BJA Guidelines for Managing Substance Withdrawal in Jails: Opioid Withdrawal

PRESENTED BY:
Shannon Robinson

October 31, 2023 @ 1:00-2:00 pm

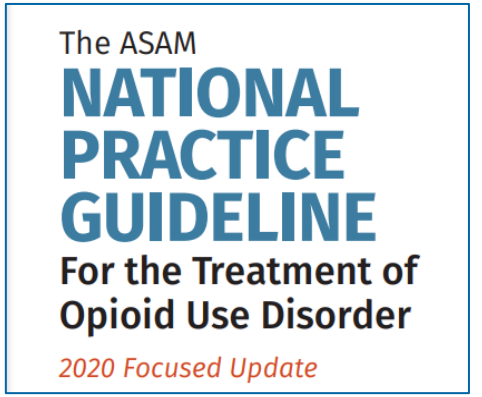
LEARNING OBJECTIVES

- Describe opioid screening, assessment, and monitoring recommendations covered in the guidelines.
- Summarize the recommendations for treatment of opioid withdrawal.
- Discuss the recommendations for treatment of opioid use disorder and continuity of care for people entering and leaving carceral settings.

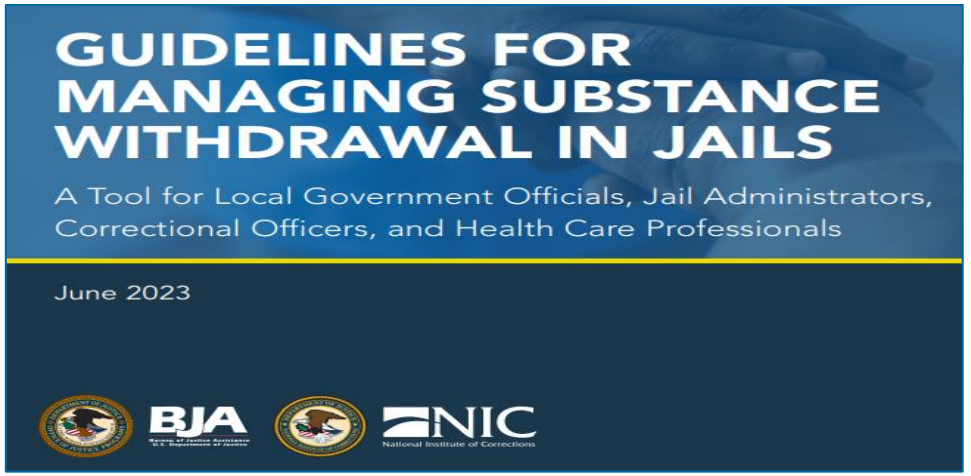
ONE STANDARD OF CARE

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

References to the ***DHCS Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative*** (released 10/20) can be found throughout the presentation in these boxes.



Link to ASAM National Practice Guidelines



Link to Guidelines for Managing Substance Withdrawal In Jails

HMA DHCS

WHY WE USE MEDICATION FOR OPIOID USE DISORDERS

- Increased retention in treatment
- Improvements in health conditions
- Improvements in employment
- Cost effective
- Reduction in use of illicit drugs
- Reduction in fatal overdose
- Reduction in suicide
- Reduction in needle sharing, HIV and HCV infection rates
- Reduction in criminal activity and sex work
- Reduction in multiple sex partners
- Reduced recidivism
- Reduced risk of litigation

Photo by Oriol Portell on Unsplash

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OPIOID WITHDRAWAL

ASAM National Practice Guidelines for the Treatment of Opioid Use Disorder (OUD) state, "Opioid withdrawal management on its own, without ongoing pharmacotherapy, is NOT a treatment method for OUD and is not recommended."

- Can be life threatening.
- Historically many jails have not offered buprenorphine or methadone.
  - Placing people at risk of death while incarcerated and upon release.

CalAIM JI Initiative Policy and Operational Guide: Assessment and provision of medication continuation and withdrawal management are available every day, with the goal of preventing gaps in care that can unnecessarily precipitate or sustain withdrawal (pg. 119).

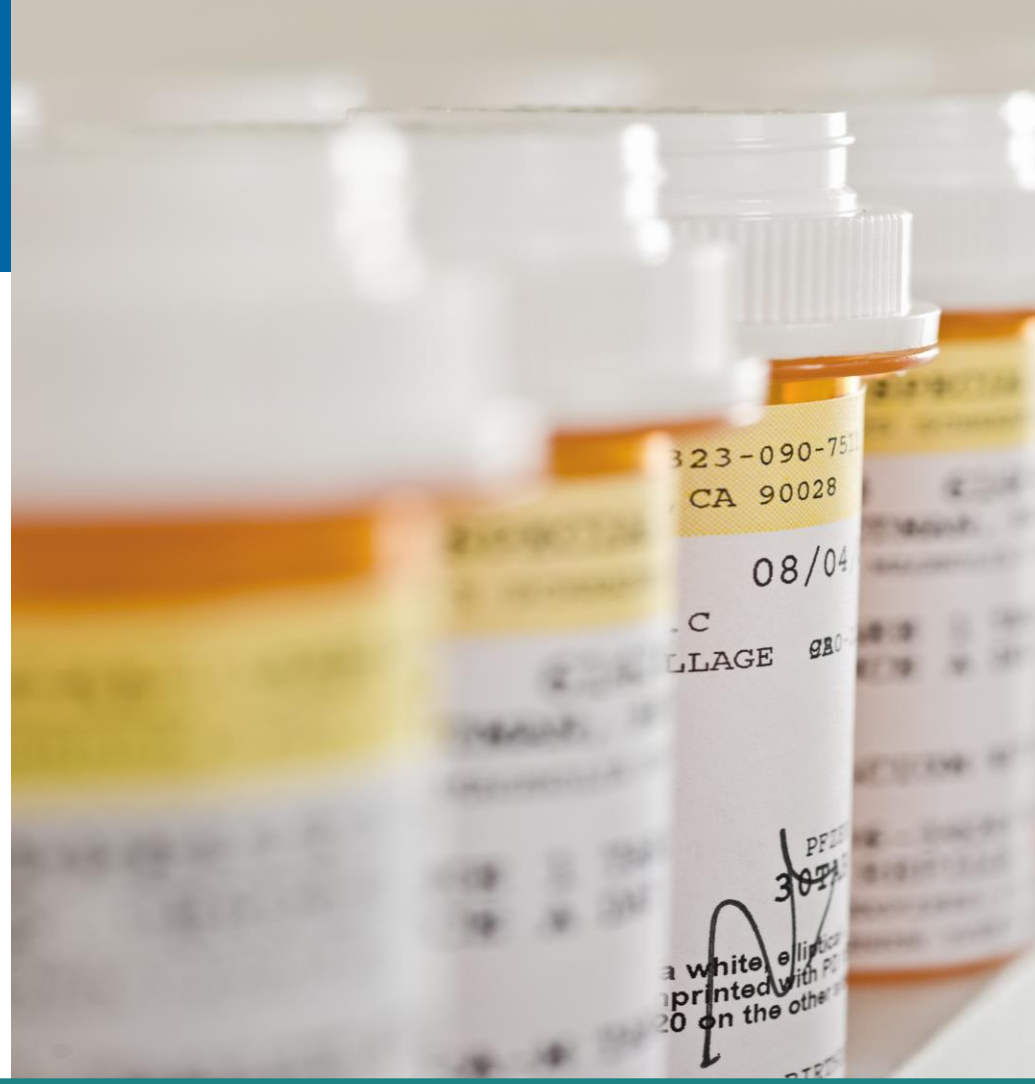
BJA GUIDELINES FOR MANAGING OPIOID WITHDRAWAL

- "It is recommended that individuals with OUD who are at risk of opioid withdrawal be offered initiation of long-term pharmacotherapy for OUD, in a timely manner. If the patient declines long-term treatment with MOUD or prefers to initiate naltrexone, the patient should be offered buprenorphine or methadone treatment to treat opioid withdrawal."
- Policy decisions disallowing or disincentivizing FDA-approved medication for withdrawal or OUD are NOT clinically appropriate.

CalAIM JI Initiative Policy and Operational Guide: All Correctional Facilities (CF) are responsible for initiating and providing medications for SUD as soon as a need is identified. Individuals with an identified need must have access to all forms of medications for opioid uses disorder (MOUD) (including one agonistic medication (i.e., either methadone or buprenorphine) ... The county CF should determine the needed medications for SUD for the incarcerated individual during the initial intake process. This determination ideally occurs within the first 8 hours of incarceration or before the county CF's next scheduled dosage time/med pass (pg. 85).

GUIDELINE RECOMMENDATIONS | CONTINUITY OF CARE

- Patients prescribed opioids pre-detention should have continued access to the medication, regardless of whether prescribed for chronic pain or opioid use disorder.



CalAIM JI Initiative Policy and Operational Guide: Timely continuation of any agonist medication prescribed in the community, for the duration of incarceration (pg. 114).

GUIDELINE RECOMMENDATIONS | SCREENING AND MONITORING

HMA Screening and Assessment Webinar Recording

- Screen with a validated tool.
- Anyone who reports regular use of opioids (including prescriptions), OUD, or opioid withdrawal should be considered at risk of opioid withdrawal.
- Some individuals will initially screen negative but later exhibit symptoms.
- Custody should be well trained to refer individuals who appear unwell for immediate clinical assessment.

CalAIM JI Initiative Policy and Operational Guide:

- 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 systematically screen all individuals entering the CF for mental illness and SUD, including any history of alcohol, sedative or opioid withdrawal
- Screening for mental health and SUD should be performed using validated tools, with demonstrated applicability in justice settings. DHCS encourages entities to use validated tools for other types of screening and assessment (physical health, functional needs, housing needs), where available (pgs. 69-70).

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https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

OPIOID WITHDRAWAL

Opioid	Onset	Peak	Duration
Heroin	6 hours	By 3 days	4-7 days
Fentanyl	6 hours	5-7 days	7-14 days
Buprenorphine/ Methadone	1-2 days	By 7 days	10-14 days

Source: Miller, S 2019 Principles of Addiction Medicine

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GUIDELINE RECOMMENDATIONS | MONITORING

- Monitor at least every 4 hours for 72 hours for codeine, fentanyl, heroin, hydrocodone, oxycodone, morphine.
- Monitor every 8 hours for buprenorphine or methadone.
- Monitor with a validated tool and vital signs.
  - Clinical Opioid Withdrawal Scale (COWS) is often used (may be embedded in electronic medical records).
- Patients who appear unwell or score a 3 on COWS should be referred for immediate clinical assessment.
- Monitoring can be conducted by a qualified healthcare professional or well-trained custody.

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Sources: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9.

WHY USE A STANDARDIZED ASSESSMENT OF WITHDRAWAL SEVERITY

- Determine severity level.
  - Determine need for elevation to higher level of care (e.g. emergency department or hospital).
- Help interpret patient symptoms and complaints, e.g., “I feel like I am going to die”.
- Minimize risk of stigma/bias for some detainees.
- Minimize gaps in handoffs between shifts.
- Regardless of treatment, using a standardized assessment tool can promote detainee safety, health, and psychological functioning; improve jail healthcare standards; and reduce liability.

COWS: COMPONENTS AND ITEM SCORING

- Pulse (after resting one minute; objective)
  - 0 - pulse < 80
  - 1 - pulse 81-100
  - 2 - pulse 101-120
  - 4 - pulse >120
- Sweating (over past 30 min., subjective & objective)
  - 0 - no report of chills/flushing
  - 1 - report of chills/ flushing
  - 2 - flushed or observable moistness
  - 3 - beads of sweat on face
  - 4 - sweat streaming off face
- Restlessness (subjective & objective)
  - 0 - able to sit still
  - 1 - reports difficulty but able to sit still
  - 3 - frequent shifting or moving extremities
  - 5 - unable to sit still for more than a few seconds
- Pupil size (objective)
  - 0 - pinned or normal
  - 1 - possibly larger
  - 2 - moderately dilated
  - 5 - so dilated only rim showing
- Bone/joint aches (subjective & objective)
  - 0 - not present
  - 1 – reports mild diffuse discomfort
  - 2 - reports severe diffuse discomfort
  - 4 - rubbing & unable to sit still

In a carceral setting you are already observing the detainee

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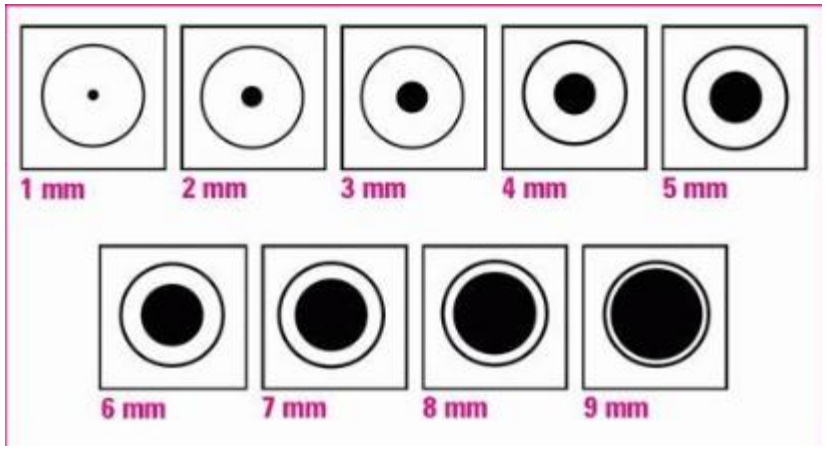
COWS: COMPONENTS AND ITEM SCORING

- Runny nose/tearing (subjective & objective)
  - 0 - none
  - 1 – reports stuffy/moist
  - 2 - runny or tearing
  - 4 - constantly running/tearing
- GI upset (subjective & objective)
  - 0 - no GI symptoms
  - 1 - reports stomach cramps
  - 2 - nausea or loose stool
  - 3 - vomiting or diarrhea
  - 5 - multiple episodes
- Tremor (subjective & objective)
  - 0 – none
  - 1 - tremor can be felt but not seen
  - 2 - slight tremor observable
  - 4 - gross tremor or twitching
- Yawning (objective)
  - 0 – none
  - 1 - once or twice during assessment
  - 2 - three during assessment
  - 4 - several times/minute
- Anxiety/Irritability (subjective & objective)
  - 0 – none
  - 1 - reports anxious or irritable
  - 2 - obviously anxious or irritable
  - 4 - so anxious or irritable participation is difficult
- Gooseflesh (objective)
  - 0 - skin is smooth
  - 3 - goosebumps felt or visible
  - 5 - prominent or goosebumps

PUPIL SIZE CHART

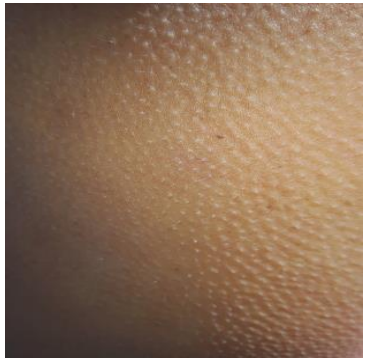


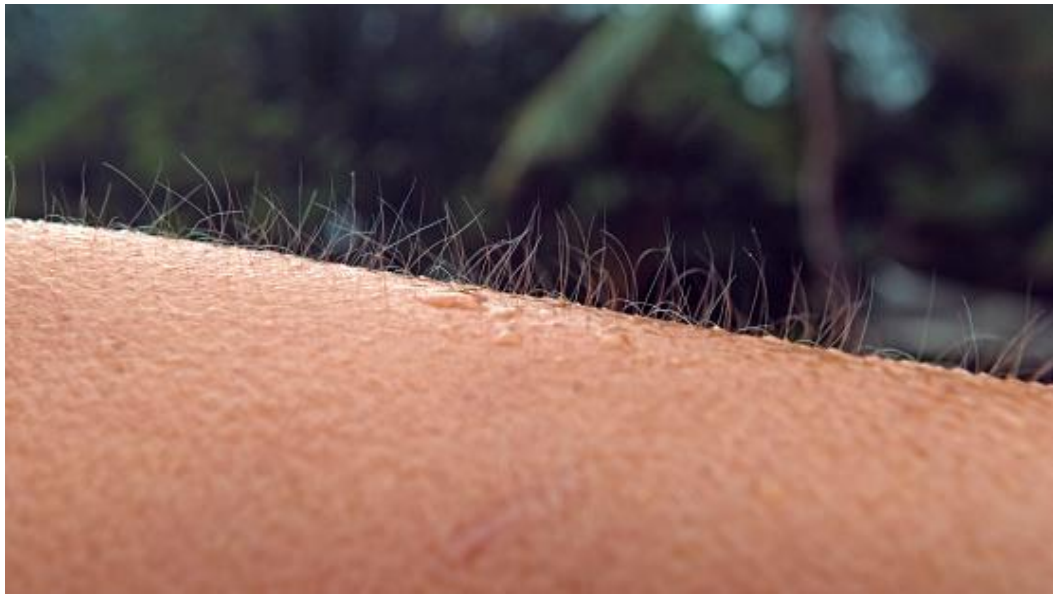
- Use tape measure or estimator card.
- Measure size from edge to edge of pupil.
- Score:
  - 0 for pinpoint or 1 mm
  - 1 for 2-3 mm
  - 2 for 4-6 mm
  - 5 for 7-9 mm

OBSERVE FOR TREMOR

- Ask patient to sit with hands in lap with palms down; ask them to reposition hands with thumbs facing upwards; do not specify that you are observing tremor.
- Continue to observe during movements such as raising hand, reaching for objects, etc.
- It is very hard to “fake” a tremor for an extended period of time.

ASSESSING GOOSEBUMPS (PILOERECTION)





- Where the term “quitting cold turkey” comes from.
- Observe skin on arms.
- Observe for “goosebumps” and/or hair standing up.

GUIDELINE RECOMMENDATIONS | CLINICAL ASSESSMENT

- Conducted by a qualified health care professional.
- Substance use history for all substances recently used.
  - Last use
  - Amount used per day
  - Prior experience with onset of withdrawal
  - Prior experience with using buprenorphine during withdrawal
- Focuses on identifying any medical risk that would necessitate a higher level of care.
- Evidence of overdose and risk of withdrawal.
- Signs and symptoms of withdrawal.

CalAIM JI Initiative Policy and Operational Guide: DHCS encourages entities to use validated tools for other types of screening and assessment (physical health, functional needs, housing needs), where available. Additionally, screening and assessments must be performed or overseen by a licensed professional (pg. 69).

GUIDELINE RECOMMENDATIONS | CLINICAL ASSESSMENT

- If the patient is not responding to buprenorphine, then consider:
  - Possible need for increased dose of buprenorphine.
  - Possible misdiagnosis
    - Heart attack
    - Infection
    - Diabetic ketoacidosis
    - Hyperthyroid
    - Pulmonary embolus

GUIDELINE RECOMMENDATIONS | WARNINGS

- Concurrent use of buprenorphine or methadone with alcohol or benzodiazepines increases respiratory depression risk. However, concurrent treatment with benzodiazepines (e.g., for co-occurring alcohol or sedative withdrawal) should NOT be a reason to withhold treatment with buprenorphine or methadone. Increased monitoring may be appropriate.
- Naltrexone is not approved by FDA for withdrawal management purposes and does not relieve withdrawal symptoms…

GUIDELINE RECOMMENDATIONS | MEDICATION (1 OF 4)

- Buprenorphine and methadone are first-line agents for opioid withdrawal and opioid use disorder.
  - All patients at risk should have rapid access to these medications.
- Because opioid withdrawal management without ongoing OUD treatment increases the risk for overdose and death…initiate ongoing treatment for OUD with buprenorphine or methadone.
- Patients should be informed of risk of return to use, overdoses and death if they choose not to engage in ongoing medication.

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GUIDELINE RECOMMENDATIONS | MEDICATION (2 OF 4)

- Once the diagnosis of OUD or withdrawal has been made, treatment should be initiated immediately, without regard to expected duration of incarceration.
- All jails should have a plan for access to medication within 24 hours.
- Access to assessment may include:
  - use of telehealth services
  - rapid transport to a facility where assessment and treatment can be provided.

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GUIDELINE RECOMMENDATIONS | MEDICATION (3 OF 4)

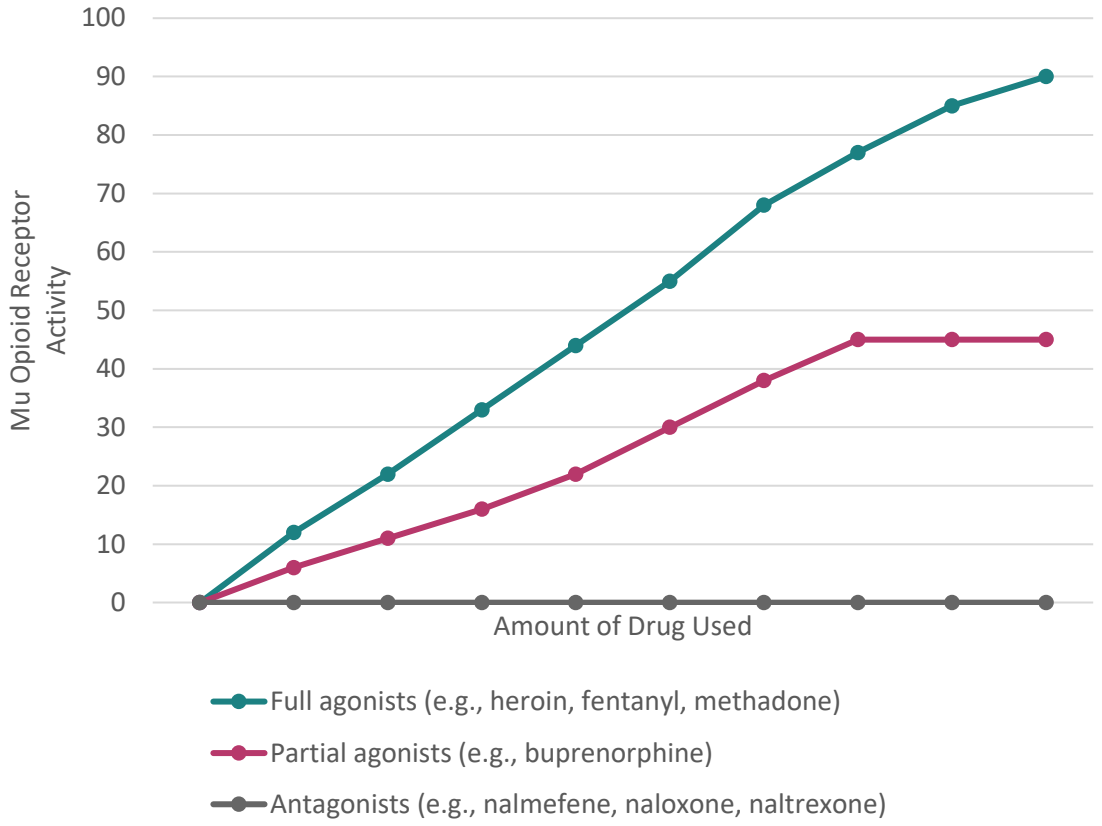
- Polysubstance use is NOT a contraindication to medication for withdrawal or OUD.
- Drug testing should NOT be used to deny patient access to medication for withdrawal or OUD.
- Regardless of ability to continue treatment in the community, buprenorphine or methadone should still be initiated.
- Completion of a full assessment is NOT required before initiating medication for withdrawal or OUD.
- A patient's decision to decline or the absence of psychosocial treatment should NOT preclude or delay medication.

GUIDELINE RECOMMENDATIONS | MEDICATION (4 OF 4)

- Opioid withdrawal management is NOT necessary if the patient is immediately initiated on buprenorphine or methadone upon intake to jail for those prescribed these medications prior to detention.
- Adjunctive medication should NOT be necessary if buprenorphine or methadone is provided in adequate doses (≥16mg per day) & should NOT be used in place of adequate doses.
- Patient discomfort during withdrawal may indicate the dose is too low.

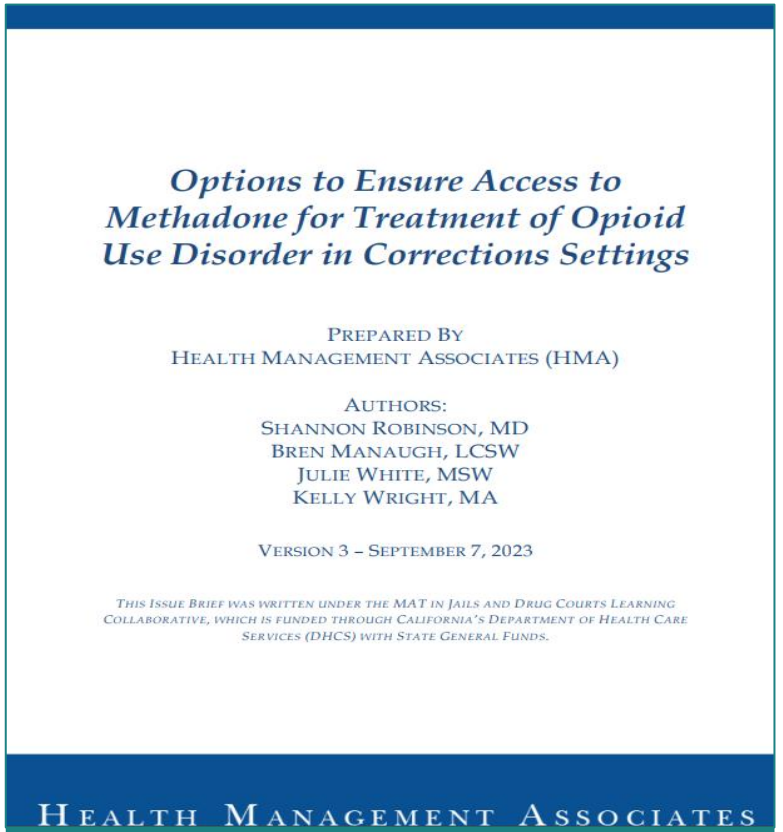
GUIDELINE RECOMMENDATIONS | BUPRENORPHINE

- Buprenorphine should be initiated when there is objective evidence of withdrawal.
- The patient should be monitored for 30 minutes.
- If precipitated withdrawal occurs the patient should have an immediate assessment with a prescriber on site, via telehealth or via transfer to outside provider.



GUIDELINE RECOMMENDATIONS | METHADONE

- Effective for opioid withdrawal and OUD.
- Utilize the 72-hour rule to provide methadone while arrangements are being made for care at a narcotic/ opioid treatment program (NTP).
  - Transport patients to NTP for methadone dosing.
    - Guest dosing for patients established with a different NTP.
  - Transport methadone to jail for dosing at jail.
    - Transport by NTP provider, jail medical provider or custody staff.



Options to Ensure Access to Methadone for Treatment of Opioid Use Disorder in Corrections Settings

GUIDELINE RECOMMENDATIONS | TRANSITIONS FROM ONE AGENT TO ANOTHER

- Patients should NOT be required to transition from an agonist to an antagonist.
- Transitioning from methadone to buprenorphine is clinically complex and should be managed by, or in consultation with, a provider experienced in managing this transition.

GUIDELINE RECOMMENDATIONS | DISCONTINUING MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

- Discontinuing buprenorphine or methadone should only be done when clinically indicated.
- It is not appropriate to require a change in or discontinuation of MOUD for nonclinical reasons.
- Discontinuing MOUD puts patients at risk for death.
- In the rare instance where discontinuing buprenorphine or methadone is indicated, the complexity of discontinuing requires the services of a medical provider with SUD treatment expertise (board certification or 2 of more years of experience in SUD treatment).

CalAIM JI Initiative Policy and Operational Guide:

- 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.
- Discontinuation determined by both clinician and patient, and on a case-by-case basis in accordance with evidence-based practice (pg. 16).

GUIDELINE RECOMMENDATIONS | DISCONTINUATION MOUD (CONT.)

- If a provider determines and documents that continuation of opioid medication is clinically inappropriate, the medication should be tapered slowly according to current clinical guidelines from US Dept of Health and Human Services, while monitoring for withdrawal.
- This document also includes a list of reasons why someone might be tapered.
- Fast: 10% of the original dose per week until 30% of the original dose, then 10% per week of the remaining dose.
- Slow: 10% per month or slower.

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US Dept HHS (2019) HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics.

GUIDELINE RECOMMENDATIONS | ALPHA-2 ADRENERGIC AGONISTS

- Are second-line treatments because they do not relieve opioid withdrawal symptoms as effectively as buprenorphine or methadone.
- Could be used when patients decline buprenorphine and methadone.
- Not part of BJA Guidelines, but important
  - For those experiencing xylazine withdrawal these medications are recommended.

D'Orazio, J 2023; Love, JS 2023; Spadaro, A 2022; Ehram-Dupre 2022

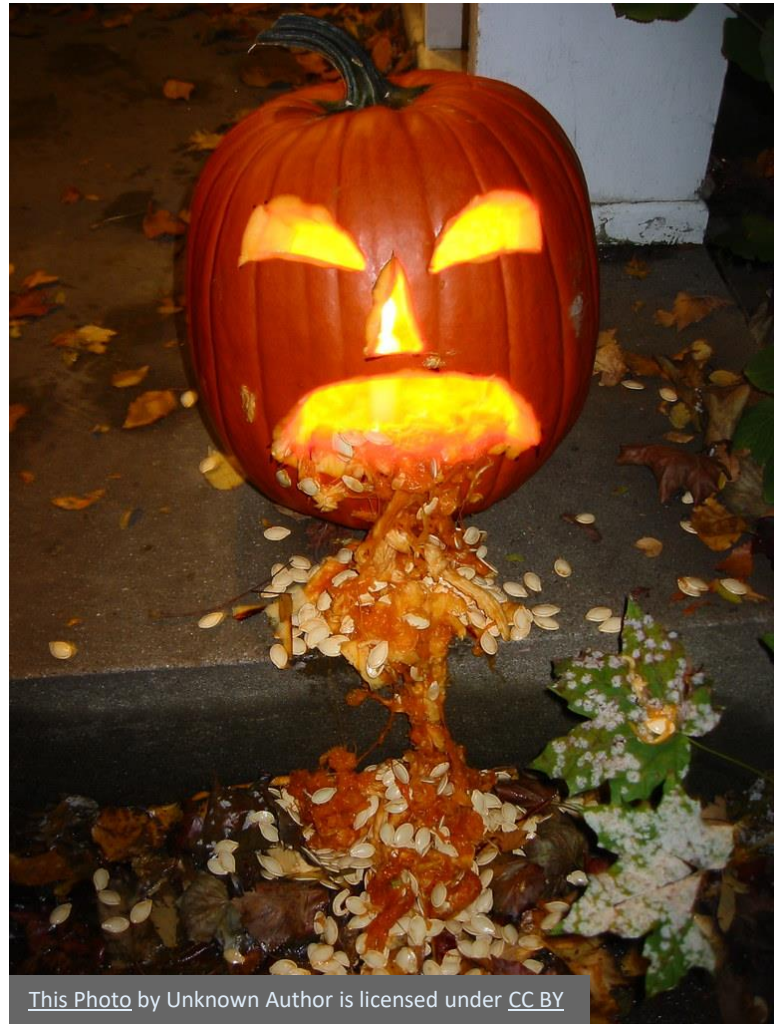
GUIDELINE RECOMMENDATIONS | CO-OCCURRING DISORDERS

Treat all conditions present.

- In patients with concurrent sedative use disorder or withdrawal, buprenorphine or methadone should be used to stabilize opioid withdrawal symptoms.
- Concurrently treat alcohol or sedative withdrawal with opioid withdrawal.
- Once opioid withdrawal is stabilized, it is appropriate to begin tapering the dose of sedative.
- Concurrent stimulant use disorder is not a reason to delay or deny MOUD.
- Treatment of mental health issues should not delay or preclude treatment with MOUD.

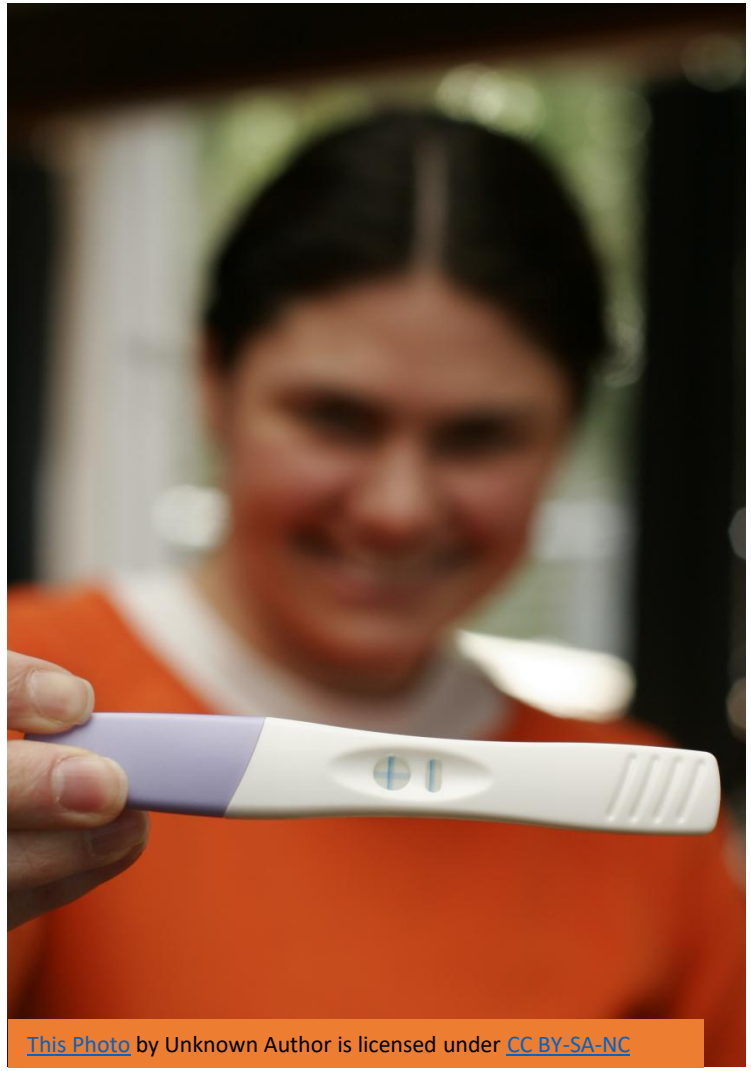
GUIDELINE RECOMMENDATIONS | SUPPORTIVE CARE

- Vomiting and diarrhea may indicate opioid withdrawal has not been adequately treated AND the patient is at risk of dehydration.
- Consider increasing the dose of medication while managing risk of dehydration.
- If the jail does not have the capacity to safely manage fluids loss, the patient should be transferred to a facility that does.



GUIDELINE RECOMMENDATIONS | PREGNANCY AND POSTPARTUM

- Opioid withdrawal during pregnancy is associated with high return to use.
- The standard of care for pregnant and postpartum persons is buprenorphine or methadone.
- Transfer to a hospital is likely to be needed, especially in the third trimester.
- Specialty consultation should not delay initiation or titration of buprenorphine or methadone.
- The pregnant person (and all staff) should be counseled on the clear efficacy and safety of buprenorphine and methadone for them and the fetus/ baby.



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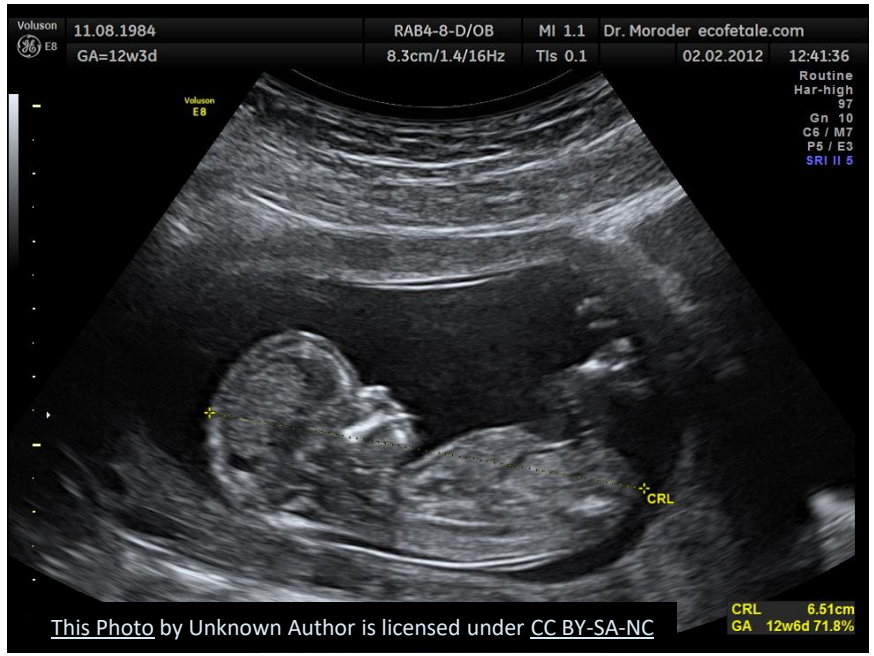
GUIDELINE RECOMMENDATIONS | PREGNANCY AND POSTPARTUM (CONT.)

- With advancing gestational age, plasma levels of buprenorphine and methadone will progressively decrease as clearance increases.
- Beginning in the second trimester patients and staff should be alert to cravings and signs and symptoms of withdrawal so medication adjustment can occur.
- After pregnancy has ended the patient should be continued on medication.
- Doses may need to be reduced if there is evidence of oversedation.
- Treatment with medication should never increase the risk of losing custody of children.



GUIDELINE RECOMMENDATIONS | REENTRY

- Treatment during incarceration improves post release outcomes.
- Jail should assist with transfer to community-based treatment upon release.
- Prescribers should ensure access to buprenorphine or methadone to prevent interruption of dosing when the patient transitions to the community.
- Back up plans are vital in the event community appointment cannot be completed. Bridge clinics and telehealth resources can be helpful.

CalAIM JI Initiative Policy and Operational Guide: The CalAIM Justice-Involved Initiative includes the provision of medications in hand to eligible individuals upon release from a correctional setting in order to ensure individuals have enough medications to follow their treatment plans; maintain stabilization on the medications they were prescribed when incarcerated; and avoid decompensation in the period between release and any appointments they may have with their community-based physical and/or behavioral health providers (pgs. 119-120).

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GUIDELINE RECOMMENDATIONS | NALOXONE

- Naloxone should be given to pregnant patients in cases of opioid overdose.
- Naloxone or prescription for naloxone should be available to all patients with OUD upon release.
- Consider providing naloxone to all patients with SUDs.
- Consider providing naloxone to family and friends of patients with SUDs.

CalAIM JI Initiative Policy and Operational Guide:

- Ensure that opioid overdose reversal medication is available, and staff have been trained in its use. Support access to overdose-reversal medication (naloxone) (pg. 113).
- At the time of release, all individuals must be offered naloxone and instruction on its use, regardless of any history of OUD (pg. 122).

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

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

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