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

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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 (SAMHSA, 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, 2014).

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 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 (Motjabai et al., 2014; SAMHSA, 2014; Small, Curran, & Booth, 2010). 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., 2014), 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, Horwitz, Green, Wisdom, Duan, & Hoagwood, 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. (2014) on care transitions. Interviews were audio-recorded and transcribed verbatim.

2.3 Data Analysis

Transcriptions were reviewed for accuracy, then coded and analyzed using methods derived from grounded theory with the qualitative data analysis software program ATLAS.ti (Glaser & Strauss, 1967). A coding scheme was developed after all interviews were completed. Two interviewer-coders began with an independent, systematic reading and coding of the transcripts using open coding techniques. Codes were compared across coders, common descriptive codes were developed ensuring that none were missed, and definitions were specified for each code. Coders returned to the interview data to confirm and clarify themes, i.e., collapse similar themes and expand divergent themes. As interviews were coded using open coding strategies where quotes were given a descriptive code, and core themes emerged, selective coding was used to code only for identified themes. Interrater reliability was .94 (kappa statistic). Discrepancies between coders were identified and resolved in discussion with all authors before themes were categorized. We report the number of providers interviewed who contributed each coded subtheme within a theme (Maxwell, 2010).

3. Results

The sample of 30 detoxification providers was mostly male (n = 16, 53.3%) and Caucasian (n = 22, 73.3%), and had a mean age of 50.8 years (SD = 9.9). Providers primarily had medical (n = 11, 36.7%) or advanced nursing (n = 10, 33.3%) degrees, and had a mean of 10.5 years (SD = 8.8) of experience providing detoxification services.

Of the 30 VA medical facilities, 19 (63.3%) offered inpatient and outpatient detoxification on site, five (16.7%) offered only outpatient detoxification on site, four (13.3%) offered only inpatient detoxification on site, and two (6.6%) stated that detoxification is offered only off site, not on site. Providers described their detoxification patients as typically middle-aged (40–60 years old; N=17, 58.1% of interviews), of lower socioeconomic status or homeless (N=23, 77.4%), having utilized detoxification more than once (N=25, 83.9%), and most commonly detoxing from alcohol (N=26, 87.1%), although one-half of providers noted there has been an increase in younger, opiate-dependent patients (N=15, 50.0%).

For the full sample, the proportion of detoxification patients who entered substance use disorder treatment was 49.9% (95% confidence interval = 49.3%−50.6%; range = 13.0% −77.2%). Among facilities in which the directors interviewed represented the “low” group, the proportion of detoxification patients who transitioned ranged from 13.0% to 31.8%. Among facilities in which interviewees represented the “high” group, the proportion ranged from 65.8% to 77.2%.

3.1 Patient Facilitators and Barriers

3.1.1 Facilitators.—Two themes emerged regarding provider-reported patient-level facilitators of the transition from detoxification to treatment: patients’ **life context**, and

patient **characteristics** (Table 1). Regarding life context, patients were more likely to transition when they had suffered negative consequences associated with their substance use (Provider #2 [P2] said, *The more they've lost, the better chance I think there is that they will actually engage treatment;* P4 said, *Yeah, often a crisis will precipitate it. Like suddenly lose housing. That's a big one. Then they decide to get in treatment.*), and when they experienced pressure or support from others to transition from detoxification to treatment (as P9 specified: *family pressures or probation officers*).

A patient characteristic facilitating the transition was being motivated for treatment. P11 explained, *If you're going straight from detox into a treatment program, you're pretty motivated to be engaging in some kind of services because certainly no one can force you to go into treatment, and so those who select to go to treatment, I think, have a higher motivation level.* Characteristics also included previous experience with treatment in that it lessens uncertainty about what to expect (P7: *They are not as wary about what goes on in terms of a rehab program*), living in close proximity to treatment, and older age.

3.2.1 Barriers.—Patient-level barriers (reported by providers) to detoxification-treatment transitions were represented in two themes: patients' **circumstances** and **lack of follow-through** (Table 1). Patient circumstances included being too distant from, or without transportation to, treatment; having responsibilities that "compete" with treatment (e.g., being employed, child care); having co-morbid conditions (e.g., traumatic brain injury, mental health conditions such as personality disorders or PTSD); financial consequences of sustained treatment; involvement with the criminal justice system; or living in a difficult environment.

Financial consequences as a barrier to treatment were explained by P13: *We've actually had patients tell us if they fully embrace and engage in treatment, they can have negative consequences in terms of losing their HUD VASH* [Housing and Urban Development Veterans Affairs Supportive Housing] *housing, losing their disability pay, things of that nature.* P23 further explained, *If they have Social Security disability or non-service connected disability, after 90 days we start taking funds from them. Then it's a hassle for them to get that straightened out. Or, sometimes Social Security will stop their payment. So the problem with a longer stay is whatever their money source, they might have trouble getting it re-started. They may lose some funds.* P29 summarized: *Loss of wages, just the time commitment, is really probably the downside of treatment.* Descriptions of difficult or high-risk environments deterring treatment post-detoxification were:

> Non-compliance characteristics really are a matter of how risky a situation they're in. So if they happen to be in a lower socioeconomic status where they're living in a crack house, they're less likely to return than if they're in a supportive family environment. (P9)

> If they're in an environment at home that's not conducive to recovery, things like that, there aren't a lot of good options for individuals who fall in that category. (P11)

The patient barrier of lack of follow-through was ascribed to stigma, e.g., *Some people, I think, don't want the stigma of being called an addict. They may not want to go to the specialty care for that reason. They prefer to see their primary care doctor* (P4). Similarly, P18 stated, *There's a large population of veterans who don't want to come to specialty care clinic and would be better served in a primary care setting. They're more comfortable. They wouldn't worry about the stigma as much and I think that's one place that should be explored for additional services.* Low motivation was also identified with regard to lack of follow-through. As P6 said, *A lot of them are much more entrenched in their addiction and sicker and just, you know, the energy just isn't there. The vision isn't there, whatever.*

3.2 Program Facilitators and Barriers

3.2.1 Facilitators.—One program-level facilitator (Table 2) of the detoxification-treatment transition concerned the **detoxification program's practices**, including the provision of discharge planning and referrals to treatment (P8: *When you come back for your* [detoxification] *follow-up visit, that's the day I talk to them about, would you be interested in maybe signing up for the substance abuse treatment program. We do refer to the substance abuse treatment program.*), patient education (P3: *I would say we give a concerted effort or message to the veterans, especially if they need an inpatient detox, the importance of engaging in a residential program and/or outpatient. I mean, we continue to educate.*), and rapport building with patients (P5: *I think that's just building a good rapport and being a good physician, good clinician along the way. Because establishing trust is the best way you can go on an individual level to get people in when they come in.*)

A second program-level facilitator was the **addiction treatment program's provision of evidence-based practices**, listed on Table 2. A third program-level facilitator, **patient-centered care,** included providing a menu of options for patients to consider as part of treatment.

> *We have a treatment mall of groups that they can select from based on their diagnoses.* (P4)

> *We have grief and loss groups. We have anger management. We even have yoga now which is so cool. The guys love it. We have a recovery group that meets three times a week. It's a process group, a feelings group. So there's just a good mixture of different things that we offer. There's, you know, all the normal groups on relationships and relapse prevention. We have things on hygiene, HIV, hypertension. We have a music group. We have a recreation group. Just we have everything. I mean it's just really pretty awesome, well-rounded.* (P6)

> *There's a whole set of groups that look at relapse prevention, coping skills, psychoeducation of the medical complications, introducing people to AA, relaxation training. And there's a AM Planning meeting and PM planning meeting each day. PM planning is what's going to happen overnight or through the weekend in terms of risk situations they might be in.* (P9)

Patient-centered care also included special services for women, e.g., P16: *We also have a kind of a women's track within our program for outpatient and then again we follow protocol, making sure that we try to engage them.*

Within the theme of patient-centered care, providers noted that facilitative addiction treatment is individualized, in terms of patient preferences for type of addiction treatment, and what patients experience in the type obtained.

> *We determine with the veteran if their preference is to go to our RRTP* [Residential Rehabilitation Treatment Program] *recovery program that we have. It's a residential, 30 day program. Or if they're wanting to return as an outpatient to be seen for individuals and groups.* (P21)

> *We just make sure that the treatment that we envision for them is the treatment that they need. We don't really like the idea of just shoving people into groups without having a visit with them, because there's all kinds of potential problems and their needs may be different. They may have PTSD so bad that a group may be impossible in the beginning. Okay, well, let's do individual sessions.* (P2)

> *I mean there are many other services that we provide at the VA which really is individualized. … So, I guess the way to do it is to have a patient-centered approach and to give them the options, because oftentimes, there's more than one option that's appropriate, rather than to have a more, I guess, directed, narrow approach. … The way to engage patients would have to be, I think, a client-centered approach.* (P10)

> *It's a smorgasbord. We try to individualize it. We have different people who do different things and we refer patients to those people depending on preference and need.* (P13)

Providers also reported that the transition from detoxification to treatment is facilitated by the addiction treatment program providing **care coordination**. This consisted of case management (i.e., the program has a case manager with whom patients meet regularly), and the provision of housing while patients are in addiction treatment. Programs also made efforts to maintain engagement, that is, keep patients engaged with the health care system, especially when wait listed for, or unwilling to consider, treatment. For example, at one facility, addiction treatment services assigned a nurse to call patients who completed detoxification with reminders about treatment appointments:

> *I think she does do a wonderful job to help engage the patients. That maybe if they were a little ambivalent and thinking oh I'm not coming back there, I'm not going to go to that appointment, she really helps kind of rope them in. … She's wonderful about calling them and getting them to come and helping convince them if they need it to come in. … That's only been the last couple of years we've had help with that. That has been a big change and a big improvement. Because we have had difficulty with especially our inpatient detox people coming back.* (P6)

> *For those who aren't willing to go into specialty treatment, we still have great follow through with them so everybody gets a seven day follow-up, everybody gets*

assigned a mental health treatment coordinator, and we work to engage them as much as possible, so we have a weekly motivational group for individuals who aren't quite ready to commit to treatment. And we have individual work with an addiction therapist, as well, available to help keeping them engaged and even though they're not willing to enter directly into specialty treatment, to keep working with them and enhancing their motivation and working on their problems. (P11)

Care coordination also included outreach to veterans receiving detoxification, and their health care providers, at VA or non-VA facilities to inform them of VA addiction treatment services.

Part of that is though again having good relationships with your community hospital, that they also call you when they have somebody in for detox. … And I think our suicide prevention coordinator has done a lot of that with the outreach efforts to make people aware of resources and have connections that they know where to call, and so that helps with that continuity of care. (P3)

We'll do outreach. We have interactions with their PC [Primary Care] *staff. If they identify somebody, we will do some outreach with them, calling them, encouraging them to come in and meet with us, as well as encouraging - you know, working with our mental health staff to engage people.* (P12)

The transition from detox to treatment … it's the addiction therapist communicating with the veteran while they're in detox for outpatient services or the RRTP admission coordinator doing the same. (P21)

Finally, care coordination involved peer support of transitioning from detoxification to treatment, with peers being both paid Peer Support Specialist employees, and non-employee 12-step group members.

From the patients' perspective, I think maybe the increased support of peer support specialists, peer involvement - and we've always had that from the AA community. They really support people getting into detox and do interventions. … We also have our peer specialists involved in that treatment team meeting and they have a group in the domiciliary that talks about transitions. (P3)

Greatest facilitator to get people into treatment is other vets. It's a crazy thing. They will listen to other vets in the group more than they will listen to us, the therapist. … It's always the vet. It's always vet to vet is best. (P23)

Some providers regarded the addiction treatment program's provision of aftercare as a facilitator of the detoxification-treatment transition. That is, patients continue to receive care after detoxification and addiction treatment completion. Aftercare includes provision of outpatient after residential care (P1: *Patients go on to follow-up in our own aftercare, which is once a week, kind of a follow-up, for up to 12 months or longer sometimes.*), and ongoing individual or group sessions after outpatient care.

We provide follow-up for veterans as long as they're willing to engage in follow-up. So we have continuing care, both individual and group, available for as long as

a veteran is willing to engage with us. So we have veterans who have been in recovery for 15 years and they keeping coming back to group and we keep working with them and helping them stay in recovery. (P11)

Another theme with regard to addiction treatment programs' facilitation of transitions was programs being **convenient**. This meant that patients have immediate access to treatment after detoxification completion.

Our program works very hard to get patients when they're done with detox and put them in the program. I feel like this is a very big strength in how quick we're able to get people into the substance abuse treatment program. (P5)

We have immediate access open enrollment for outpatient treatment, there's no waiting list at all. (P6)

Anybody who's interested in treatment will get an evaluation and if they're interested in going directly into specialty treatment, we can place them, for sure, if they're willing to be flexible about their placement. And so nobody has to leave detox without entering directly into treatment. (P11)

What we try to do is provide as quick access, even same day access, to people if they show up and are experiencing issues with substance abuse, depression, whatever, whatever tangential issues would be occurring in relation to their substance abuse. (P12)

I think because we're always accessible here, the veterans look at it as a safe haven and want to, when they hit rock bottom, they like to come in for treatment. They know they'll get the services. In fact, I think the main draw here is there's no set appointment. They can come in as a walk-in into the ED [Emergency Department] *and inquire about detox. Some places, they would have you go through a rigmarole of an intake process. They want to verify insurances. They want to have you follow up another day. This one, you can just go as a walk in to the ED, and you'll get referred.* (P22)

Also making addiction treatment convenient was its availability after hours (i.e., outside of normal business hours, including on weekdays after 4:30 p.m., on weekends, and on holidays), providing transportation to treatment, and offering treatment via telehealth.

Another theme that emerged as to facilitators of transitions from detoxification to treatment was having **well-trained and professional** addiction staff. This included staff members having many years of experience providing addiction treatment in a variety of settings (e.g., state hospital, private agency), and being skilled and committed.

I think if there's a pervasive attitude across everybody that they interact with, that is professional, non-judgmental, matter-of-fact but concerned, but with a certain degree of treatment optimism. …The more that general philosophy pervades the system, that facilitates people's access into treatment. (P25)

3.2.2. Barriers.—Two themes emerged with respect to addiction treatment programs' barriers to patient transitions from detoxification: **Lack of accessible addiction treatment**,

and program **inflexibility**. Lack of accessibility covered wait times between detoxification and treatment.

> *If they are not engaged quickly after the detox, and readily get back into the specialty care treatment, if there's a long lag time, I see that the patients often go back to using.* (P4)

> *I would say the biggest problem in our whole continuum of care here is typically a person who completes detox at our inpatient detox is going to have to wait some weeks, even if they want to go to rehab and we agree with it, before they get accepted and get an admission date. … Then when they of course relapse they have to be re-detoxed to be sober to go into the rehab, which is not a great situation.* (P25)

Lack of accessibility also covered the problem of patients having no housing while obtaining treatment (P2: *Some of these guys come from two, three hours away and I think the biggest problem is trying to find them shelter in the local area. … If they come from an area far away and we can't provide housing to them, then it becomes a real challenge on getting them here.),* staff shortages and workload (P11: *We have an overwhelming workload and more patients who need help than we have staff to help them.*), having too few treatment beds (P6: *For residential rehab, we can't admit somebody if we don't have a bed for them. Demand for those beds are higher than the beds we have.*), and limited treatment hours.

Addiction treatment programs' inflexibility that deterred transitions included staff resistance to treating detoxification patients.

> *Within psychiatry there's some very negative attitudes of individuals who have addiction, and I think that often their behavior reflects their underlying beliefs about an individual who has an addiction. … There's some pretty nonprogressive attitudes here about addiction and detoxification, and the biggest barriers we face are attitudinal.* (P11)

> *Staff tend to particular biases - I think sometimes some of us don't realize where those lie and can be significant barriers to keeping people engaged in treatment.* (P12)

> *The terminology seems to be more punitive and judgmental towards this population when they are cycling in and out. I mean it's not enjoyable to be dealing with that, but I think the judgmental aspect actually gets in the way.* (P25)

It also included strict program policies regarding patient eligibility for services.

> *We find some of the programs to be kind of frustrating in terms of what are their criteria. … It feels as though there's this narrow window of eligibility that you're either too sick or not sick enough.* (P25)

Another example of strict policies was at P30's location: when patients are administratively discharged for breaking the treatment program's rules, they are required to wait one year to reenter an addiction treatment program, even if they complete detoxification at any point

during that year. *And then you lose people quite naturally that return to using because they're denied services* (P30).

3.3 System Facilitators and Barriers

3.3.1 Facilitators.—System-level facilitators of patients transitioning from detoxification to treatment were **communication between, and integration of, detoxification and treatment**, and **handoffs** from detoxification to treatment (Table 3). Communication involved a good working relationship between the detoxification and treatment programs and providers.

> *I just think it's relationships, relationships, relationships, phone calls, that coordination of care that goes on between facilities.* (P3)

> *We have a big addiction or substance abuse forum where all services or most services can be done at our VA, and of course, ease of communication because of that, meaning communication with outpatient treaters, with the rehab program treaters.* (P10)

> *Communication, obviously, is an important factor between our drug and alcohol staff, our addiction psychiatry staff, the other psychiatry staff, primary care docs.* (P12)

> *We're having good dialog with the medical providers and para-professional staff, and the referring providers.* (P22)

Communication was related to the integrated, rather than sequential, provision of detoxification and addiction treatment services.

> *Detox is embedded within the specialty clinic. So there really isn't a transition to that clinic. We do try to have a lot of overlap between the different programs if somebody's transferring from one program to another. Those will often overlap to where they're connected to both for a week or so until the transition is made. Providing detox more as a service rather than a separate program helps with that transition. There really isn't a transition at that point because it's embedded.* (P18)

> *I wouldn't really say that it's detox followed by specialty treatment. It's specialty treatment at the time when they're getting detox. It's not a sequential thing. It's an integrated thing.* (P19)

Furthermore, integration of detoxification and treatment allows for warm handoffs from detoxification to treatment.

> *The strength, yeah, the warm hand-off. I think that's the main strength that we do. We're part of a larger unit together. There's a nurse closely following it and the doctor and, I mean, intensive treatment, there're other staff who can receive the patient.* (P14)

> *We work extremely closely - the outpatient staff and the rest of the staff, whether it be the residential staff - but the medication providers work very closely geographically and we have meetings and we're always available to talk to each*

> *other. So I think it's a matter of kind of warm handoffs, kind of these are some special things that I think are going on with this patient that need paid attention to.* (P19)

Only one theme appeared for system-level barriers to treatment after detoxification: **limited integration** between the two services.

> *I think integration could be better. You lose people in between transitions. Inpatient to residential works well. Inpatient to outpatient, we tend to lose more people.* (P4)

4. Discussion

Detoxification providers from VHA facilities with high and low rates of detoxification patients transitioning to addiction treatment identified transition facilitators and barriers at the patient, program, and system levels. 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. Most of the themes identifying facilitators of successful transitions focused on modifiable practices of addiction treatment programs, but modifiable factors were also identified within the patient and system domains.

Consistent with previous studies, we found that patient motivation was seen by detoxification providers as related to the detoxification-to-treatment transition; its presence was a facilitator, and its lack was a barrier (Corsi et al., 2007; Silins et al., 2008). Considerable research has focused on bolstering patient motivation in order to facilitate initiation and engagement with addiction treatment (CSAT, 2013). Approaches to eliciting and enhancing motivation view it as a dynamic and fluctuating state that can be modified (CSAT, 2013). In light of providers in the present sample advising that discharge planning and referral to treatment should take place within detoxification programs to facilitate transitions, it may be possible to incorporate motivational strategies during planning and referral sessions. For example, a motivational intervention provided to detoxification inpatients was more successful than brief advice in facilitating patient engagement in 12-step groups and reducing substance use at six months post-detoxification (Vederhus, Timko, Kristensen, Hjemdahl, & Clausen, 2014).

Motivational counseling approaches may have the additional advantage of helping patients consider other patient-level transition facilitators and barriers that detoxification providers identified, such as negative consequences of substance use, and social support for obtaining treatment (Table 1). In addition, detoxification programs' efforts to facilitate transitions via discharge planning and referral, educating patients about the benefits of addiction treatment, and building rapport with patients (Table 2) may need to be adapted for patients with co-occurring problems such as the presence of traumatic brain injury, PTSD, or criminal involvement, which were seen as patient-level transition barriers. For example, patients with these problems may face reduced frustration tolerance and problem-solving skills, and increased disinhibition and impulsiveness, which can lead to making poor choices around health behaviors (Trudel, Nidiffer, & Barth, 2007). Accordingly, adaptations with regard to

detoxification programs' transition facilitators may include addressing comprehension and memory challenges of patients by increasing the number of brief treatment planning and referral counseling sessions while limiting session content to help facilitate learning, retention, and following through with new information.

Providers viewed patients' negative financial consequences of sustained treatment and recovery as a barrier to treatment transitions (Table 1). Although substance use disorders cannot be stated reasons for a disability claim, they are highly prevalent among veterans presenting for disability evaluations; in addition, substance use disorders frequently co-occur with psychiatric disorders, such as PTSD, that do confer eligibility for service-connected disability. Most veterans studied by Meshberg-Cohen and colleagues (Meshberg-Cohen, Reid-Quinones, Black, & Rosen, 2014) believed that gaining paid employment would result in loss of benefits, and agreed that they would turn down a job if it entailed loss of disability payments. In addition, Veterans with substance use problems agreed more strongly than non-substance using Veterans that they would rather turn down a job offer than lose financial benefits. Disability income, such as from Social Security, provides a vital safety net to people who need funds for housing and other necessities, and substance using individuals do not want to give up the stability provided by their disability benefits (Rosen, McMahon, Lin, & Rosenheck, 2006). Resolution is needed at the policy level to resolve patient needs for both disability payments and long-term residential treatment stays to enable recovery.

Concerns that disability income is associated with substance use (Rosen et al., 2006) contribute to the stigma of addiction (on the part of individuals using substances, and health care providers) being a barrier to treatment initiation and engagement after detoxification. In discussing stigma, providers interviewed offered the solution that addiction treatment is less stigmatizing when it is available in primary rather than specialty care. However, primary care physicians report low levels of preparedness to identify and assist patients with substance use disorders (Shapiro, Coffa, & McCance-Katz, 2013), in part because treating addiction is rarely taught in medical school or residency training (CASA, 2012). The Affordable Care Act and parity laws are expected to result in increased addiction treatment through integration of addiction services with primary care. The degree of integration varies across settings, from selective screening, diagnosis, brief treatment, and referral, to a truly integrated care approach in which all aspects of primary care recognize both medical and behavioral perspectives (Crowley & Kirschner, 2015). Research supports the effectiveness of various approaches to integrated care, but there are several obstructions to implementation, including insurance and payment issues, long-standing conflicting treatment cultures, and workforce issues, as well as stigma (Crowley & Kirschner, 2015; Urada, Teruya, Gelberg, & Rawson, 2014).

Although the reasons are not clear from our data as to why providers viewed addiction programs' evidence-based treatments and aftercare to be facilitators of the transition to treatment (Table 2), previous research found that programs offering evidence-based practices (i.e., those supported by scientific evidence sufficient to merit widespread implementation) were more likely to have other positive attributes that are similar to addiction program-level transition facilitators identified by our sample (Power, Nishimi, & Kizer, 2005). These attributes include the program having the ability to provide patient-centered (reflecting the

patient's preferences, values, and needs) and individualized (comprehensive, continuous over time, and coordinated) care, and procedures to ensure timely access to care. Such programs also were found to have a strong process for developing and measuring staff competence and providing appropriate clinical supervision, thereby ensuring the availability of appropriately trained staff. Programs having evidence-based practices were also found to foster a collaborative model by ensuring staff communication, which was a system-level facilitator of transitions identified by detoxification providers in this study. (Power et al., 2005).

Whereas providers in the present study saw a well-trained staff as a transition facilitator, staffing shortages were seen as a barrier (Table 2). In fact, there is a growing staffing crisis in the addictions field due to shortages, high turnover rates, an aging workforce, stigma, and inadequate compensation. As noted, the Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act are anticipated to increase the number of individuals seeking substance use disorder services, and so may exacerbate current workforce challenges (SAMHSA, 2013). Research to promote staffing retention suggests the usefulness of workplace interventions to enhance quality of worklife and reduce workplace stress and burnout, such as providing staff members with greater autonomy, participation in work-related decisions, and career development opportunities, enhancing leadership effectiveness, improving coworker relationships through teambuilding or conflict management training, and clarifying role expectations (Eby, Burk, & Maher, 2010)

Finally, care coordination within addiction treatment programs was identified as a facilitator of the detoxification to treatment transition (Table 2). Specifically, providers identified the availability of case management as an important facilitator within this theme. Studies show case management to be associated with treatment retention, patient satisfaction and quality of life, and reduced use of acute inpatient services (Rapp, Van Den Noortgate, Broekaert, & Vanderplasschen, 2014; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). The overarching focus of case management on collaborative problem-solving regarding barriers to treatment initiation, including helping patients identify feasible transportation options and overcome geographical barriers to treatment utilization, may partially account for this finding (Table 1).

Another solution to overcoming transportation and distance barriers, mentioned by providers under the theme of making addiction treatment convenient for patients (Table 2), is the provision of telehealth services. Telehealth treatments, including telephone-based care, web-based screening and treatment, videoconferencing, and smartphone mobile applications (apps), may enhance the flexibility of addiction treatment and help address the patient-level transition barrier of responsibilities that "compete" with treatment (Table 1), such as employment or child care, because they can be obtained in the patient's office or home (Molfenter, Boyle, Holloway, Zwick, 2015). A review of telehealth interventions for substance use disorders found that, despite persistent challenges in sustaining participation, most participants were enthusiastic supporters of telemedicine, and the majority of studies reported evidence of clinical effectiveness. Such findings support continued research on telehealth development and implementation for facilitating substance use treatment following detoxification (Young, 2012).

4.1 Strengths and Limitations

Strengths of the current study include the use of a care transition conceptual model to guide the multi-level factor interviews and data analysis process (Cucciare et al., 2014). Another strength is the inclusion of a sample of providers of detoxification from facilities with high and low rates of detoxification to treatment transitions within an integrated health care system. However, the current study also had limitations. We interviewed only 30 providers, one from each of the 30 facilities with high or low rates of transition. Although we interviewed only one provider at each facility, that provider was identified as the most informed provider in the facility regarding both inpatient and outpatient detoxification services. While larger sample sizes with varying informants, including patients, may be preferable for some qualitative projects, our sample size represented over 20 percent of VHA health care system facilities, was informed by similar formative evaluation projects, and was within the suggested range for qualitative studies (Harris et al., 2013; Sandelowski, 1995). A related caution was that the sample consisted of only VHA medical facilities, which may limit the generalizability of the findings to non-VHA health care facilities. However, as noted, VHA is the largest health care system and provider of substance use disorder treatment services in the US, and systematic reviews show that health care provided in VHA is similar to that in non-VHA health care systems (Trivedi et al., 2011).

4.2 Conclusion

Interviews with detoxification providers identified several themes that suggest feasible approaches for improving the transition from detoxification to treatment. Themes represented facilitators within detoxification and addiction treatment programs' approaches. Specifically, facilitators of this care transition included delivering discharge planning and referral while receiving detoxification services, increasing the availability of evidence-based treatments, and providing patient-centered, coordinated, and convenient care from a well-trained and professional staff. The results of this study are clinically useful in that, rather than focusing on pre-treatment characteristics of detoxification patients that cannot be altered, our findings suggest multiple options for quality improvement efforts and further research investigations to attempt to manage ways to increase treatment entry, and decrease the "revolving door" of repeated detoxifications. Next steps could involve adopting the concept of plan-do-study-act (PDSA) cycles, in which researchers provide suggestions of rapid changes to detoxification and addiction program leaders. Specifically, changes such as the provision of post-detoxification monitoring by means of telephone contacts would be piloted with limited staff and patients to assess their feasibility and initial effects, and then, practices identified as successful would be adopted and sustained, cumulatively leading to larger-scale improvements in organizational functioning. Change would occur via coaching (experts help units make improvements using limited site visits with follow-up phone calls and emails), making successes visible, and having champions of successful efforts available to those seeking similar successes (Nolan, Schall, Erb, & Nolan, 2005; 85. Gustafson et al., 2013). Identifying, implementing, and evaluating suggested program-level approaches to facilitating treatment transitions after detoxification are important for increasing treatment engagement, improving patient outcomes, and reducing high-cost readmissions.

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Table 1.

Provider-Reported Patient Facilitators and Barriers to Transitioning from Detoxification to Treatment

Patient Facilitators	N
1. **Life context**	
a. Negative consequences of substance use	9
b. External pressure or support to enter treatment	8
2. **Characteristics**	
a. Motivation for treatment	4
b. Previous treatment	3
c. Proximity	2
d. Older age	1
Patient Barriers	
1. **Circumstances**	
a. Distance	17
b. Responsibilities	8
c. Co-morbid conditions	8
d. Financial consequences	4
e. Justice-involved	3
f. Environment	3
2. **Lack of follow-through**	
a. Stigma	11
b. Lack of motivation for recovery	10

Note: N=number of providers who indicated the facilitator or barrier theme

Table 2.

Program Facilitators and Barriers to Transitioning from Detoxification to Treatment

Patient Facilitators	N
1. **Detoxification program practices**	
a. Discharge planning and referrals	15
b. Patient education	12
c. Rapport building	5
2. **Addiction treatment program provides evidence-based practices**	
a. Pharmacotherapy	18
b. Cognitive Behavioral Therapy	17
c. Twelve Step Facilitation and/or 12-step groups	16
d. Motivational Interviewing, Motivational Enhancement Therapy	15
e. Relapse Prevention	13
f. PTSD treatment, e.g., Cognitive Processing, Prolonged Exposure	12
g. Contingency Management	6
h. Harm reduction	4
i. Dialectical Behavioral Therapy	2
3. **Addiction treatment program provides patient-centered care**	
a. Menu of options for help	16
b. Special services for women	16
c. Individualized treatment (patient needs and experiences)	10
4. **Addiction treatment program offers care coordination**	
a. Case management	20
b. Housing	14
c. Engagement	10
d. Outreach	6
e. Peers	5
5. **Addiction treatment provides aftercare**	24
6. **Addiction treatment is convenient**	
a. Immediate access	11
b. After hours	8
c. Provides transportation	4
d. Telehealth	4
7. **Addiction treatment staff is well-trained and professional**	17
Patient Barriers	
1. **Lack of accessible addiction treatment**	
a. Wait time	29
b. No housing	12
c. Staff shortages	6
c. Not enough treatment beds	4
d. Limited hours	4
b. **Addiction treatment programs' inflexibility**	

a. Staff resistance	13
b. Strict policies	7

Note: N=number of providers who indicated the facilitator or barrier theme

Table 3.

System Facilitators and Barriers to Transitioning from Detoxification to Treatment

System Facilitators	N
1. **Communication between detoxification and addiction treatment**	20
2. **Integration of detoxification and addiction treatment** (embedded and simultaneous services)	14
3. **Handoffs**	13
System Barriers	
1. **Limited integration of detoxification and addiction treatment** (sequential services)	6

Note: N=number of providers who indicated the facilitator or barrier theme