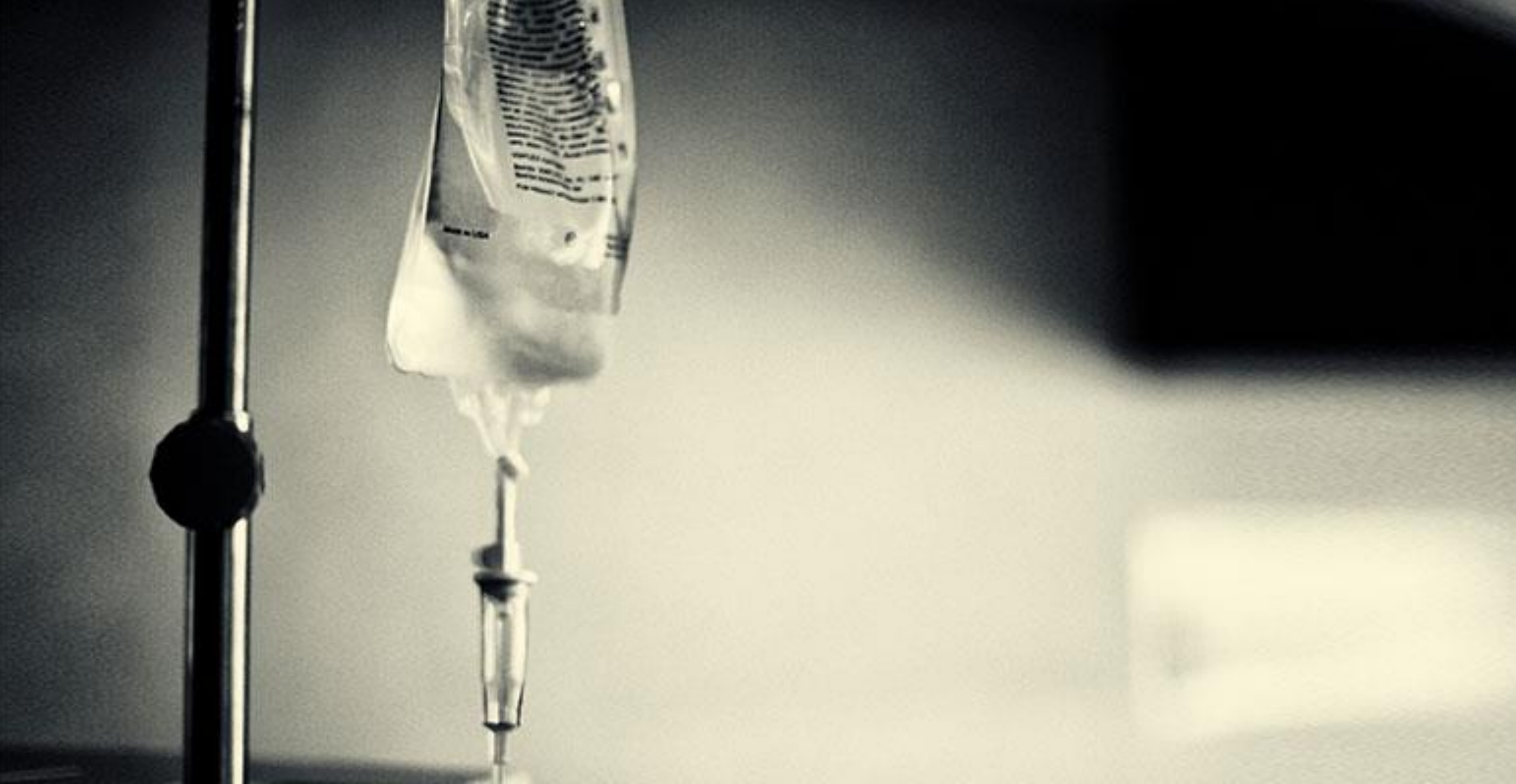

Fetal Alcohol Spectrum Disorder (FASD) in Detoxification Centers: A Call on Withdrawal Management Professionals to Become FASD-Informed

By Jerrod Brown, Rae Mitten, Cody Charette, and Bob Rohret

Abstract

This article explores the challenges associated with identifying and diagnosing fetal alcohol spectrum disorder (FASD) in detoxification centers throughout the United States. Detoxification centers are natural entry points to the health care system for many individuals with complex health conditions. These facilities continue to be under-utilized as a portal for screening, identifying, diagnosing, and treating patients with FASD. The purpose of this article is to increase awareness about the tremendous potential detoxification centers have for addressing these needs through the services they offer. Additionally, strategies for improving FASD services within these settings are discussed. This article assumes the reader has a basic understanding of FASD.

Detoxification Centers

Detoxification services typically exist in the United States as entities separate and distinct from mainstream health care settings. Initially developed as a unique service system, they have evolved to serve both public safety and public health functions. Within these centers, there is an omnipresent conflict at play in attempting to balance the sometimes-conflicting roles of public safety and public health, with

priority often given to public safety. In many cases, the use of physical restraints and seclusion room placement is common. When these procedures are used, program policies often emphasize practices of detention and security at the expense of more therapeutic interventions. Moreover, restraint, seclusion, and institutionalization are generally problematic for those with FASD, who may have problems coping with harsh sensory stimulation, including over- or under-stimulation, and may resort to various defensive or self-stimulating behaviors as a result (Mitten, 2013). While appearing authoritarian and correctional from the outside, in actuality detoxification centers such as these typically do not qualify as correctional placement, or as organizations overtly providing correctional services. Instead, freestanding detoxification centers are typically designed as short-term solutions providing stable environments and brief treatment for patients experiencing acute intoxication and/or withdrawal from alcohol and other drugs.

In contrast to extant public safety-focused policies, the freestanding detoxification centers often lack funding to adequately staff programs with qualified medical and behavioral health professionals. Nursing staff are often present at rounds and staff meetings, yet nursing care is seldom available 24 hours a day. Physician care also tends to be limited due to expense, resulting in telephone consultation with physicians or on-call services.

The reluctance of private insurers and Medicaid to acknowledge the value of detoxification centers and their services as medically necessary, by limiting reimbursement to hospital-based care, presents further challenges to resourcing the center with adequate health and medical personnel. A promising development in recent years has involved the transformation of detoxification centers to "withdrawal management" programs, conforming to American Society of Addiction Medicine (ASAM) criteria and qualifying for Medicaid reimbursement through states opting into Medicaid expansion. Withdrawal management programs often include multi-disciplinary teams that attend to whole-person health needs. ASAM also identifies severity within dimensions of health to better focus clinical interventions, applying the proper "dosage" of care based on this multi-dimensional assessment tool. Canada has advanced withdrawal management services in similar ways, although little attempt has been made to screen and diagnose for FASD in these Canadian centers, nor are the treatment methods used particularly FASD-informed (Mitten, 2004). Health plans vary greatly on the definition of "medical necessity," with most plans following Medicaid guidelines covering only the most expensive level of care involving hospital settings. The lack of medically trained professionals hired within detoxification centers leads to the under-identification and misdiagnosis of individuals with FASD, and therefore, the lack of positive, long-term outcomes (Chasnoff, Wells, & King, 2015; Petrenko, Tahir, Mahoney, & Chin, 2014; Sokol, Delaney-Black, & Nordstrom, 2003). Considering the higher rates of substance misuse and addiction problems associated with FASD (Grant, Brown, Graham, & Ernst, 2014; Streissguth, Barr, Kogan, & Bookstein, 1996), the probability of such individuals being seen in detoxification centers within the United States is very high. However, the actual prevalence rate of individuals with FASD coming into contact with detoxification centers is currently unknown, which only serves to emphasize the need for further research and epidemiological study (Mitten, 2011).

Screening Challenges

The challenges of screening and identifying FASD within detoxification settings are numerous. First and foremost, the short duration of stay typical at most detoxification centers does not allow sufficient time for the proper identification of intrinsic comorbid disorders such as FASD. This lack of time to make appropriate diagnoses by a staff with multi-disciplinary expertise, in conjunction with a lack of knowledge about FASD within the addiction treatment workforce, contributes to lower identification rates.

Further compounding the issues presented is overlapping, or latent masking, of the symptoms of FASD (Famy, Streissguth, & Unis, 1998; O'Connor et al., 2002). This overlapping can take many forms including short-term cognitive impairments from alcohol and neurological conditions such as traumatic brain injury (TBI) or Wernicke-Korsakoff syndrome (WKS). Unfortunately, even when an individual is successfully screened for FASD, many centers may not have appropriate referral options within their geographical region for further assessment and treatment, nor the expertise to adapt detoxification programming to accommodate individuals with FASD (Mitten, 2009).

Institutions for Mental Diseases (IMD)

One additional challenge facing addiction treatment providers and withdrawal management programs involves the "IMD Exclusion" under Medicaid law. The IMD Exclusion prevents federal dollars from being used to pay for care in programs with more than 16 beds. The IMD Exclusion was intended to prevent large mental health institutions from developing, while encouraging the development of smaller, community-based programs. While the law may have been well-intentioned, the result is that programs providing addiction care cannot expand beyond 16 beds without losing the federal share of their funding. One potential solution involves states applying for a waiver (1115b) through the Centers for Medicare and Medicaid Services (CMS), allowing the flow of federal dollars to programs with more than 16 beds, for up to 30 consecutive days. The 1115b waiver requires that states reform their addiction treatment system to include comprehensive care options, such as mental health, peer support, direct access to care, and care coordination services. Several states have applied for this waiver under CMS, though few have been successful to date in acquiring it. Statewide reform measures require extensive planning and complex reimbursement, licensing, and policy revisions. Addiction providers have advocated for exemption from this law, which was intended to prevent "institutionalization" of those requiring mental health services, a definition that does not conform to the typically shorter-term acute needs of those with addiction disorders.

Potential Strategies for Improvement

Efforts are currently underway nationwide to re-define the purpose and function of detoxification centers. The overall goal is to integrate the centers into the mainstream health care system (Ford & Zarate, 2010). Behavioral Health Homes (BHH) and Certified Community Behavioral Health Clinics (CCBHC) are two strategies that offers promise. Government strategies, at all levels, to develop withdrawal management centers as a component of Behavioral Health Homes and/or CCBHCs offer the potential to move away from short-term acute treatment of those suffering from addiction toward a longitudinal, chronic disease treatment model. If this reconceptualization of treating complex health conditions is successfully implemented, there would be little or no distinction between treatment of addiction disorders and other chronic diseases. In order to successfully integrate detoxification services and all other addiction services into mainstream health care, a better definition of the service is necessary. Detoxification and withdrawal management services must be clearly defined as medically necessary, with reimbursement provided by all health plans including Medicaid, regardless of severity of the disorder. There must be agreement among policy makers, health care plans, physicians, and the academic community that addiction and co-occurring disorders are medical conditions with established diagnostic criteria, treatment options, and billing protocols. There can be no confusion about the mission and purpose of detoxification and withdrawal management services. Not establishing a consistent identity or purpose for what constitutes these centers will only undermine the legitimacy of the research that

supports treating detoxification as a medically necessary service. However, those with addictions often present with a variety of co-occurring conditions besides FASD, which will require flexible approaches and accommodations fashioned by an informed staff (Mitten, 2003). Cost associated with the use of emergency rooms as primary care centers is receiving more attention daily as health care costs rise. By integrating primary care into behavioral health care settings, diagnoses along the spectrum of FASD may be more accurately identified, diagnosed, and treated. We need solutions that modernize detoxification centers and provide high-quality, cost-effective care for people with FASD and substance use disorders now more than ever before. In order to maximize efficacy of each center, it is important that they be located within a system of care that considers addiction as a chronic disease of the brain requiring specialized, therapeutic care and not as a condition warranting detention or other punitive measures.

Conclusion

Detoxification centers throughout the United States stand on the cusp of entering mainstream health care settings, including hospitals and their primary care physicians. With re-conceptualization of their identity through a redefined mission and purpose, these centers could serve as valuable resources for the identification and treatment of not just substance use disorders but also related mental health and neurocognitive disorders including the spectrum of disorders along the FASD continuum. With a reallocation of community resources, these centers could provide a valuable service to the community as a whole while reducing costs of crime and health care, which accumulate without specialized diagnosis and treatment. One should also be mindful that those with diagnoses of FASD or similar neurological conditions, coupled with addictions, often have a history of trauma. In fact, addictions may be a form of self-medication for such trauma, and thus detoxification and treatment services should also address the underlying condition precedent of trauma that may have led to addiction and the need for detox in the first place. Detoxification centers, then, are tasked with the duty of recognizing and accommodating numerous complex needs with which their patients may present. Location in and close liaison with the primary health care system are thus essential for properly addressing these complex needs. Ideally, the term "detox center" will fade into history, and treatment for addictions will evolve to the place where it is viewed as any other health condition would be.

Biographies

Jerrod Brown, M.A., M.S., M.S., M.S., is the Treatment Director for Pathways Counseling Center, Inc. Pathways provides programs and services benefiting individuals impacted by mental illness and addictions. Jerrod is also the founder and CEO of the American Institute for the Advancement of Forensic Studies (AIAFS), lead developer of an online Master of Arts in Human Services with an emphasis in Forensic Behavioral Health from Concordia University, St. Paul, Minnesota, and the Editor-in-Chief of Forensic Scholars Today (FST) and the Journal of Special Populations (JSP). Jerrod is currently in the dissertation phase of his doctorate degree program in psychology.

Rae Mitten, B.A., B.Ed., M.A., J.D., LL.M., Ph.D., is a researcher, lawyer, and former teacher in Saskatchewan, Canada. She has written fairly extensively on FASD from both a legal and interdisciplinary perspective, and she has benefited from her experience as an adoptive parent of three children with FASD, as well as from her career as a teacher-researcher in that field.

Cody Charette holds an M.A. and Ph.D. from the Psychology, Policy, and Law program of the California School of Forensic Studies at Alliant International University located in Fresno, California. He specializes in threat assessment, deception detection, intelligence analysis, and the use of technology for indirect assessment of offenders. In addition to his degrees in psychology, Cody holds a Bachelor of Science in business information systems with a mathematics minor and an MBA in marketing, both from California State University, Fresno.

Bob Rohret holds a Master of Public Health degree from the University of Iowa with an emphasis on Community and Behavioral Health. His primary focus for the past 22 years has centered on the treatment of addictions and co-occurring mental health disorders. He is currently employed as the Executive Director of a statewide association representing behavioral health programs and professionals in Minnesota. Bob also serves as a national consultant and trainer for the American Indian and Alaska Native Addiction Technology Transfer Center (AI/AN ATTC) under the College of Public Health at the University of Iowa.

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