key areas as personal finances, health insurance coverage and vocational training.			
The patient's housing status and needs are determined.			
A relevant support group is identified.			
The patient is asked about past criminal activity, and the risk of recidivism is assessed.			

INITIATIVE	COMPLIANCE STATUS	COMMENTS	DATE ACHIEVED
CASE MANAGEMENT			
A discharge advocate is assigned to perform the following duties, at a minimum: - educate the patient regarding the discharge process - reconcile current medications - schedule follow-up appointments - locate pharmacies - identify emergency contacts			
The patient (if physically capable) participates in case management sessions, preferably with members of his/her support group.			
The patient is educated about his/her diagnosis and the negative effects of substance abuse, and educational activities are documented.			
The following data, among others, are stored in easily accessible electronic form for use in discharge planning: - diagnostic tests taken - test results - medication plans - consultations - history of withdrawal reactions - post-discharge services needed and obtained			
The discharge team identifies needs across multiple health sites and addresses deficiencies in a written discharge plan.			
AFTER-CARE RESOURCES			
The discharge team identifies available community resources, minimally including - addiction counseling - employment counseling - sober housing options - therapy (cognitive, behavioral, family and/or motivational)			
Both short- and long-term goals concerning rehabilitation and recovery are established, and appropriate referrals are made.			

INITIATIVE	COMPLIANCE STATUS	COMMENTS	DATE ACHIEVED
SHELTER PROVISION			
The patient is asked whether he/she is homeless – i.e., lacks a fixed nighttime abode.			
Local shelters are contacted regarding availability of recuperative care beds.			
The patient is discharged only after ensuring that shelter is available and other basic care needs have been met.			
Prior to discharge, the receiving shelter is called to reconfirm bed availability.			
The patient is transported to the shelter in a hospital vehicle.			
A medical attendant accompanies the patient to the shelter and documents patient placement.			
DOCUMENTATION REQUIREMENTS			
The patient is informed in writing of post-discharge care needs.			
A transfer summary accompanies the patient during transit to another healthcare facility.			
The patient receives written information about prescribed medications, including drug benefits, dosages, administration times, potential counter-indications and side effects.			
The patient is provided with a calendar of follow-up care and testing appointments, each scheduled at a convenient time and place.			
Written contact information is provided for local social service agencies and organizations.			

Healthcare organizations can ensure that after-care measures address patients' physical, psychological and social deficits, thereby smoothing the transition and lessening the potential for relapse and hospital readmission.

RESOURCES

- American Society of Addiction Medicine (ASAM), at **www.asam.org/**
- Center for Substance Abuse Prevention (CSAP), at **www.samhsa.gov/about/csap.aspx**
- Center for Substance Abuse Treatment (CSAT), at **www.samhsa.gov/about/csat.aspx**
- National Association of State Alcohol/Drug Abuse Directors (NASADAD), at **http://nasadad.org/**
- National Center on Addiction and Substance Abuse at Columbia University (CASAColumbia), at **www.casacolumbia.org**
- National Clearinghouse for Alcohol and Drug Information (NCADI), at **http://healthliteracy.worlded.org/docs/culture/materials/orgs_015.html**
- National Institute on Alcohol Abuse and Alcoholism (NIAAA), at **www.niaaa.nih.gov/**
- National Institute on Drug Abuse (NIDA), at **www.drugabuse.gov/**
- Research Institute on Addictions at the State University of New York at Buffalo (RIA), at **www.ria.buffalo.edu/**
- Society of Hospital Medicine (SHM), at **www.hospitalmedicine.org/**
- Substance Abuse and Mental Health Services Administration (SAMHSA), at **www.samhsa.gov/**

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