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Overview of BJA Guidelines for Managing Substance Withdrawal in Jails: Other Withdrawal

PRESENTED BY:
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LEARNING OBJECTIVES

- Relate guidelines recommendations for alcohol and sedative hypnotic screening, assessment, and monitoring
- Summarize the recommendations for treatment of alcohol withdrawal
- Summarize the recommendations for treatment of sedative hypnotic withdrawal

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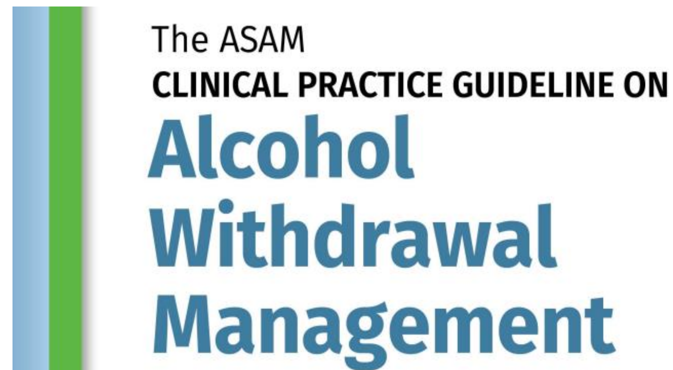
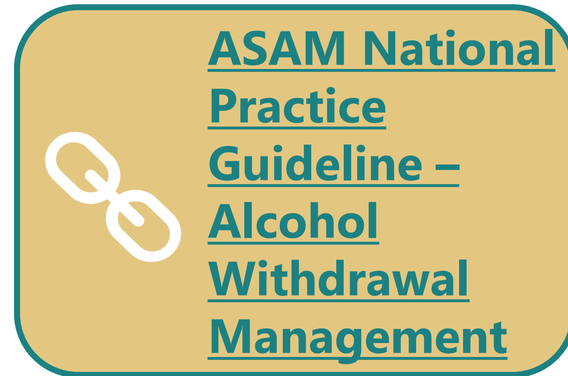
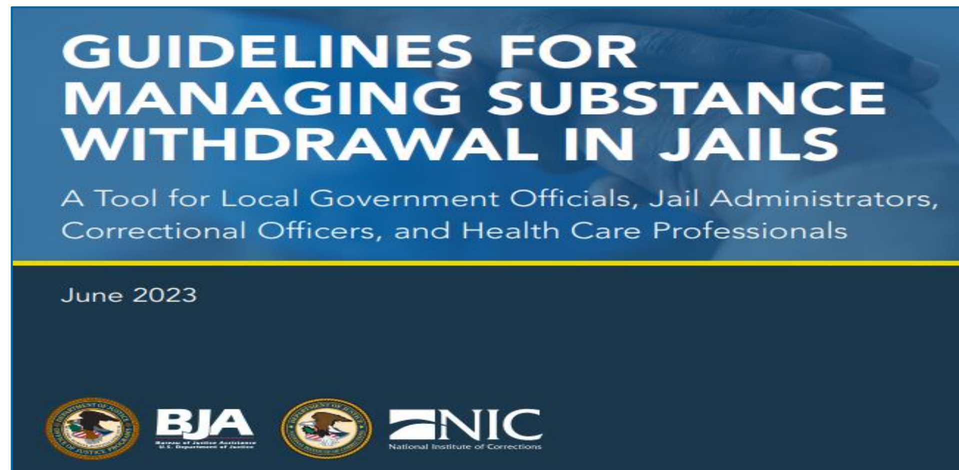
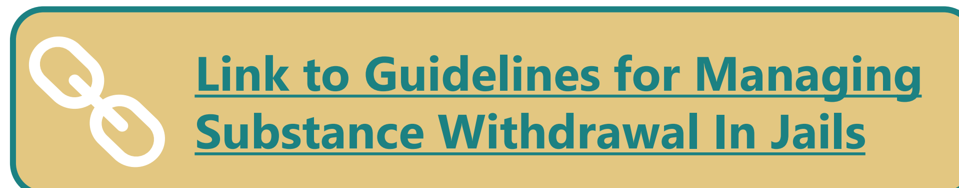
ONE STANDARD OF CARE

- Bureau of Justice Assistance (BJA) & National Institute of Corrections (NIC) guidance aligns with ASAM National Practice Guidelines
- BJA NIC Guidelines are for:
  - Local Government Officials
  - Jail Administrators
  - Correctional Officers
  - Jail & Community Health Care Professional









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BACKGROUND

- Alcohol is the most used substance of abuse
- Alcohol-related deaths increased 25% from 2019 to 2020, despite only a 16% increase in all cause mortality
- Alcohol-related emergency department visits exceeded 2.9 million in 2021, compared to 2.5 million for all other drugs combined
- Annual estimated hospital costs for SUD was 13.2 billion, 7.6 billion attributed to alcohol

SAMHSA. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
SAMHSA. (2022). Preliminary Findings from Drug-Related Emergency Department Visits, 2021; Drug Abuse Warning Network (HHS Publication No. PEP22-07-03-001). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.
White, A. M. et al. (2022). Alcohol-Related Deaths During the COVID-19 Pandemic. JAMA, 327(17), 1704–1706. https://doi.org/10.1001/jama.2022.4308

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WHY IS MANAGING ALCOHOL WITHDRAWAL IN JAILS IMPORTANT?

- Undetected, unmonitored, and untreated withdrawal can lead to seizures, delirium and death
- Most common cause of substance withdrawal-related death while incarcerated, accounting for 64%

Photo by Matthew Ansley on Unsplash

Fiscella, K. et al. (2020). Drug- and Alcohol-Associated Deaths in U.S. Jails. Journal of correctional health care : the official journal of the National Commission on Correctional Health Care, 26(2), 183–193.

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SCREENING

- Establish recent use
- 59% of people with alcohol dependence will experience withdrawal based on DSM IV criteria

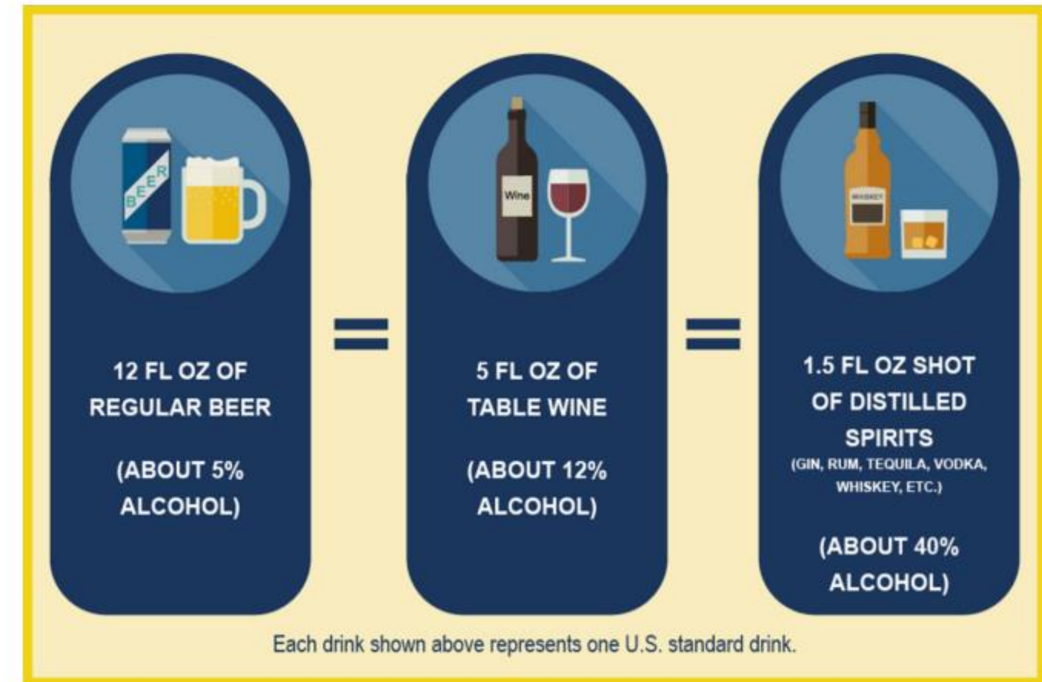

Exhibit 1: U.S. standard drink equivalents (Adapted from National Institute on Alcohol Abuse and Alcoholism)

Image Source: *BJA/NIC Guidelines for Managing Substance Withdrawal in Jails(2023)*

Schuckit, M. A. et al. (2003). A 5-year prospective evaluation of DSM-IV alcohol dependence with and without a physiological component. Alcoholism, clinical and experimental research, 27(5), 818–825. https://doi.org/10.1097/01.ALC.0000067980.18461.33

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REFER FOR IMMEDIATE CLINICAL ASSESSMENT

- If a person appears intoxicated or breathalyzer indicates intoxication
- Any alcohol over past week and a history of complicated withdrawal
- Self report risk of alcohol withdrawal, regardless of amount of alcohol consumption reported

8 or more standard drinks/ day for men on 4 or more days/week for men

6 or more standard drinks/ day on 4 or more days/week for women

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WITHDRAWAL ONSET

- Withdrawal symptoms occur within 6-24 hours after last drink
- Alcohol withdrawal delirium can occur within 96 hours of last drink

BAC	Time	# hours
.4	12AM	0
.38	1 AM	1
.36	2 AM	2
.34	3 AM	3
.32	4 AM	4
.30	5 AM	5
.28	6 AM	6
.26	7 AM	7
.24	8 AM	8
.22	9 AM	9
.20	10 AM	10

BAC	Time	# hours
.18	11 AM	11
.16	12 PM	12
.14	1 PM	13
.12	2 PM	14
.10	3 PM	15
.08	4 PM	16
.06	5 PM	17
.04	6 PM	18
.02	7 PM	19
.0	8 PM	20

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SIGNS AND SYMPTOMS OF WITHDRAWAL

Table A-1: Possible Indicators of Alcohol Withdrawal*[18]

Many conditions listed below are expected responses to incarceration but, when presented as part of a constellation of symptoms, may indicate alcohol withdrawal.	
• Agitation‡	• Loss of appetite
• Anxiety or nervousness	• Mood swings
• Depression	• Nausea and vomiting
• Difficulty thinking clearly	• Nightmares
• Fatigue	• Pallor
• Fever‡	• Rapid heart rate
• Hallucinations‡	• Elevated blood pressure
• Insomnia	• Seizures‡
• Headache	• Severe confusion‡
• Irritability	• Sweating, clammy skin
• Jumpiness or shakiness	• Tremor of the hands or other body parts

*Staff should be alert to any indications that an individual is unwell, not only those listed here.
‡Indicative of alcohol withdrawal delirium

Image Source: *BJA/NIC Guidelines for Managing Substance Withdrawal in Jails(2023)*

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MONITOR FOR WITHDRAWAL

- Every 6 hours using a validated tool
- Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised CIWA-Ar
  - Measures severity of withdrawal
- When withdrawal symptoms occur refer for clinical assessment

Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). *British journal of addiction*, *84*(11), 1353–1357. https://doi.org/10.1111/j.1360-0443.1989.tb00737.x

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CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-AR)

- Alcohol withdrawal severity assessment
- Public domain
- Anchors (descriptions) are provided
  - No nausea and no vomiting=0
  - Mild nausea=1
- Does not include vitals
- Well validated
- Can be conducted by healthcare staff or well-trained custody officers
- Not the only alcohol withdrawal measure
- Should not be used alone because scores can be influenced by other conditions and medications

MD+ CALC
Search "QT interval" or "QT" or "EKG"

CIWA-Ar for Alcohol Withdrawal

The CIWA-Ar objectifies severity of alcohol withdrawal.

When to Use | Pearls/Pitfalls | Why Use

Nausea/vomiting
Ask 'Do you feel sick to your stomach? Have you vomited?'

Option	Points
No nausea and no vomiting	0
Mild nausea and no vomiting	+1
(More severe symptoms)	+2
(More severe symptoms)	+3
Intermittent nausea with dry heaves	+4
(More severe symptoms)	+5
(More severe symptoms)	+6
Constant nausea, frequent dry heaves and	

https://www.mdcalc.com/calc/1736/ciwa-ar-alcohol-withdrawal

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CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL REVISED (CIWA-AR)

- **Nausea/Vomiting:** "Do you feel sick to your stomach? Have you vomited?" Observation
- **Tremor:** arms extended, and fingers spread apart. Observation
- **Paroxysmal Sweats:** Observation
- **Anxiety:** "Do you feel nervous?" Observation
- **Agitation:** Observation
- **Tactile Disturbances:** "Have you any itching, pins & needles, any burning, numbness or do you feel bugs crawling under your skin?" Observation
- **Auditory Disturbance:** "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything disturbing you? Are you hearing things you know are not there?" Observations
- **Visual Disturbance:** "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing you? Are you seeing things you know are not there?" Observation
- **Headache or fullness in the head:** "Does your head feel different? Does it feel like there is a band around your head? " Do not rate dizziness or lightheadedness.
- **Orientation and clouding of sensorium:** "What day is this? Where are you? Who am I?" Observation

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Sullivan, J. T., et al. (1989).

ALCOHOL WITHDRAWAL SEVERITY

Severity Category	Associated CIWA-Ar Range*	Symptom Description
Mild	CIWA-Ar <10	Mild or moderate anxiety, sweating and insomnia, but no tremor
Moderate	CIWA-Ar 10-18	Moderate anxiety, sweating, insomnia, and mild tremor
Severe	CIWA-Ar ≥19	Severe anxiety and moderate to severe tremor, but no confusion, hallucinations, or seizure
Complicated	CIWA-Ar ≥19+	Seizures or signs and symptoms indicative of delirium – such as an inability to fully comprehend instructions, clouding of the sensorium or confusion – or new onset of hallucinations

Source: American Society of Addiction Medicine. (2020). *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*. American Society of Addiction Medicine, Inc. https://www.asam.org/quality-care/clinical-guidelines/alcohol-withdrawal-management-guideline. Retrieved 9.22.23

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CLINICAL ASSESSMENT CONSISTS OF:

- Focused medical history
  - Conditions with symptoms that look like or mask alcohol withdrawal
  - Medication that can cause similar symptoms to or mask alcohol withdrawal
- Review or completion of vital signs
- Review or completion of CIWA
- Evidence of sedation
- Hydration status
- Factors associated with increased risk of complicated withdrawal

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RISK OF COMPLICATED WITHDRAWAL

- Age >65
- History of complicated withdrawal
- Multiple prior withdrawal episodes
- Comorbid illness (e.g., traumatic brain injury)
- Marked autonomic instability at presentation
- Long duration of heavy alcohol consumption
- Seizure during current withdrawal episode
- Physiological dependence on sedatives
- Positive alcohol test in the presence of signs of withdrawal

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CLINICAL ASSESSMENT

- Completion of the CIWA does not replace a clinical assessment
- Completion of clinical assessment can be conducted
  - In person or via telehealth
- Frequency of clinical assessment
  - At least every 8 hours during withdrawal treatment
    - until the CIWA is below 10 for 24 hours
  - If CIWA-Ar >19 repeat every 6 hours until score falls below 19, then every 8 hours

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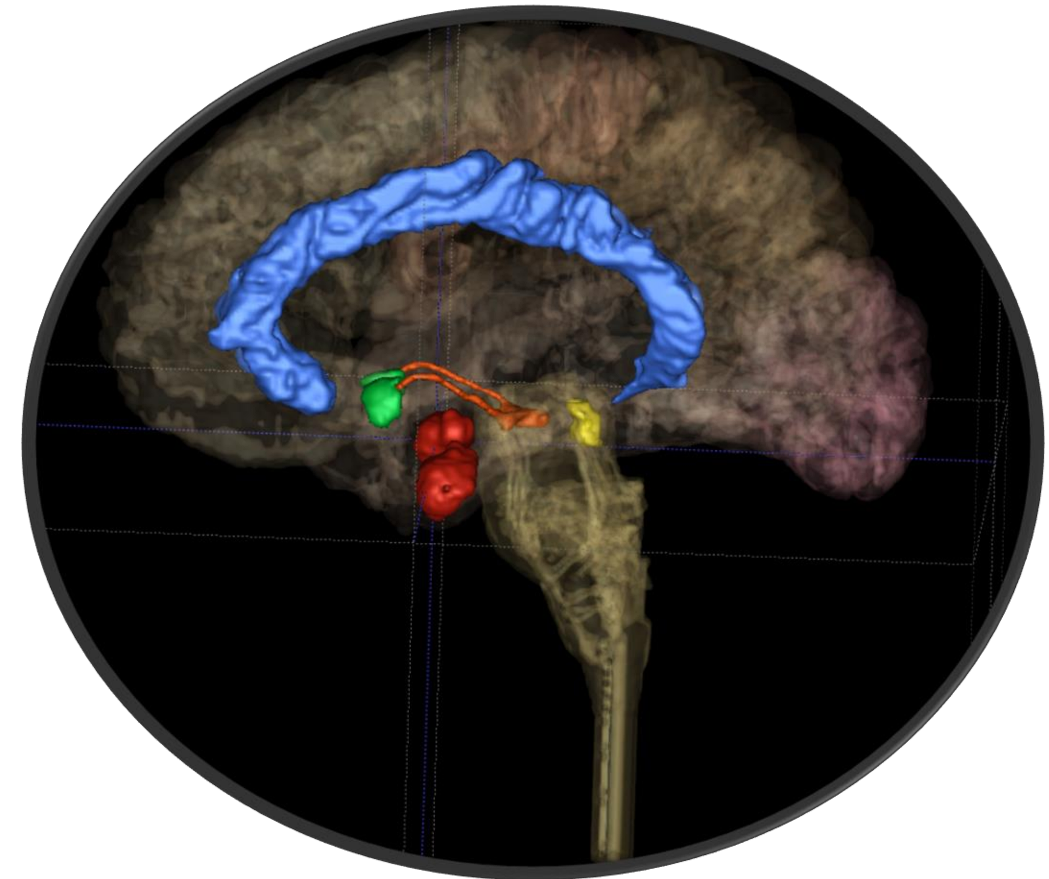
COMPLICATED WITHDRAWAL

- Psychosis
- Seizures
- Delirium (confusion and often hallucinations)
  - Wernicke's encephalopathy
    - Confusion
    - Loss of muscle coordination (leg tremor or unsteady gait)
    - Vision changes (due to paralysis of eye muscles)



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TRANSFER TO HIGHER LEVEL OF CARE IF…

- Worsening medical or mental health condition during alcohol withdrawal
- Moderate or severe withdrawal with comorbid conditions
- Unstable vital signs
- Severe withdrawal
- Current complications of withdrawal
- Severe ongoing sedation
- If the person requires transfer, then treat immediate needs while awaiting transfer
  - Thiamine
  - Benzodiazepines

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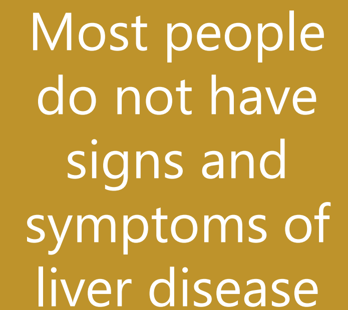
BENZODIAZEPINES

- Longer acting benzodiazepines are preferred due to:
  - Longer duration of action
  - Greater symptom control
  - Fewer rebound symptoms
- If signs and symptoms of liver disease use benzodiazepine with less hepatic metabolism:
  - Oxazepam
  - Lorazepam



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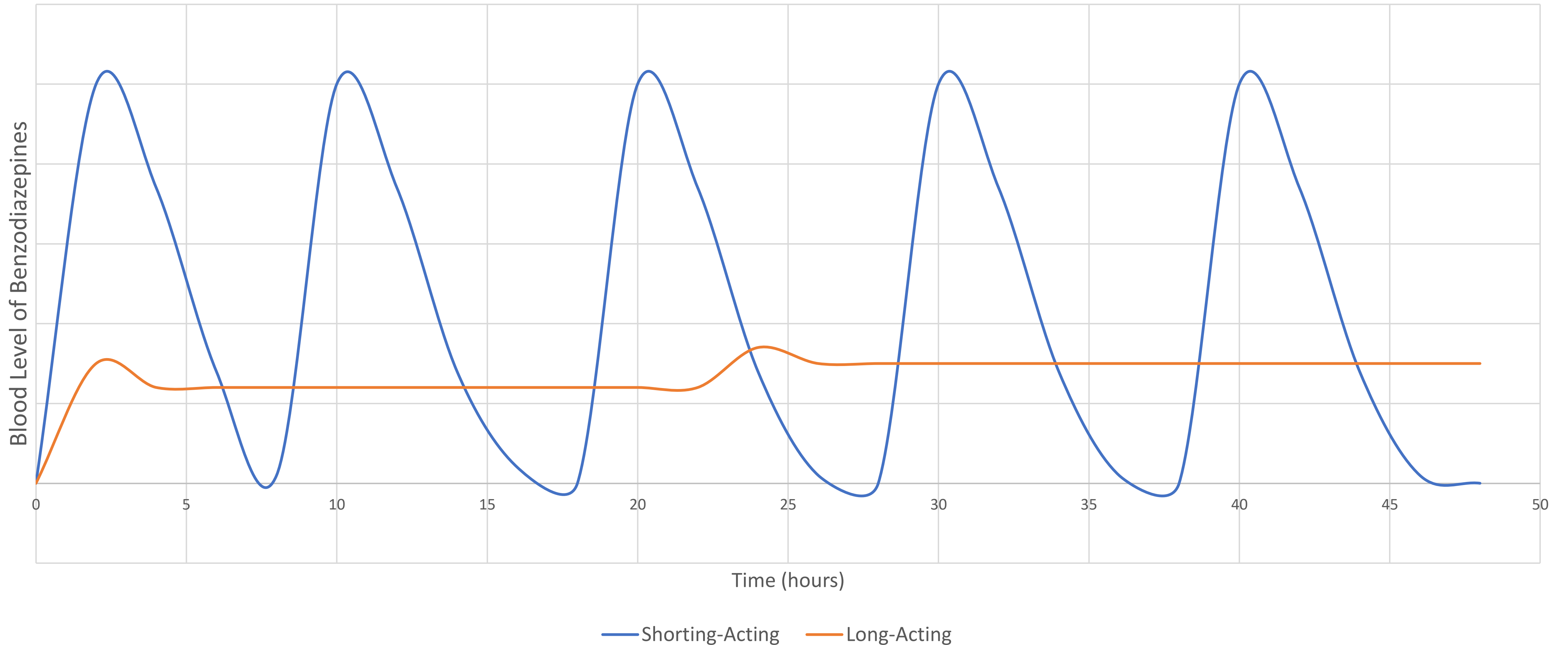
SHORT VS LONG-ACTING BENZODIAZEPINES



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ALCOHOL WITHDRAWAL: DOSING REGIMENS

Single dose
- For those at low risk of alcohol withdrawal

Front loading
- Moderate to high doses of long-acting agents given at the start of treatment
- Can be followed by symptom triggered or fixed dose regimens
- Recommended for patients at risk of severe or complicated withdrawal

Symptom triggered
- Patients are given medication only when symptoms cross a threshold

Fixed dose
- A predetermined dose is administered at fixed intervals, according to a schedule
- Doses usually decrease in a gradual taper over several days

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ALCOHOL WITHDRAWAL TREATMENT

Treatment	CIWA–Ar <10	CIWA–Ar >10
Supportive Care	+	+
Benzodiazepine	+/-	+

- If symptoms are not controlled, consider increased dose of benzodiazepine
- Benzodiazepines should be tapered and discontinued following treatment
- Do not give antiseizure medication, unless the patient also has a seizure disorder

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ALCOHOL WITHDRAWAL: SUPPORTIVE CARE

- Nutrition
- Fluids
- Thiamine 100mg for 3-5 days
- May include multivitamin
- Alcohol Use Disorder (AUD) treatment initiation and engagement
- Continue medication for AUD, if on this prior to detention

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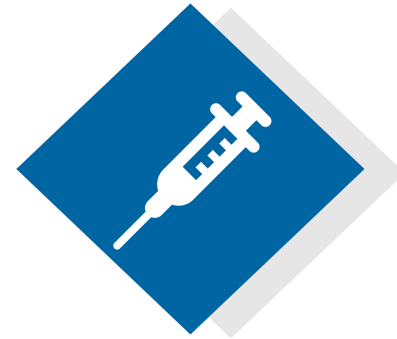
POLYSUBSTANCE USE

If the patient is using alcohol with:

- Sedatives
  - then withdrawal should be handled in the same way as for sedatives
- Opioids
  - then start taper after opioid withdrawal is stabilized
- Stimulants
  - then proceed with alcohol withdrawal as if not using other substances



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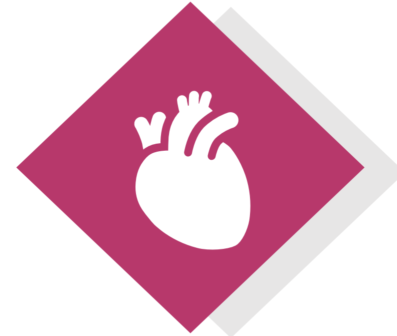
COMORBIDITIES

- Hallucinations that develop in the context of alcohol withdrawal may indicate alcohol-induced psychotic disorder or delirium
  - Give benzodiazepine prior to transport
  - Consider giving antipsychotic medication
- If patients are unable to swallow (not due to withdrawal), give IV or IM medication or transfer to higher level of care
- If a patient cannot take oral medication due to vomiting, patient will need transfer to higher LOC



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PREGNANCY AND ALCOHOL WITHDRAWAL

- Recommendation of 24-hour care, not jail
- Long-acting benzodiazepines preferred until third trimester
- In third trimester, minimize risk of neonatal benzodiazepine sedation
- Engage in treatment for AUD
- Inform of all wrap-around services
- Follow state laws regarding reporting
  - Alcohol use dose not equal inability to parent

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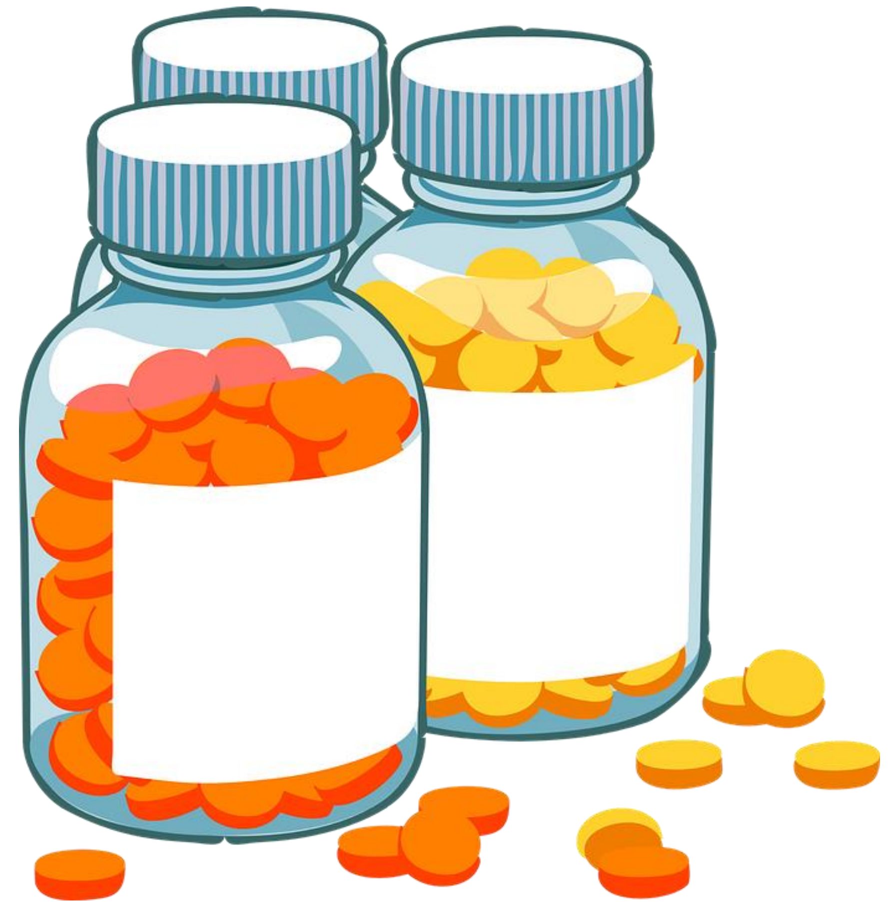
SEDATIVE HYPNOTICS

- Benzodiazepines
- Z-Hypnotics
- Barbiturate
- Gamma Hydroxy Butyrate (GHB)
- Other sedatives
  - Gabapentinoids
  - Baclofen



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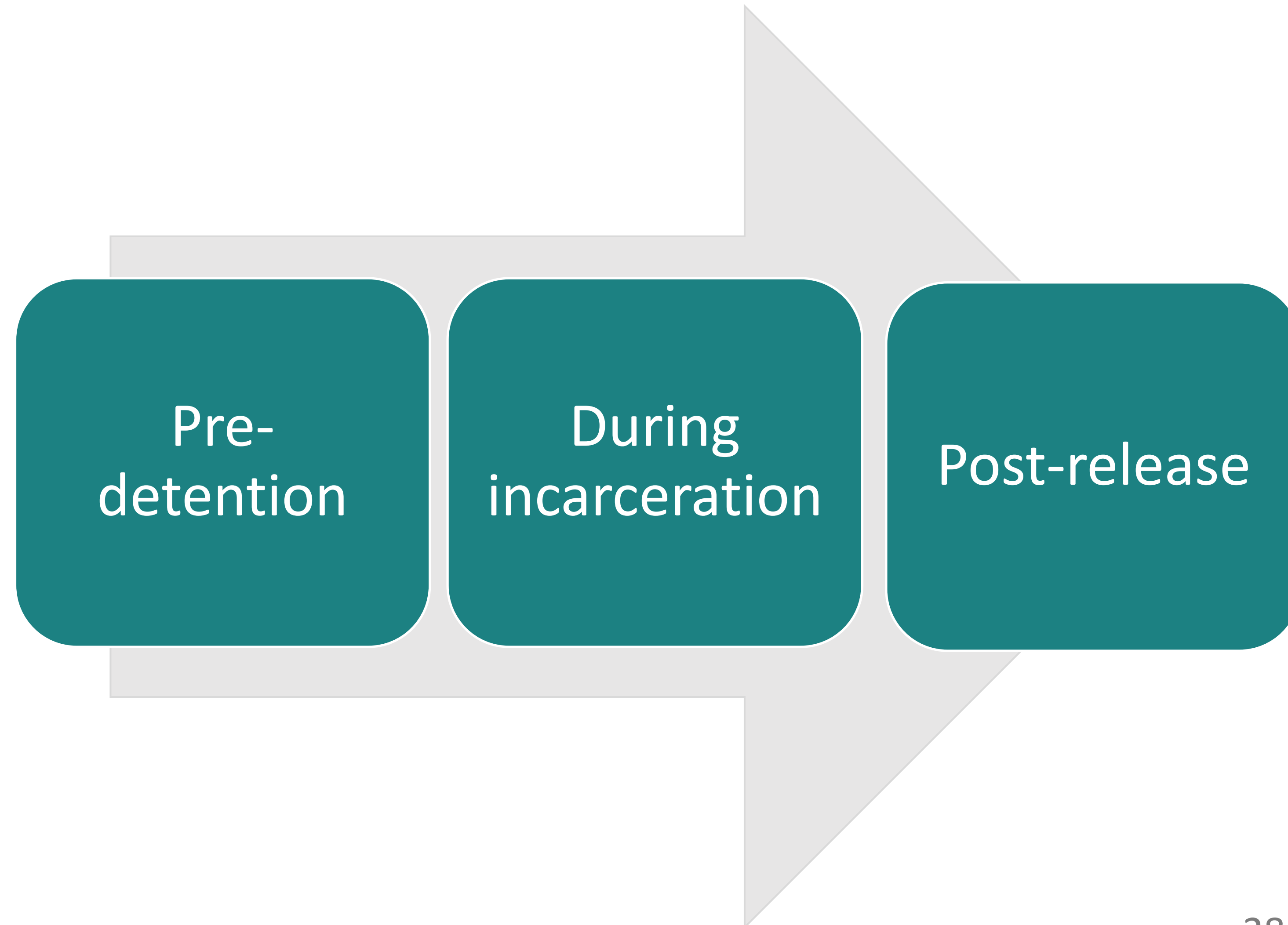
CONTINUITY OF CARE

- Prescribed medication in the community should be continued unless there is a documented clinical reason for discontinuing the prescription



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SCREENING

- Near daily use or greater use of nonprescribed sedatives

OR

- Past week use of nonprescribed sedatives and history of complicated withdrawal
  - Complicated withdrawal: psychosis, seizures, or delirium

- Should result in referral for immediate clinical assessment

Why does this slide say nonprescribed?

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MONITORING FOR WITHDRAWAL

- Anyone reporting risk of withdrawal or use less than daily, should be monitored every 6 hours for 1 week

Duration	Examples	Timeframes
Short-acting	alprazolam (Xanax®), lorazepam (Ativan®)	Withdrawal onset within 24 hours
Long-acting	clonazepam (Klonopin®), diazepam (Valium®)	Withdrawal onset within 24-48 hours

Adopted from *BJA/NIC Guidelines for Managing Substance Withdrawal in Jails (2023)*

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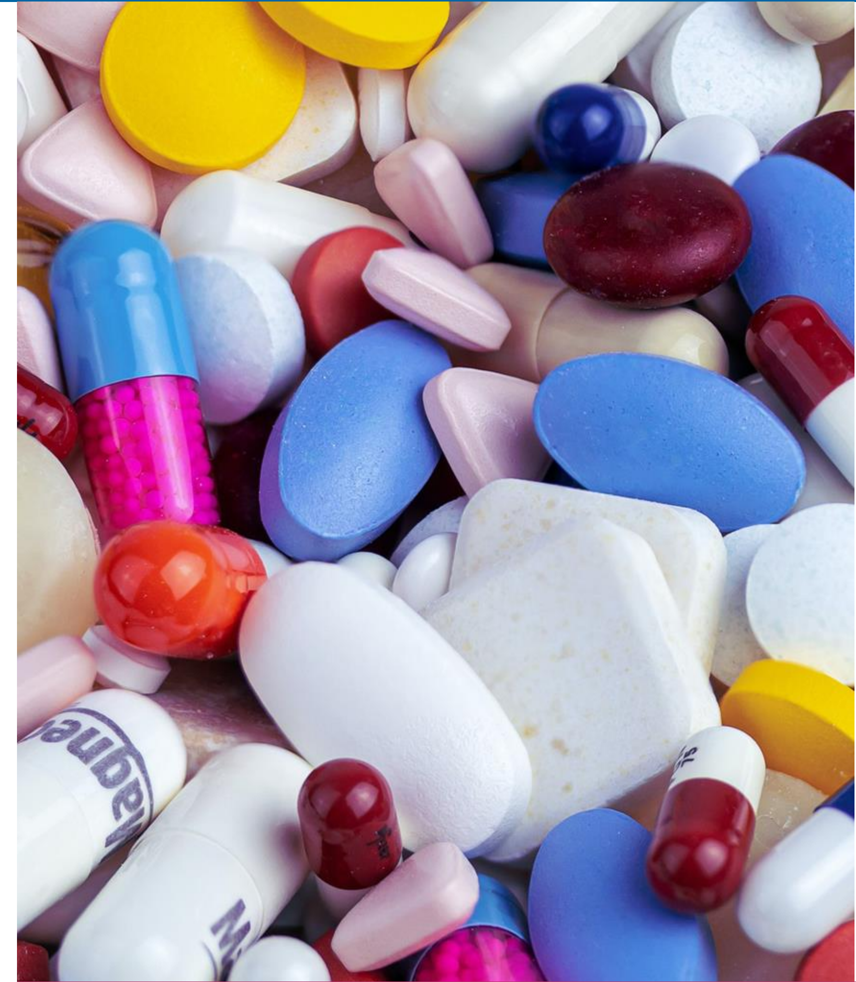
SEDATIVE WITHDRAWAL SYMPTOMS

- Anxiety and restlessness
- Confusion and delirium
- Increased temperature, heart rate or blood pressure
- Nausea, vomiting, gastrointestinal pain
- Psychosis
- Tremors
- Trouble sleeping
- Seizures



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CLINICAL ASSESSMENT

- Can use Clinical Institute Withdrawal Assessment Scale for Benzodiazepines (CIWA-B)
  - Validity & reliability not fully determined
- Do not use CIWA-Ar
- History
- Physical Exam
- Vital signs

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LEVEL OF CARE

- Hospitalization is suggested for
  - Changes in consciousness
  - Delirium
  - Hallucinations
  - Profound agitation
  - Seizures
  - Unstable vital signs
- Consider transfer for
  - Less severe withdrawal in a patient with history of complicated withdrawal

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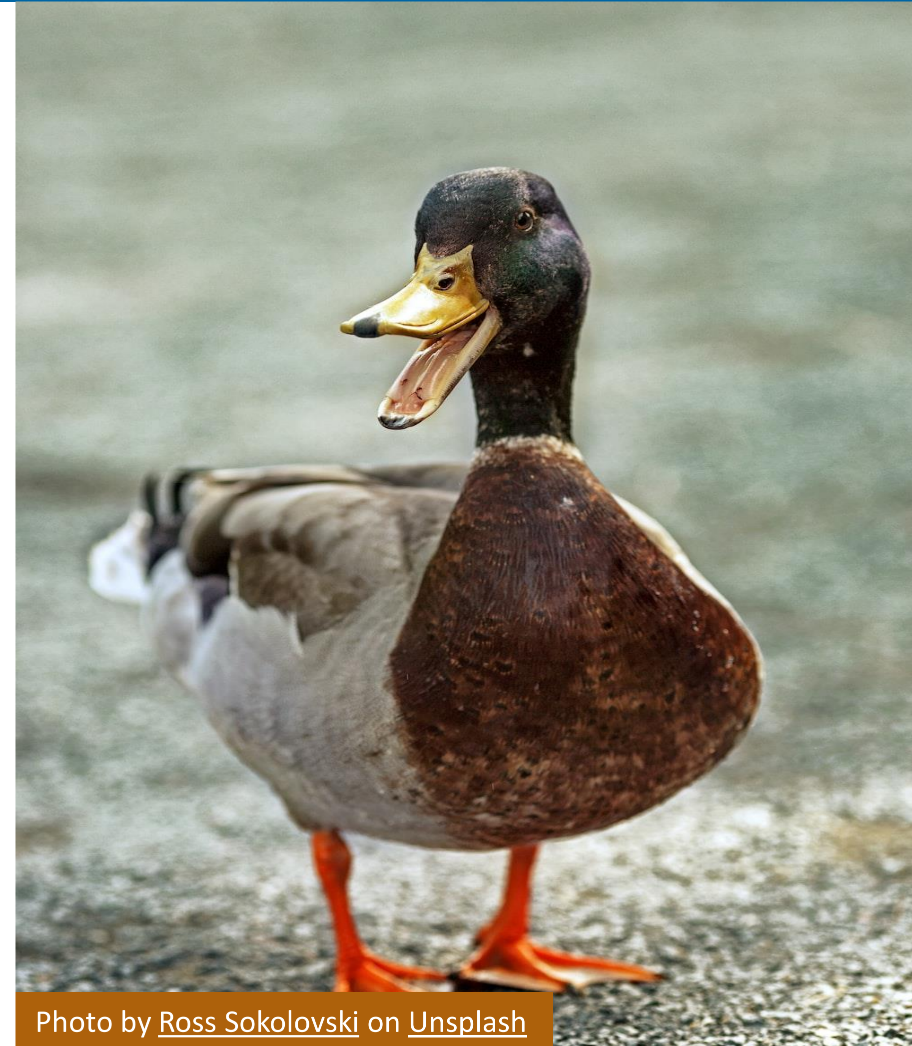
LEVEL OF CARE

- Withdrawal from GHB or barbiturates is complex and should not occur within a jail
- Transfer to higher LOC
- Many sedatives are not detected on routine toxicology tests, including GHB



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MONITORING DURING WITHDRAWAL

- **During the first week** of treatment for sedative withdrawal a qualified healthcare professional should conduct a **daily** clinical assessment
    - In person or via telehealth
- **After the first week**, a qualified healthcare professional should conduct an assessment at least **twice per week**

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TREATMENT & REENTRY

Because of the risk of delirium, seizures and death

- **All sedative withdrawal should be treated regardless of length of detention**
- Slow taper is recommended
  - 10-25% per week
- Tapers extending beyond detention will require a prescription and ongoing linkage to care

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TREATMENT

- Convert short acting benzodiazepines to an equivalent dose of long-acting benzodiazepine
- Pay attention to signs and symptoms of withdrawal when establishing the baseline dose to taper from, i.e., stabilize patient prior to starting taper
- If withdrawal symptoms emerge then return to higher dose and slow taper
- The second half of the taper might need to be slower than the first half

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SUPPORT

- In addition to everything in the general section
- Recommend
  - Cognitive behavior therapy (CBT)
    - Shown to improve taper completion
  - Stress management
  - Sleep hygiene
  - Relaxation training

Microsoft Stock Photo

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Spiegel, D. et. al. (1994)

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ADDITIONAL RECOMMENDATIONS

- Pregnancy
  - Follow recommendations above
  - Co-manage with obstetrics provider
- Polysubstance use is normal
  - Stabilize the opioid withdrawal before tapering benzodiazepines
  - Patients using alcohol and benzodiazepines should be tapered over months
- Do not give antiseizure medication as this does NOT prevent delirium or death

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CONTACT US

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OVERVIEW OF BJA GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS – RECORDINGS AND SLIDES

Webinar 1: General Overview and Stimulant Withdrawal

- https://vimeo.com/875392801

Webinar 2: Opioid Withdrawal

- https://vimeo.com/879965517

PDF of slides available at AddictionFreeCA website

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MAT in Jails and Drug Courts

This project is funded by the California Department of Health Care Services (DHCS) through the California FY 2022/23 budget, which included an allocation of State General Funds for ongoing

Webinars and Podcasts

Webinars and Podcasts +

Increasing Healthcare Professionals' Understanding of Juvenile Justice in California (9-14-2023)
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CACC Webinar Series - Legal Landscape of Medications for Opioid Use Disorder (MOUD) (9-19-2023)
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Overview of BJA Guidelines for Managing Substance Withdrawal in Jails – Part 1 (10-17-2023)
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Screening & Assessment (10-26-2023)
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POLLING QUESTIONS

1. Overall, today's webinar was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

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APPENDIX – CALAIM JI INITIATIVE

CALAIM GUIDANCE – AUD / STUD

- 3g. Support for MAT – Infrastructure and processes are in place to support MAT. **This entails covering all forms of FDA-approved medications for the treatment of alcohol use disorder (AUD) and substance use disorder (SUD)**, and **providing assessment, counseling, and patient education**. Providing at least one form of an FDA-approved opioid agonist or partial agonist for opioid use disorder treatment is required to go live.
- The scope of targeted pre-release services under the Section 1115 demonstration includes medications and medication administration to treat substance use disorder (SUD). This is also known as medication-assisted treatment or medications for addiction treatment both referred to as MAT. **The scope of coverage for SUD medications includes MOUD and MAUD both during the pre-release period and to have in hand upon release. Under federal guidance for the 1115 Reentry Demonstrations, medications for substance use disorder are a required minimum service as clinically appropriate.**

DHCS Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative
https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf

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CALAIM JI INITIATIVE – REQUIREMENTS FOR TREATMENT FOR AUD INCLUDE THE FOLLOWING (1 OF 2)

- **Assessment of individuals who screened positive for AUD, using the ASAM criteria to determine the appropriate level of treatment when applicable.**
- Treatment planning is consistent with Medi-Cal requirements, in collaboration with the patient.
- **Management of alcohol withdrawal using evidence-based tools and interventions**
- **Timely introduction of medication-based treatment. This includes access to disulfiram, naltrexone, acamprosate and other medications as appropriate**
- Timely continuation of any medication prescribed in the community, for the duration of incarceration.
- Policies and procedures to support evidence-based treatment of AUD and patient expectations/consent.
- Tapering or discontinuation determined in shared decision-making between the clinician and the patient on a case-by-case basis and in accordance with policies.

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Source: DHCS Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative

CALAIM JI INITIATIVE – REQUIREMENTS FOR TREATMENT FOR AUD INCLUDE THE FOLLOWING (2 OF 2)

- Discontinuation determined by both clinician and patient, and on a case-by-case basis in accordance with evidence-based practice.
- Services and placement in non-residential level of care (if available within CF) as determined by a full ASAM Criteria assessment. The ASAM Criteria assessment shall be completed for individuals who are estimated to be in the CF for more than 30 days. For county CFs, the ASAM Criteria assessment shall be completed within 30 days of the individual's first visit with an LPHA and/or SUD counselor.
- Examples of evidence-based practices include: motivational interviewing; cognitive behavioral therapy; peer support services; and psychoeducation.
- Maintain continuity of care by transitioning to community provider (including but not limited to medication access through primary care and SUD treatment) through close coordination with pre- and post-release care managers.
- Providing an appropriate supply of take-home medication in hand upon release to meet the need between release and transition to community provider.

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CALAIM JI INITIATIVE – SEDATIVES

- To ensure individuals with behavioral health needs are identified and behavioral health links are provided, as required by AB 133, DHCS will require that **CFs have the ability to systematically screen all individuals entering the CF for mental illness and SUD, including any history of alcohol, sedative or opioid withdrawal.**
- Screening tools can be used by non-clinical staff and should be used alongside regular screenings upon intake for individuals in CFs. Screening for mental health and SUD should be performed using validated tools, with demonstrated applicability in justice settings.

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