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Transitioning From Detoxification to Substance Use Disorder Treatment: Facilitators and Barriers

Christine Timko, PhD [a,b,*], Nicole R. Schultz, MA [c], Jessica Britt, MS [a,d], Michael A. Cucciare, PhD [e,f,g]

[a] Center for Innovation to Implementation (Ci2i), Department of Veterans Affairs, Palo Alto Health Care System, Palo Alto, CA 94304, USA
[b] Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, CA 94305, USA
[c] Department of Psychology, Auburn University, Auburn, AL 36849, USA
[d] Clinical Psychology Graduate Program, Pacific Graduate School of Psychology-Stanford University Consortium, Palo Alto, CA 94304, USA
[e] Center for Mental Healthcare and Outcomes Research, Central Arkansas Veterans Affairs Healthcare System, North Little Rock, AR 72205, USA
[f] Veterans Affairs South Central (VISN 16) Mental Illness Research, Education, and Clinical Center, Central Arkansas Veterans Healthcare System, North Little Rock, AR 72205, USA
[g] Department of Psychiatry, University of Arkansas for Medical Sciences, Little Rock, AR 72205, USA

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ABSTRACT

Although successful transitions from detoxification to substance use disorder treatment are associated with improved outcomes, many detoxification patients do not initiate treatment. This qualitative study informs detoxification and addiction treatment providers, and health systems, about how to improve detoxification to treatment transitions, by reporting detoxification providers' views of transition facilitators and barriers. The sample consisted of 30 providers from 30 Veterans Health Administration detoxification programs. Themes regarding transition facilitators and barriers emerged at the patient, program (detoxification programs, and addiction programs), and system levels. Detoxification program-level practices of discharge planning, patient education, and rapport building were reported as facilitating the transition to treatment. Six themes captured transition facilitators within addiction treatment programs: the provision of evidence-based practices, patient-centered care, care coordination, aftercare, convenience, and a well-trained and professional staff. This study expands previous literature on detoxification and addiction treatment by systematically and qualitatively examining factors that promote and hinder treatment initiation after inpatient and outpatient detoxification, from a provider perspective, in an era of health care reform and expanded substance use disorder treatment.

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1. Introduction

Detoxification is the medical management of substance withdrawal to prevent complications, such as seizures or delirium tremens, which may be fatal. About one-fifth of addiction treatment admissions are for detoxification (Substance Abuse and Mental Health Services Administration and Center for Behavioral Health Statistics and Quality, 2014). However, detoxification does not serve as standalone care for substance dependence. Rather, detoxification should function as an entry point to addiction treatment. Successful transitions from detoxification to addiction treatment are well-known to benefit outcomes such as reduced relapse, criminal justice system involvement, and crisis-related health care utilization, and increased employment and stable housing (Ford & Zarate, 2010; Lee et al., 2014). Nevertheless, many patients do not successfully transition from detoxification to treatment, and rates of transition are highly variable across detoxification settings (Campbell et al., 2010; Carrier et al., 2011). Relatively little is known about patient-, program-, and system-level factors that may facilitate or hinder this transition process. This qualitative study informs detoxification and addiction treatment providers, and the health systems in which they work, about how to improve detoxification to treatment transitions, by reporting detoxification providers' views of transition facilitators and barriers. It draws from a conceptual model that describes patient (e.g., demographics, prior treatment, resources), provider (e.g., knowledge of, and relationships with, care sites), and system-level (e.g., collaboration, communication and feedback) facilitators and barriers to health care transitions, while also considering resource demands required for strategies to improve transition processes (Cucciare, Coleman, & Timko, 2015).

1.1. Detoxification to treatment transitions

Facilitators of detoxification to treatment transitions have been identified at the patient, program, and system levels, as we review here. Patient-related facilitators of entering treatment after detoxification include difficult circumstances caused by substance use, such as

* Corresponding author at: 795 Willow Rd (152-MPD), Menlo Park, CA 94025. Tel.: +1 650 617 2746; fax: +1 650 617 2736.
E-mail addresses: Christine.Timko@va.gov, ctimko@stanford.edu (C. Timko), nrs0011@auburn.edu (N.R. Schultz), jbritt@paloaltou.edu (J. Britt), Michael.Cucciare@va.gov, macucciare@uams.edu (M.A. Cucciare).

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lost housing or relationships (Raven et al., 2010; Tucker, Vuchinich, & Rippens, 2004), and pressures from friends and family to enter treatment (Kenny, Harney, Lee, & Pennay, 2011; Tucker et al., 2004). They also include personal motivation (Corsi, Kwiatkowski, & Booth, 2007), which may be due to fatigue with the drug using way of life (Silins, Sannibale, Larney, Wodak, & Mattick, 2008). Other patient factors, such as increased drug use or a recent overdose, or health or legal problems, as well as previous treatment admissions, have also been found to facilitate treatment initiation for substance use disorders (Siegal, Falck, Wang, & Carlson, 2002; Zule & Desmond, 2000).

Program-level characteristics functioning as facilitators to addiction treatment have been identified in both detoxification programs and addiction treatment programs. Rates of transition from detoxification to treatment were improved by the detoxification program escorting patients directly to the program and providing transportation costs (Chutuape, Katz, & Stitzer, 2001). In addition to transportation, treatment admission was associated with active discharge planning with clients during detoxification (Carroll, Triplett, & Mondimore, 2009). Transition rates may be better when substance use disorder programs have more clinically skilled, engaged, supportive, and committed providers (Broome, Flynn, Knight, & Simpson, 2007), and when they provide motivational enhancement therapy and peer support (Blondell et al., 2011; Soyka & Horak, 2004; Wiseman, Henderson, & Briggs, 1997). Other addiction program characteristics that increase the likelihood of treatment include the availability of women-only programs and case management, including assistance with child care and housing (Corsi et al., 2007; Rapp et al., 2008; Sun, 2006).

One system-level characteristic that facilitates treatment after detoxification is detoxification–treatment integration. Ross and Turner (1994) found that transfer rates from a detoxification unit to a rehabilitation unit were highest when both units were contained within a single setting. Integration across the continuum of care to address all of a patient's needs within a single system enhances the likelihood of transitions between types of services (Appel, Ellison, Jansky, & Oldak, 2004).

Transition barriers, also at the patient, program, and system levels, have also been identified. At the patient-level, detoxification patients may resist treatment because they are not ready or motivated to stop using substances, or feel that their problems will get better on their own or can be handled without help (Carroll & Rounsaville, 1992; Mowbray, Perron, Bohnert, Krentzman, & Vaughn, 2010). Other personal concerns, such as competing responsibilities entailed by having a job and family, or lacking a stable living situation or transportation, function as barriers to treatment entry (Appel et al., 2004; Jackson & Shannon, 2012; Kenny et al., 2011). Patients' perceptions of the stigma associated with substance use and the need for treatment are commonly noted as a major deterrent to seeking treatment (Mojtabai, Chen, Kaufmann, & Crum, 2014). Individuals may resist seeking treatment in fear that they will be labeled as an addict, negatively judged (Allen, Copello, & Orford, 2005; Jackson & Shannon, 2012), treated poorly (Luoma et al., 2007), or face repercussions such as losing custody of their children (Boeri, Tyndall, & Woodall, 2011).

Program characteristics or rules can also serve as barriers to treatment utilization post-detoxification (Jessup, Humphreys, Brindis, & Lee, 2003; Pullen & Oser, 2014). Addiction treatment is hindered by program barriers such as wait times to available beds or appointments, requirements for patient identification and meeting other eligibility criteria, and inconvenience of services (Appel et al., 2004; Boeri et al., 2011; Redko, Rapp, & Carlson, 2006). Wait times are exacerbated by staffing shortages, and staff members having heavy caseloads and too many administrative, record-keeping tasks (Pullen & Oser, 2014).

System barriers such as cost and location limit the accessibility of services (Mojtabai et al., 2014; Small, Curran, & Booth, 2010; Substance Abuse and Mental Health Services Administration and Center for Behavioral Health Statistics and Quality, 2014). Barriers to substance use treatment entry include lack of coordination across components of the system in qualifying, enrolling, and supporting persons needing detoxification and treatment (Appel et al., 2004). Specifically, a lack of inter-program cooperation, communication, and collaboration deters addiction treatment availability following detoxification completion (Pullen & Oser, 2014).

1.2. Present study

Drawing from the conceptual model of determinants of health care transitions (Cucciare et al., 2015), this study provides important information for health care providers and systems seeking to improve detoxification to treatment transition successes by (1) qualitatively and systematically identifying multilevel (patient, program, and system) facilitators and barriers to post-detoxification substance use disorder treatment, and (2) providing recommendations for improving rates of post-detoxification treatment, from the perspective of direct providers of detoxification services within an integrated health care system. Specifically, we focus on identified themes of modifiable factors that can improve the detoxification to treatment transition, within and outside of the system studied (such as other large integrated or publicly-funded health care systems). This system, the Veterans Health Administration (VHA), is the largest integrated health care system in the United States. The aim of the present study was to identify factors that can be altered or transformed to improve substance use disorder treatment utilization after detoxification, and thus increase the likelihood of improved patient outcomes and sustained recovery.

2. Methods

2.1. Participants and settings

The sample consisted of 30 providers from 30 VHA detoxification programs. To obtain the sample, the VHA National Patient Care Database was used to calculate, for each VHA facility (N = 141), the proportion of patients diagnosed with alcohol and/or opiate dependence who utilized inpatient or outpatient detoxification and subsequently obtained specialty substance use disorder treatment within 60 days of detoxification admission in Fiscal Year 2013 (i.e., October 2013–September 2014). To ensure representation of a range of facilities with regard to transition success, the 15 facilities with the highest, and the 15 with the lowest, proportions of patients obtaining substance use disorder treatment following a detoxification admission were targeted for participation. That is, the study used a maximum variation sampling approach (a type of purposive sampling) due to the importance of understanding the local context and diversity across different facilities (Palinkas et al., 2013). Project staff contacted each facility's substance use disorder treatment and/or inpatient psychiatry unit to identify the director or main provider of inpatient or outpatient detoxification, i.e., the staff member most knowledgeable about detoxification at that facility. Of the targeted 30 directors, 10 were replaced (five declined participation, five did not respond after multiple attempts) with a provider at another facility that had the next highest or next lowest proportion of patients transitioning from detoxification to treatment.

2.2. Interview procedures and measures

Project staff emailed each provider a description of the study and an informed consent form. Providers were informed that the interviews would be conducted by phone, audio recorded with consent, and last approximately one hour (interviews ranged from approximately 30–90 minutes). Interviews were pretested with two providers at two facilities outside of the high and low groups. We used semi-structured interviews to examine participants' perspectives on facilitators and barriers, at the patient, program, and system levels, that affect patients' transition from detoxification to addiction treatment. The interview guide adapted the conceptual model developed by Cucciare et al. (2015) on care transitions. Interviews were audio-recorded and transcribed verbatim.