WASHTENAW HEALTH INITIATIVE
SUBSTANCE USE

DETOX PROTOCOL GUIDE

A resource guide for
Healthcare Professionals
who work with persons
with substance use disorders in Washtenaw County

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ATTACHMENTS:

COMMUNITY RESOURCE GUIDE

LAMINATED PROTOCOL

Background

The work in this document is the culmination of the Mental Health and Substance Abuse workgroup of the Washtenaw Healthcare Initiative, which came together to identify system improvements needed to prepare for National Healthcare Reform and the expected influx of individuals on the existing safety net system. Low-income residents of Washtenaw County with no health insurance, Washtenaw Health Plan B, or Medicaid have limited or sometimes no access to covered mental health or substance abuse services. Widespread experience and perception among health care providers that MH/SA needs are substantial and frequently unmet. Resources to provide services may exist among: a) cost savings from avoided Emergency Room and hospital stays, b) expanded Medicaid benefit under health reform. Partnering with primary care for medical consultation at the detox and treatment providers may result in innovative ways to resolve existing barriers.

Clinical Rationale for the Washtenaw Detoxification Protocol

For Alcohol and/or Sedative-Hypnotics

Introduction

In Washtenaw County, in the State of Michigan, existing "social detoxification" programs are able to admit individuals with moderate pharmacological support when prescribed by their primary care physician, emergency department, or consulting physician. While benzodiazepines are generally recognized as the treatment of choice for alcohol withdrawal, there are reasons to consider alternative medications for the specialized purposes and treatment contexts as described below. In particular, the treatment settings; Dawn Farm and Home of New Vision, were initially designed for social detoxification without the use of medication. The Engagement Center is a sobering facility that can be used as an alternative to detox or diversion from the emergency departments. Over time, based on the experience of treatment professionals associated with these facilities, they began to accept patients in need of pharmacological detoxification only if taking Phenobarbital or Gabapentin when medication was indicated to treat either alcohol or other sedative-hypnotic withdrawal. The rationale for using phenobarbital, rather than benzodiazepines (BZDs), stems from considerations for safety, efficacy, and the level of professional supervision available during the detoxification process.

Phenobarbital has an extensive literature, and a long history to support its use for alcohol and sedative hypnotic withdrawal.(1) Like Oxazepan and Lorazepam, it does not give rise to pharmacologically active metabolites but differs in that the T ½ is up to 5 days vs. a mean T1/2 of about 12 hours. Clinically, the use of Oxazepan or Lorazepam requires dosing every 2 to 6 hours during active withdrawal, along with trained staff to make serial assessments (using, for example, the Clinical Institute Withdrawal Assessment-Alcohol, revised, or CIWA-Ar), and to then make judgments regarding appropriate dosing. (2)(3) In a social detoxification setting, there is no continuous supervision by licensed healthcare professionals. Staff has varying backgrounds and experience, so the use of a medication that allows relatively simple monitoring and response, rather than skilled assessment of vital signs and symptoms, is optimal.

Chronic, high dose alcohol can induce conformational changes in the GABA receptor which can manifest as benzodiazepine-resistant withdrawal. This may not become apparent for one or more days into the syndrome. Because barbiturates act on chloride channels without involving the BZD binding site on the GABA receptor, they tend to be more predictable in capturing symptoms so as to prevent the progression into severe withdrawal. This is especially relevant where there will be limited contact with the physician or other trained medical personnel beyond the initial assessment and prescription. (4,5)

Phenobarbital intoxicates very slowly in comparison to highly lipid-soluble benzodiazepines such as lorazepam and diazepam, and so rarely produces disinhibition and/or euphoria, leaving most substance-dependent patients relatively indifferent to its use. Alternatively, benzodiazepines such as oxazepam and chlordiazepoxide also act slowly and are useful when this is a concern. Like other social detoxification settings, licensed personnel to maintain accountability and a mechanism to account for or dispense controlled drugs are absent. Many of the staff are in recovery themselves. The presence of controlled substances poses a risk of relapse for staff and volunteers, and misuse by patients, particularly in the absence of established mechanisms to account for these medications. It is understood that both phenobarbital and benzodiazepines are Schedule IV controlled substances. (6)

The total dose of phenobarbital in a typical detoxification prescription is 450 - 600mg (30mg tid to qid x 5 days). The lethal dose of phenobarbital ranges from 2-10grams.(6) Given the fact that individuals who are dependent upon alcohol and sedatives are, by definition, highly tolerant to the effect of these substances, the risk of serious central nervous system (CNS) depression is relatively low. This is

especially true since the patient does not have the medication in his or her possession while being treated at one of these facilities, and is not given the remainder if they were to leave against medical advice (AMA).(5) Nevertheless, we appreciate that the total dose of phenobarbital required over 5 days does overlap with its lethal dose. Benzodiazepines, by contrast, have a more favorable therapeutic ratio. When taken alone, their lethal dose is relatively higher. For either long-acting benzodiazepines or phenobarbital, however, there is further concern for lethality if a patient leaves treatment and drinks due to the combination of either class of medication with alcohol. This may be less of a concern with a shorter-acting benzodiazepine such as oxazepam.(7, 8)

The management of patients undergoing alcohol and/or sedative withdrawal and having elevated liver enzymes or known liver impairment requires caution when using drugs that are metabolized by the liver. Where liver function tests (LFTs) are greater than 3 times normal, gabapentin or Oxazepan may be preferred as an alternative to Phenobarbital as the former do not undergo hepatic metabolism, whereas the latter may result in delayed clearance and related complications.(9,10,11)

Summary

(1) Hendey, et al. *A prospective, randomized, trial of phenobarbital versus benzodiazepines for acute alcohol withdrawal*, American Journal of Emergency Medicine. 2011 May;29(4):382-5. Epub 2010 March 25.

(2) Reoux and Oreskovich. A Comparison of Two Versions of the Clinical Institute Withdrawal Assessment for Alcohol: The CIWA-Ar and CIWA-AD. Am J Addict. 2006; 15: 85–93

(3) University of Michigan Clinical Homepage →Clinical References →Internal Guides and Protocols → Alcohol Withdrawal →ADULT Michigan Alcohol Withdrawal Guidelines (Updated 6/15/09) http://www.med.umich.edu/clinical/

(4) Hanver, et al. *Phenobarbital treatment in a patient with resistant alcohol withdrawal syndrome.* Pharmacotherapy. 2009 Jul;29(7):875-8.

(5) Cagetti, et al. *Withdrawal from chronic intermittent ethanol treatment changes subunit composition, reduces synaptic function, and decreases behavioral responses to positive allosteric modulators of GABA A receptors*. MolPharmacol. 2003; 63(1):53.

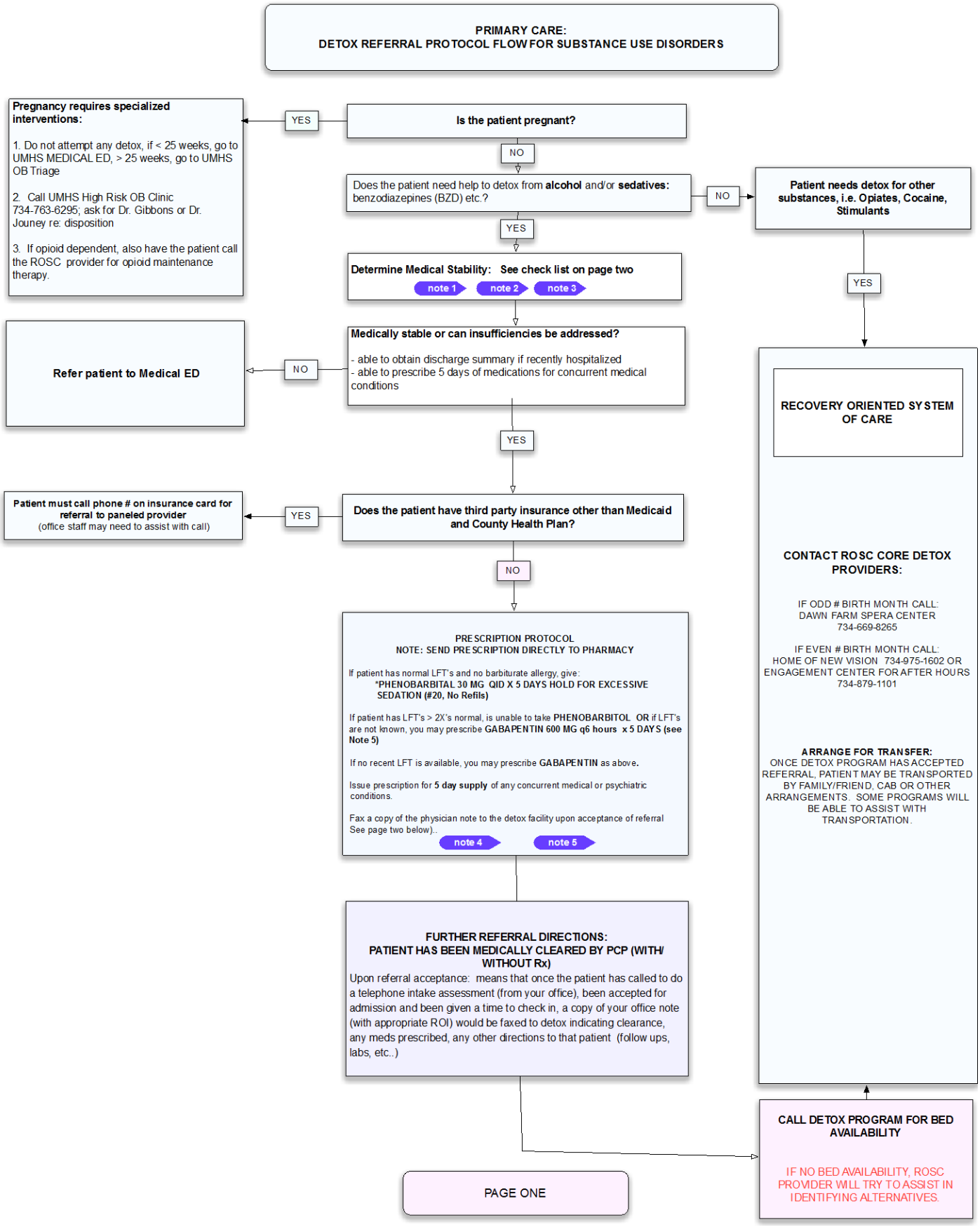
(6) Lindberg, et al. Acute Phenobarbital intoxication. South. Med. J. 1992 Aug; 85(8):803-7.

(7) Lowinson and Ruiz's Substance Abuse: A Comprehensive Textbook. By Pedro Ruiz, Eric C. Strain. Lippincott Williams & Wilkins (2011) - Hardback - 1074 pages - ISBN 1605472778

(8) Mariani, et al. *A randomized, open-label, controlled trial of gabapentin and phenobarbital in the treatment of alcohol withdrawal*. American Journalof Addictions. 2006 Jan-Feb;15(1):76-84.

(9) Voris, et al. Gabapentin for the treatmentof alcohol withdrawalSubst Abuse. 2003 Jun; 24(2):129-32.

(10) Bonnet U, et al. An open trial of gabapentin in acute alcohol withdrawal using an oral loading protocol. Alcohol Alcohol. 2010 Mar-Apr; 45(2):143-5. Epub 2009 Dec 17. PubMed PMID: 20019070.


PRIMARY CARE:
DETOX REFERRAL PROTOCOL FLOW FOR SUBSTANCE USE DISORDERS
Is the patient pregnant?
YES
Pregnancy requires specialized interventions:
1. Do not attempt any detox, if < 25 weeks, go to UMHS MEDICAL ED, > 25 weeks, go to UMHS OB Triage
2. Call UMHS High Risk OB Clinic 734-763-6295; ask for Dr. Gibbons or Dr. Jouney re: disposition
3. If opioid dependent, also have the patient call the ROSC provider for opioid maintenance therapy.
NO
Does the patient need help to detox from alcohol and/or sedatives: benzodiazepines (BZD) etc.?
NO
Patient needs detox for other substances, i.e. Opiates, Cocaine, Stimulants
YES
Determine Medical Stability: See check list on page two
note 1
note 2
note 3
YES
Medically stable or can insufficiencies be addressed?
- able to obtain discharge summary if recently hospitalized
- able to prescribe 5 days of medications for concurrent medical conditions
NO
Refer patient to Medical ED
YES
RECOVERY ORIENTED SYSTEM OF CARE
CONTACT ROSC CORE DETOX PROVIDERS:
IF ODD # BIRTH MONTH CALL:
DAWN FARM SPERA CENTER
734-669-8265
IF EVEN # BIRTH MONTH CALL:
HOME OF NEW VISION 734-975-1602 OR
ENGAGEMENT CENTER FOR AFTER HOURS
734-879-1101
ARRANGE FOR TRANSFER:
ONCE DETOX PROGRAM HAS ACCEPTED REFERRAL, PATIENT MAY BE TRANSPORTED BY FAMILY/FRIEND, CAB OR OTHER ARRANGEMENTS. SOME PROGRAMS WILL BE ABLE TO ASSIST WITH TRANSPORTATION.
Does the patient have third party insurance other than Medicaid and County Health Plan?
YES
Patient must call phone # on insurance card for referral to paneled provider
(office staff may need to assist with call)
NO
PRESCRIPTION PROTOCOL
NOTE: SEND PRESCRIPTION DIRECTLY TO PHARMACY
If patient has normal LFT's and no barbiturate allergy, give:
*PHENOBARBITAL 30 MG QID X 5 DAYS HOLD FOR EXCESSIVE SEDATION (#20, No Refils)
If patient has LFT's > 2X's normal, is unable to take PHENOBARBITOL OR if LFT's are not known, you may prescribe GABAPENTIN 600 MG q6 hours x 5 DAYS (see Note 5)
If no recent LFT is available, you may prescribe GABAPENTIN as above.
Issue prescription for 5 day supply of any concurrent medical or psychiatric conditions.
Fax a copy of the physician note to the detox facility upon acceptance of referral See page two below)..
note 4
note 5
FURTHER REFERRAL DIRECTIONS:
PATIENT HAS BEEN MEDICALLY CLEARED BY PCP (WITH/ WITHOUT Rx)
Upon referral acceptance: means that once the patient has called to do a telephone intake assessment (from your office), been accepted for admission and been given a time to check in, a copy of your office note (with appropriate ROI) would be faxed to detox indicating clearance, any meds prescribed, any other directions to that patient (follow ups, labs, etc..)
CALL DETOX PROGRAM FOR BED AVAILABILITY
IF NO BED AVAILABILITY, ROSC PROVIDER WILL TRY TO ASSIST IN IDENTIFYING ALTERNATIVES.
PAGE ONE

NOTES FROM PAGE ONE

note 1

MEDICALLY STABLE: The condition is either not active or if active, is manageable with appropriate medications/monitoring, that the patient has adequate medication to cover the detox stay (5 days) and has the ability to independently participate in managing their condition if this is required, i.e., use, glucometer, draw up/inject insulin, do dressing changes, foot soaks, etc.)

MEDICALLY STABLE:
Does the patient have any of the following conditions?

1. History of seizure disorder regardless whether the patient is on medications or not.
3. Hospitalized in the past week with no discharge information immediately available.
4. History of head injury with LOC in last 72 hours.
5. History of alcohol or BZD withdrawal related complications, e.g. seizures, delirium, cardiac Chest pain or difficulty breathing in the last 48 hours.
6. Current suicidal ideation or attempt in the past month.
7. Rx medications, patient does not know the types or dosage (see note 2).
8. Vitals are above the accepted range (see note 3)
9. History of benzodiazepine use for more than one week.
10. Psychiatric hospitalization in the past month.
11. Patient is taking medication listed in the alert box…
12. Patient is on prescription medication, knows the meds and the dose, but does not have a five day supply.

note 2

MEDICATION ALERTS:
Contact the DETOX Triage Physician if Patient is taking one or more of the following meds:

Wafarin (Coumadin)
Prednisone
Nitroglycerin
Digoxin
Phenobarbital
Any Meds for Seizure Disorder

PLEASE GIVE Rx FOR FIVE DAYS!

note 3

VITAL SIGNS ABOVE THE EXPECTED RANGE:

The decision point to a send a patient from detox to the ED because of elevated vital signs:

SBP>200, x2 at 1 hour interval, send to ED; DBP>100 – 120 x2 at 1 hour interval, send to ED;Pulse > 130 x 2 at 1 hour interval

**any VS above these values at a 1 time reading + chest pain, tightness, SOB, dizziness or other Sx, client sent to ED for evaluation

Once at ED, question for physician is what is the cause? can abnormal situation be treated to move into a "stable" situation (i.e, medication for withdrawal, B/P, etc. if so, can send client back to detox with meds/ instructions, if not, decision is whether to medically admit for stabilization

note 4

PHARMACIES

CVS PLYMOUTH ROAD
ANN ARBOR
734-994-3636

WENK'S PRESCRIPTION SHOP
ANN ARBOR 734-747-8080

NOTE: Detox And Rx Should Be Transmitted By Phone Or Electronically. Do Not Hand Patient Paper Or "Starter" Doses. Detox Program Will Assist With Getting Rx Filled.

note 5

GABAPENTIN Rx:

Myrick, et al, A double-blind trial of Gabapentin versus lorazepam in the treatment of alcohol withdrawal. Alcohol Clin Exp Res. 2009 Sep; 33(9):1582-8. Epub 2009 May 26.

CONCLUSIONS: Gabapentin was well tolerated and effectively diminished the symptoms of alcohol withdrawal in our population especially at the higher target dose (1200 mg) used in this study. Gabapentin reduced the probability of drinking during alcohol withdrawal and in the immediate post withdrawal week compared to lorazepam. *more extensive explanation for use of Gabapentin will be given in "Clinical Rationale" accompanying this document", this will be available for review prior to finalization. Gabapentin is eliminated from the systemic circulation by renal excretion as unchanged drug. Gabapentin is not appreciably metabolized in humans, requires no dose adjustment in presence of liver disease and is relatively non-abusable in a setting where there is no clear mechanism to account for benzodiazepines.

PAGE TWO

WASHTENAW DETOX PROTOCOL
GLOSSARY OF TERMS

Abstinence: Refraining from the use of alcohol, illicit drugs and other addictions. Examples of other addictions include, but are not limited to, smoking, eating disorders, gambling, and self- harm.

Abstinence-Based Recovery: The strategy of complete and enduring cessation of the use of alcohol, drugs and/or other addictions. Examples of other addictions include, but are not limited to, smoking, eating disorders, gambling, and self-harm. The achievement of this strategy remains the most common definition of recovery in addiction, but the necessity to include it in this glossary signals new conceptualizations of recovery that are pushing the boundaries of this definition.

Acute Detox: Detoxification procedures managed in an acute inpatient setting where the withdrawal process is life threatening and needs intensive medical supports.

Acute Episodes: A period when a chronic illness is most intense. It includes flare-ups during periods when the chronic illness has been otherwise controlled or in remission. Acute episodes are indicated by marked increase or intensity in the severity of the illness. These episodes require immediate attention and can be short term if given an appropriate intervention and support.

Acute Illness: Rapid and severe onset of illness.

Acudetox (Auricular Detox): The specific application of Acupuncture techniques to five points on the ear for the purpose of treatment or relapse prevention of substance use disorders.

Addiction: A chronic disease, characterized by compulsive (loss of control) substance seeking or using behavior or other behavior despite adverse health, social, or legal consequences to continued use.

Alcoholism: A disease characterized by excessive and habitual intake of alcoholic beverages or other liquids containing alcohol resulting in physical, psychological, and social harm.
American Society of Addiction Medicine (ASAM): A professional organization for physicians who specialize in the treatment of addiction.

ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition - Revised (ASAM PPC-2R): This document contains the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with alcohol and other drug problems. It provides two sets of guidelines, one for adults and one for adolescents, and five broad levels of care for each group. Within these broad levels of service is a range of specific levels of care.
Bureau of Substance Abuse and Addiction Services (BSAAS): Located within the Michigan Department of Community Health, Mental Health and Substance Abuse Administration, oversees the administration of the state's public substance use disorder service network of prevention, treatment, and recovery services. In addition, BSAAS administers the problem gambling program, which includes education, prevention and treatment services, and a 24-hour help-line.

Care Coordination: The facilitation of access to specialized services, and community and natural supports to ensure that needs of the individual are met.

Case Management: A process to coordinate behavioral health care resources used in the provision of care and services.

Chemical Dependency: A general term used to describe a physical and/or psychological reliance on alcohol, tobacco or other drugs.

Choice: The manner in which the person selects their individualized treatment, rehabilitation, recovery, and life from a variety of options. This is a key concept in recovery-oriented care.

Confidentiality: Refers to the rules and regulations that protect the individual being served and the information that must not be conveyed to another individual in any written, spoken, or inferred manner. Authorization must be acquired from the individual to allow for the exchange of information. Specific laws and regulations regarding confidentiality can be found in 42 CFR. Part 2, and the Health Insurance Portability and Accountability Act (HIPAA).

Continuing Care: Ongoing services and supports for chronic conditions. Continuity of Contact: Sustained relationships within services and supports, over the course of recovery.

Continuum of Care: An available range of service types utilized to address the level of needs individuals have over time.

Co-occurring Disorder: A term used when a person has both a mental health disorder and a substance use disorder. Both the mental health and the substance use disorders may create significant challenges, but the interactions of these disorders require integrated treatment.

Coordinating Agency: Organizations established by law that are responsible for the performance of administrative functions and assuring compliance with federal and state mandates and guidelines for the division of SUD services. Additional responsibilities include assessing the substance abuse services needs within their region, establishing a panel of providers to address these needs, and monitoring provider contract compliance.

Detoxification: The metabolic process by which the toxic qualities of a poison or toxin are eliminated by the body. Pertaining to addiction, it is generally a medically supervised treatment for alcohol or drug addiction designed to purge the body of intoxicating or addictive substances. Such a program is used as a first step in overcoming physiological or psychological addiction.

Detoxification (as a service): A set of interventions performed within a treatment program aimed at managing acute intoxication and withdrawal. It denotes to a clearing of toxins from the body of the patient who is acutely intoxicated and or dependent on substances of abuse.

Disease Model of Addiction: Identifies addiction as a primary, chronic disease with genetic, physiological, psychosocial and environmental factors influencing its development and manifestations.

Disease Management: A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. It is the process of reducing healthcare costs and/or improving quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition, through integrative care. The common goal is to enhance clinical outcomes by developing and implementing methods and technologies that result in symptom abatement and the reduction of the number, intensity and duration of needed service interventions.

Early Intervention: (two definitions)

Prevention “Early Intervention” is a term generally used to describe those early efforts to intervene when an individual is seen as being at risk or in the early stages of use (not yet indicating a need for treatment).

Treatment “Early Intervention” refers to specifically focused programs, including stage- based intervention for persons with substance use disorders, as identified through a screening or

assessment process, including individuals who may not meet the threshold of abuse or dependence.
Engagement: Implementing a process to successfully connect and retain individuals in a treatment or therapeutic program.

Harm Reduction (as a stage of recovery): A set of practical strategies that reduce negative consequences of substance use.

Illness Self-management: An intervention designed to empower individuals to better manage their illness in which the individual takes responsibility for doing what is necessary to manage his/her illness effectively in partnership with professional care providers and support systems.

Integrated Treatment: A treatment practice in which multiple disorders or concerns are addressed through a primary provider. In this treatment approach, the primary provider engages in the provision of direct services with an individual and facilitates the acquisition of other needed services that may not be available at the primary provider site. This treatment approach acknowledges the interaction or interrelationship of the multiple disorders, and service planning addresses these interactions.

Medication-Assisted Recovery: The use of specific medications, in combination with counseling and/or other components of recovery.

Motivational Interviewing (MI): A structured therapeutic practice that addresses barriers to change through the resolution of ambivalence and focuses on intrinsic motivation and values. MI is not limited to a set of techniques or tools, and is a style of interacting with clients that supports the collaborative partnership to which each brings valued expertise.

Natural Recovery: A term used to describe those who have initiated and sustained recovery within their environment and without professional intervention.

No Wrong Door: A term used to describe a philosophy and practice where individuals can go to any agency to find the information, services and referral they are seeking.

Outpatient Therapy: A wide variety of programs for people who visit a clinic at regular intervals. Most of the programs involve individual or group counseling. It is a program where individuals are treated, while residing at home or in another supportive environment.

Paths to Recovery: The many different ways people use to achieve recovery. Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors and expectations for recovery. An individual's path to recovery is highly personal and can involve a redefinition of identity or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources that provide support. Recovery is a process of change that permits an individual to make healthy choices and improve the quality of his or her life.

Peer: A person in a journey of recovery who identifies with an individual based on shared background and life experience.

Peer-Delivered Service: Any service or support provided by a person in recovery from a mental health and/or substance use Peer Specialist: A peer (see above) who has been trained to utilize their personal history of recovery to share hope and provide support to people in their own journey of recovery condition.

Person in Recovery: A person who has chosen to address attitudes and behaviors that interfere with his/her desired quality of life, and has chosen to learn skills that will support personal wellness.

Recovery Capital: The quantity and quality of both internal and external resources that a person can utilize to initiate and maintain recovery.

Recovery Centers: Places where recovery support services are designed, tailored, and delivered to individuals within local communities.

Recovery Coach: An individual who links the recovering persons to the community, serves as a personal guide or mentor in the process of personal and family recovery, and helps remove personal and environmental obstacles.

Recovery Community: A term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that includes both professionals working in the addictions field and recovery supporters within the wider community.

Relapse: The process of returning to patterned thoughts and behaviors, and/or active substance use after a period of stability. Relapse is considered to be part of the recovery process and a component of a chronic disease, and should be viewed as an opportunity for learning.

Relapse Prevention: A method of teaching recovering individuals to recognize and manage relapse warning signs. This includes teaching the individual about the relapse process, and how to manage it, as well as identifying the problems and situations that may cause a relapse (triggers).

Residential Treatment Program: Services that are provided in a full or partial residential setting where individuals reside while receiving services. Such services may be supplemented with diagnostic services, counseling, vocational rehabilitation, work therapy, or other services that are judged to be valuable to clients in a therapeutic setting. Levels of residential services are defined by the *American Society of Addiction Medicine.*

Social Detoxification: Detoxification in an organized residential non-medical setting delivered by appropriately trained staff that provides safe, twenty-four-hour monitoring, observation, and support in a supervised environment. It is characterized by its emphasis on peer and social support and it provides care for clients whose intoxication or withdrawal signs and symptoms are sufficiently severe to require twenty-four-hour structure and support.

Stages of change: As identified by Prochaska and DiClemente, levels of readiness to modify behavior:

1) *Pre-contemplation:* The user is not considering change, is aware of few negative consequences, and is unlikely to take action soon.
2) *Contemplation:* The user is aware of some pros and cons of substance abuse but feels ambivalent about change. This user has not yet decided to commit to change.
3) *Preparation:* This stage begins once the user has decided to change and begins to plan steps toward recovery.
4) *Action:* The user tries new behaviors, but these are not yet stable. This stage involves the first active steps toward change.
5) *Maintenance:* The user establishes new behaviors on a long-term basis.

Stigma: The assignment of an attribute, behavior, or reputation that is socially discrediting.

Substance Abuse: Refers to the overindulgence in and dependence on a drug or other chemical, leading to effects that are detrimental to the individual's physical and mental health and/or the welfare of others.

Substance Dependence: An individual's persistence in use of alcohol or other drugs despite problems related to use of the substance. Compulsive and repetitive use may result in tolerance to the effect of the drug and withdrawal symptoms when use is reduced or stopped. This can be diagnosed with or without physiological dependence, evidence of tolerance or withdrawal.

Substance Use Disorders: Those disorders in which repeated use of alcohol and/or other drugs results in significant adverse consequences. Substance dependence and substance abuse are both considered substance use disorders.

Tolerance: The need for increased amounts of a substance to achieve intoxication or a desired effect.

Treatment: An array of services whose intent is to enable the individual to cease substance abuse in order to address the psychological, legal, financial, social, and physical consequences that can be caused by abuse or dependence.

Twelve-Step (12-Step): A program designed to assist in the recovery from addiction or compulsive behavior, especially a spiritually-oriented program based on the principles of acknowledging one's personal responsibility and accepting help from a higher power. Examples of such programs include Alcoholics Anonymous, Al-anon, Al-Ateen, Cocaine Anonymous, and Narcotics Anonymous.

Wellness: A term generally used to mean a healthy balance of the mind, body and spirit, which results in an overall feeling of well-being. Additionally, it is considered an active process of becoming aware of and making choices toward a more successful and fulfilling life.

Withdrawal: The characteristic psychological and physiological signs and symptoms that appear when alcohol, or another drug that causes physical dependence, is regularly used and then is suddenly discontinued or decreased in dosage.

Adopted from: Michigan's ROSC Glossary of Terms 12 February 2011