Overview of BJA Guidelines for Managing Substance Withdrawal in Jails: General Overview and Stimulant Withdrawal

PRESENTED BY:
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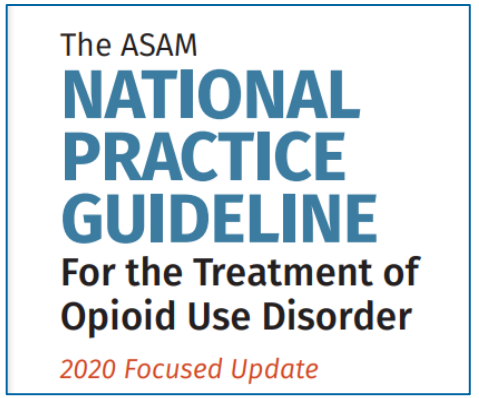
October 17, 2023 @ 1:00-2:00 pm

LEARNING OBJECTIVES

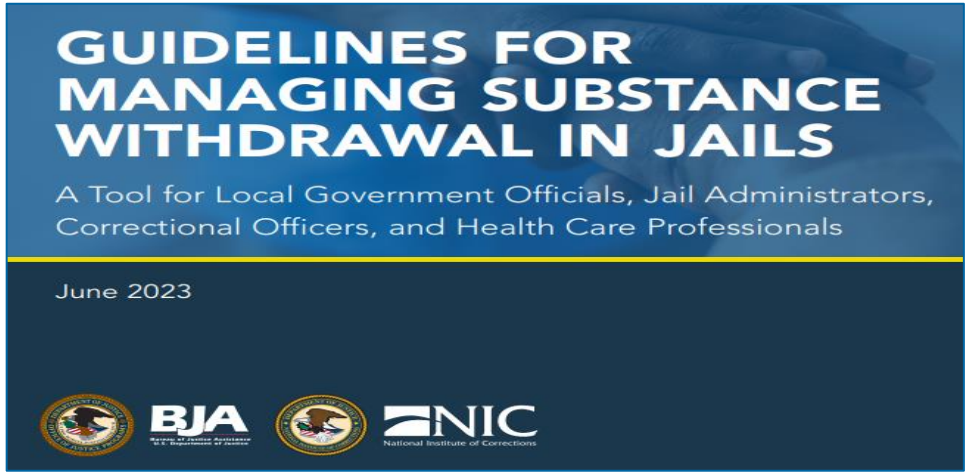
- Discuss what custody's role is in identifying and monitoring withdrawal
- Relate the screening, assessment, and monitoring recommendations within the guidelines for all people entering jails with recent substance use
- Summarize the recommendations for treatment of stimulant withdrawal

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



Link to ASAM National Practice Guidelines



Link to Guidelines for Managing Substance Withdrawal In Jails

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GUIDELINE PURPOSE

- Shared understanding for responding to individuals at risk of withdrawal in carceral settings
- Understanding standards of care
- Determine the level of clinical severity that can be managed in a jail vs need for transfer to higher level of care
- Small jails must meet the same standards
  - How they achieve this will be different from large jails

TERMINOLOGY

Clinical staff

- Physician, prescriber, provider, qualified healthcare professional, qualified mental health care professional, and responsible provider

Qualified health care professional

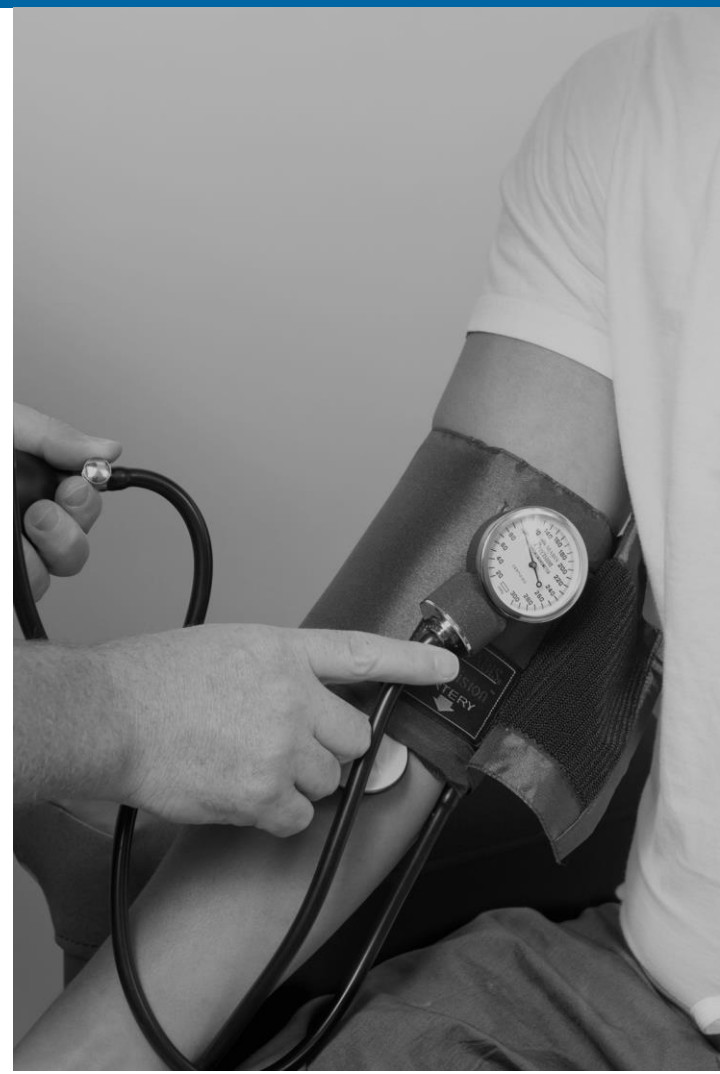
- Physician, physician assistant, nurse, nurse practitioner, or another who by virtue of education, credentials, experience and licensure can competently and legally execute the clinical activity

Qualified health care staff

- A qualified healthcare professional as well as administrative and support staff who are appropriately trained and where required credentialed for the task at hand

TERMINOLOGY

Individual	Patient
• A person not currently being treated	• A person who is being treated for a condition



APPEARS UNWELL

- Individual who appear unwell are referred for immediate clinical assessment conducted by a qualified healthcare professional
  - Intoxication
  - Withdrawal
  - Other symptoms
- Includes anyone with a worsening or unstable condition or becoming a danger to self or others

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SCREENING

- All individuals, regardless of their length of stay in jail, should be screened for risk of withdrawal
- Screening helps to identify anyone in need of immediate clinical assessment including anyone who
  - Appears unwell
  - Reports or is known to have regular use of alcohol or sedatives
  - Reports using alcohol or sedatives in the past week AND has a history of complicated withdrawal
  - Is pregnant and has used alcohol, sedatives or opioids
- Otherwise, individuals who screen positive for withdrawal risk are monitored by healthcare staff or well-trained custody staff and referred for immediate clinical assessment upon emergence of withdrawal signs or symptoms

CONFIDENTIALITY

- Affirm that the information utilized in healthcare screening, even when conducted by custody staff, will not be used against the individual
- Health screening is being conducted to determine if there are any healthcare conditions that need addressed during detention

CLINICAL NEEDS AND CUSTODY LEVELS

Clinical needs do not justify loss of privileges

- When the clinical needs of a patient demand transfer to a more restrictive area the impact on privileges should be minimized

Clinical care is available in all security levels

- Medical decisions should be independent of the custody level of classification of the patient

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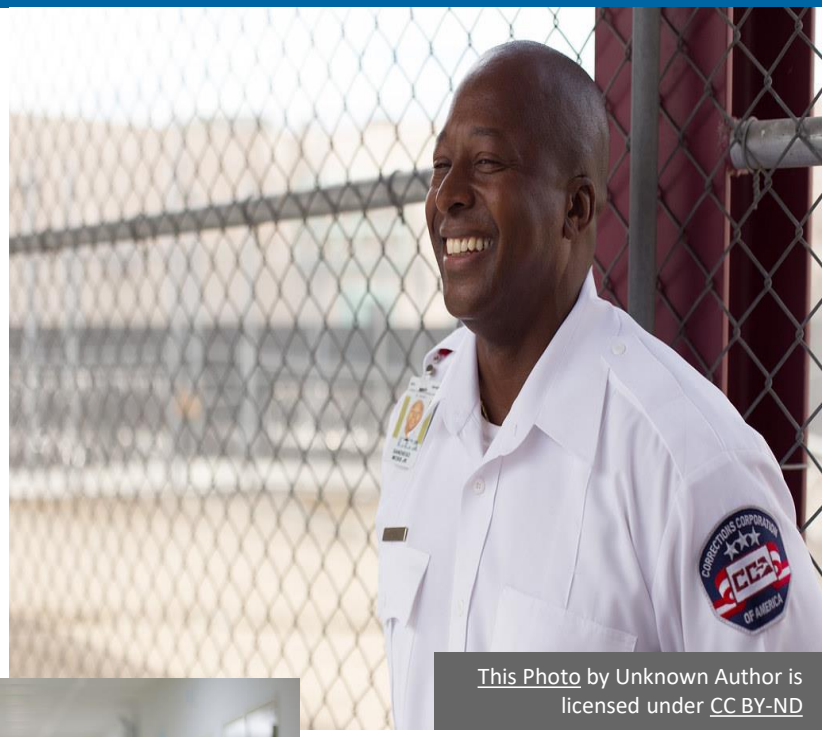
SCREENING USING A VALIDATED TOOL

- Recent types of substances used
  - Routes
  - Amounts
  - Frequency
  - Most recent use
  - History of complicated withdrawal
- SUD diagnoses
- Risk of withdrawal
- Prescribed medications



PRESCRIPTION VERIFICATION

- Verified prescribed opioids for pain or opioid use disorder, sedatives, anxiolytics, or stimulants should be continued upon entering jail unless otherwise ordered by a prescriber based on documented clinical need
- Up to 24 hours to verify and administer medication
  - Check Prescription Drug Monitoring Program (PDMP)
  - Obtain release of information on as needed basis, rather than as standard practice- individualized approach
- If unable to verify, notify the provider

WHO NEEDS MONITORED

- Individuals presenting with intoxication are presumed to be at risk of withdrawal
- Recent regular substance use constitutes a positive screen, even if asymptomatic
- Individuals exhibiting sign or symptoms of withdrawal
  - Custody should be trained on signs or symptoms of withdrawal as individuals may not always be forthright about recent use
  - Referral for clinical assessment differs based on substance

GOALS OF WITHDRAWAL MONITORING

- Monitoring of vitals and withdrawal symptoms using structured objective scales
  - By qualified healthcare staff
  - Custody staff well trained for the task
- Engage in treatment of withdrawal
- Engage in treatment for underlying substance use disorder(s) (SUD)
  - Community resources
  - Reentry planning

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COHORTING INDIVIDUALS AT RISK OF WITHDRAWAL

- Consider housing individuals at risk of withdrawal together to provide
  - Improved monitoring & care (staff focused on mission)
  - Efficiency (can make rounds more quickly)
  - Lower risk of diversion

CLINICAL ASSESSMENT BY QUALIFIED HEALTHCARE PROFESSIONAL

- To avoid critical biomedical or psychiatric issues related to intoxication or withdrawal
- To determine if the patient's condition can be treated at the jail or requires a transfer to a higher level of care
- Need for transfer is dependent on what medical and mental health care is available at your facility
  - This will vary based on each facility
  - Including ability to utilize telehealth
  - This will require your higher level of care understand what is available within your facility

CLINICAL ASSESSMENT

1. **Current substance use**
2. **Signs & symptoms of withdrawal**
3. **History of severity of prior withdrawal**
4. **Medical & psychiatric comorbidities**
5. **Psychiatric history including suicidality**

While comprehensive assessment of the patient is critical for treatment planning, treatment should **NOT** be delayed while awaiting all assessments or laboratory tests. Treatment should not be delayed based on potential timeline for release.

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CLINICAL ASSESSMENT SHOULD IDENTIFY

- Emergent medical & psychiatric needs, including suicidality
- Current withdrawal signs and symptoms
- Risk for complicated withdrawal
- Appropriate level of care (LOC)

- Full assessment may need to wait until intoxication or withdrawal symptoms subside or resolve

ONSITE MANAGEMENT

- Jail can mange anticipated severity of withdrawal and medical and psychiatric comorbidities. This includes:
  - Monitoring
  - Supportive environment with access to hydration, nutrition and sleep
  - Medication

CONSIDER TRANSFER TO HIGHER LEVEL OF CARE

- History of severe or complicated withdrawal
- Moderate to severe withdrawal from multiple substances
- History of severe psychiatric symptoms
- Pregnant patients with alcohol or opioid withdrawal

- Higher levels of care might be available inside your facility or require transport to community partner

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TRANSFER TO HIGHER LEVEL OF CARE

- Nursing, medical or psychiatric resources recommended are NOT immediately available
- Moderate to severe withdrawal with significant comorbidity
- Overdose is suspected
- Severe ongoing sedation
- Unstable vitals or significant withdrawal symptoms despite multiple medication doses
- Medical or psychiatric conditions requires higher level of care
- Patient cannot take fluids or medication orally
- Complicated symptoms (seizure, delirium, hallucinations not due to primary psychotic disorder)
- Severe alcohol or sedative withdrawal or known or suspected barbiturate or gamma hydroxybutyric acid (GHB)

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HOSPITAL BACK TO JAIL

- Clear Policy & Procedure on readmittance will help prevent unsafe and needless transport
- The transporting party AND the accepting party must agree that the accepting party can provide the required ongoing care
- ‘Clearance by an external medical authority should not be automatically accepted by the jail when common sense dictate otherwise’

WITHDRAWAL MANAGEMENT

- A prescriber should receive a daily census of all patients being monitored for withdrawal
- A clinical assessment should be conducted by a qualified health care professional (prescriber or nurse or…) not less than twice per day, not more than 16 hours apart unless otherwise stated in substance specific area
  - Can utilize telehealth when QHCP are not available on site

CLINICAL ASSESSMENT INCLUDES

- General physical condition
- Vital signs
- Hydration status
- Orientation
- Sleep
- Mental health status, including risk for suicide or self-harm
- Progression of the patients' withdrawal symptoms
- Timing of next assessment

CLINICAL ASSESSMENT RESULTS IN

- Patient-specific orders regarding
  - What to monitor
  - Changes to look for
  - What to do
- The prescriber must order implementation of a specific withdrawal protocol or pathway for a specific patient
- When there are no longer signs and symptoms of withdrawal without medication, the prescriber must order patient specific orders to discontinue monitoring

WITHDRAWAL MANAGEMENT & MONITORING

- Monitoring can be conducted by a qualified healthcare professional or well-trained custody staff
  - Sedation from withdrawal or withdrawal management can result in falls
  - Lower bunks are recommended
  - Consider timing of monitoring to avoid interfering with sleep

NALOXONE AVAILABILITY

Photo by NEXT Distro on Unsplash

- Naloxone should be readily available to custody and medical staff for overdose reversal, including in all housing units
- Consider making naloxone readily available in all housing units to individuals in custody

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STAFF AND STAFF TRAINING

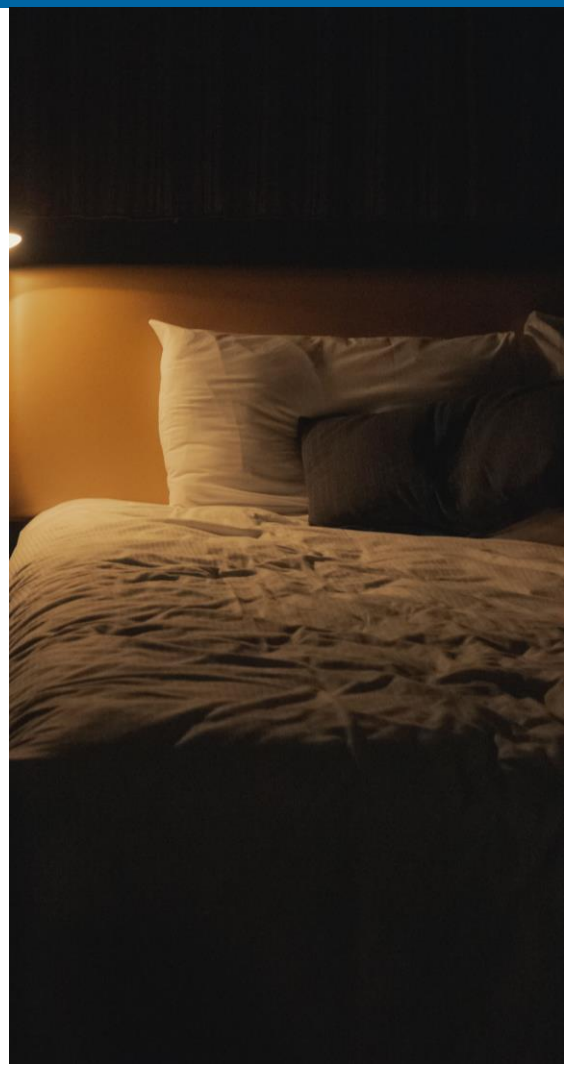
- Minimum 24 hour on call clinical support from a registered nurse
- All staff who conduct screening or assessments should be assessed at least yearly
- Supervisors should observe real patient interviews
- All custody should receive training that addresses misconceptions and stigma regarding SUD and medication for addiction treatment
- First aid training for staff should include CPR, managing overdose & seizures while awaiting transport
- All training relevant to these guidelines should be reviewed every 2 years
- Policy & procedures should be reviewed every 2 years

Quality Assurance

Withdrawal management should be part of jail quality assurance process

SUPPORTIVE CARE

- Patients undergoing withdrawal may benefit from
  - Dimming lights
  - Reducing noise
  - Housing patients in withdrawal on smaller units
    - Isolating is not advised due to increased risk of self-harm
  - Knowing that treatment of withdrawal is NOT treatment of SUD



SUPPORTIVE CARE

- Patients undergoing withdrawal may benefit from
  - Nutritional supplementation
  - Glucose
  - Management of electrolytes

- Unimpeded access to water or electrolyte solution unless there is a medical reason to restrict access

PATIENT EDUCATION

- Signs and symptoms of withdrawal
- The assessment process
- What to expect during treatment and monitoring
- What to do if released prior to completion of withdrawal
- The patient's role in helping manage withdrawal
- Importance of engaging in SUD care to support sustained recovery

REENTRY

- Appropriate sharing of health records
- Establishing insurance coverage
- Arranging support via community SUD treatment
- At a minimum, provide information about where care can be provided in the community

SUICIDE & DEPRESSION

- The frequency of suicide attempts is higher in those with SUD, even in those without a pre-existing psychiatric condition
- Monitor for thoughts of self harm during withdrawal
- Depression may be a consequence of substance use or withdrawal
- Depression that does not improve as withdrawal improves may require evidence-based treatment

PREGNANCY AND POSTPARTUM

Stock Photo. Posed by Model.
Photo by Enrique Guzmán Egas on Unsplash

- Risk of unmanaged withdrawal often outweighs the risk medications pose to fetus
- Withdrawal during pregnancy often results in return to substance use
- Drug use does not equate to a lack of parenting ability

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PREGNANCY AND POSTPARTUM

- All patients of childbearing potential should be assessed for pregnancy
- Do not assume nausea, headache, anxiety or insomnia are due to pregnancy
- Provide judgement free explanation of the risks and benefits of medication for the patient and the fetus
- Initiation or continuation of medication should not be delayed due to a patient's pregnancy or lactation status

OLDER ADULTS

- Increased incidence of comorbid medical conditions
- Slower metabolism of medication/ drugs
- Prescribed medications that blunt physiological responses normally associated with withdrawal
- Misinterpretation of cognitive changes associated with withdrawal as being due to dementia
- The threshold for transferring an older adult to a higher level of care should be lower than for younger adults

OVERVIEW: WHAT ARE STIMULANTS?

Cocaine

"Psychostimulants with abuse potential"

- Ma huang/ ephedra & khat
- Pseudoephedrine, ephedrine & cathinone & cathine
- Amphetamine
  - Methamphetamine
  - MDMA/ecstasy = Molly = methylenedioxy-methamphetamine
  - Amphetamine
  - Methylphenidate = Ritalin ™
- Methylxanthines
  - Caffeine (coffee)
  - Theophylline (tea)
  - Theobromine (chocolate)


Powder cocaine/ methamphetamines


Free Base Cocaine


Ephedra


Ma huang


Bath Salts

STIMULANT INTOXICATION & WITHDRAWAL

- Intoxication can present with medical symptoms and psychiatric symptoms, either of which may require a higher level of care
- SAMHSA singles out self harm as the greatest risk during stimulant withdrawal due to intensity of depression
- Signs & symptoms of stimulant withdrawal typically occur within 72 hours; opioid withdrawal symptoms may also occur
- Monitor twice per day for 72 hours from intake for anyone who reported stimulant use in last 48 hours

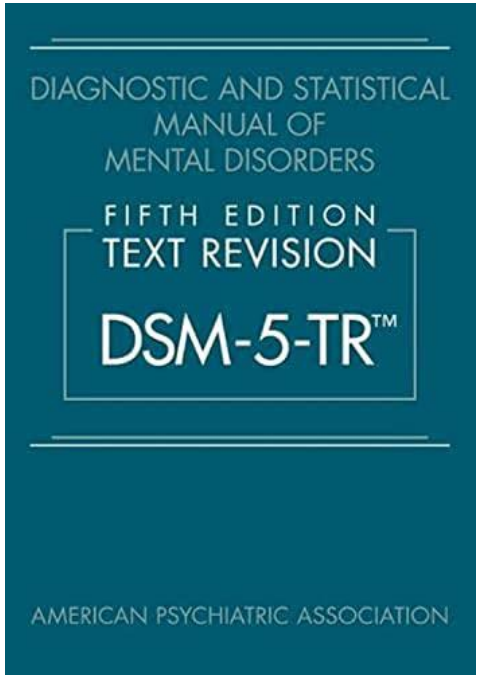
DSM-5 DIAGNOSTIC CRITERIA FOR STIMULANT WITHDRAWAL

A. Cessation of (or reduction in) prolonged amphetamine-type substance, cocaine or other stimulant use

AND

B. Dysphoric mood and at least 2 of the following physiological changes, developing within a few hours to several days after Criterion A:
   - Fatigue
   - Vivid, unpleasant dreams
   - Insomnia or hypersomnia
   - Increased appetite
   - Psychomotor retardation or agitation

AND…



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DSM-5 DIAGNOSTIC CRITERIA FOR STIMULANT WITHDRAWAL

AND

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

AND

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

AND

Specifier

- Specify the specific substance that causes the withdrawal syndrome

POSSIBLE INDICATORS OF STIMULANT WITHDRAWAL

- Agitation
- Anxiety
- Dysphoria/ depression
- Intense desire to sleep, (possible insomnia)
- Psychotic symptoms
- Strong cravings
- Suicidality/ impulse for self-harm

No well validated clinical assessment tools for stimulant withdrawal

TREATMENT OF STIMULANT WITHDRAWAL

Usually accomplished in jail

Behavioral/ environmental management

- Reduced stimulation
- Provide calm interactions
- Allow sleeping
- Ensure access to fluids and nutrition

Medication

- No medication FDA approved or standard of care for withdrawal or stimulant use disorder
- Medication can be utilized for symptomatic relief
  - ex. Antipsychotic if psychotic

Depression is usually secondary to withdrawal

- If it does not resolve, then utilize evidence-based treatments

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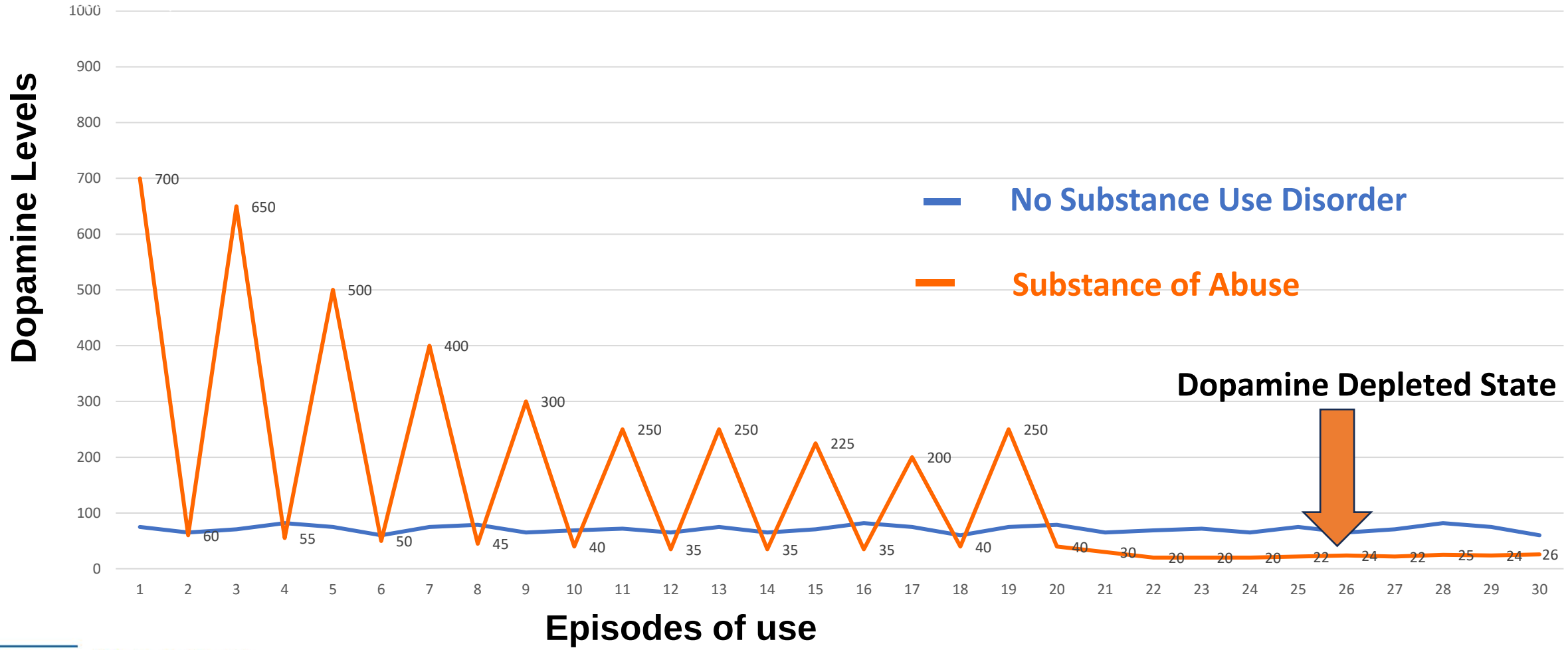
NEUROBIOLOGY OF ADDICTION



PROLONGED DRUG USE CHANGES THE BRAIN IN LONG LASTING WAYS

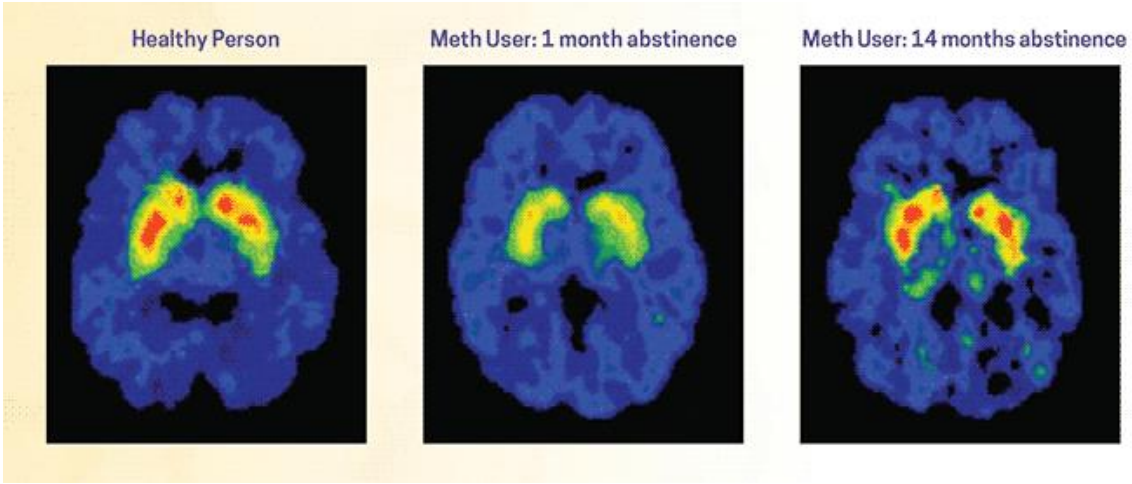
Source: National Institute on Drug Abuse

MYTH: “Detox” is treatment for stimulant use disorder.

REALITY: Return to the brain function you had before abuse of substances takes over 1 year.

RETURN TO NORMAL (WHEN POSSIBLE) TAKES OVER A YEAR

- 2/3 of those with amphetamine use disorder have cognitive impairment
- This does not always reverse with abstinence
- This can make it difficult to engage patients in treatment because they have trouble with attention, memory, processing time, sequencing events
- It is critical to engage patients in more than withdrawal management
- Educate them about evidence-based treatments available



These images showing the density of dopamine transporters in the brain illustrate the brain's remarkable ability to recover, at least in part, after a long abstinence from drugs—in this case, methamphetamine. [51]

Source: The Journal of Neuroscience, 21(23):9414-9418. 2001

TREATMENT FOR STIMULANT WITHDRAWAL (1 OF 2)

Stimulant Withdrawal: Monitoring & Treatment

HMA INSTITUTE ON ADDICTION

Common Signs and Symptoms of Stimulant Withdrawal/Abstinence Syndrome	
PHYSIOLOGICAL	**PSYCHOLOGICAL/BEHAVIORAL**
• Weight gain • Dehydration • Fatigue with lack of mental or physical energy • Psychomotor lethargy and retardation —may be preceded by agitation • Hunger • Chills • Insomnia followed by hypersomnia	• Dysphoric mood that may deepen into clinical depression and suicidal ideation • Persistent and intense drug craving • Anxiety and irritability • Impaired memory • Anhedonia (i.e., loss of interest in pleasurable activities) • Withdrawal from interpersonal relationship • Intense and vivid drug-related dreams

Source: Adapted from SAMHSA TIP 33: Treatment for Stimulant Use Disorders

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Download Stimulant Withdrawal: Monitoring & Treatment Resource

TREATMENT FOR STIMULANT WITHDRAWAL (2 OF 2)

Critical Management Points for Stimulant Withdrawal

- Assess for possible pregnancy
- Monitor for suicidal thoughts
- Consider simultaneous opioid withdrawal as many stimulant drugs are contaminated with fentanyl and other opioids
- Manage environment for agitation and paranoia: calming, low light, low noise
- Allow individual to opt out of other therapeutic activities for first 24 to 36 hours
- Address any critical medical issues such as wounds, trauma, etc.
- Provide adequate fluids (critical due to decreased secretions associated with stimulant use) and nutritious food

Ongoing Management

- Evaluate for underlying psychiatric illness such as PTSD, depression, anxiety, ADHD
- Manage oral hygiene; provide toothbrush and toothpaste and/or mouth rinse; consider dental evaluation
- Universal testing for HIV and hepatitis testing is recommended

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Substance Abuse and Mental Health Services Administration. Treatment for Stimulant Use Disorders. Treatment Improvement Protocol (TIP) Series 33. SAMHSA Publication No. PEP21-02-01-004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

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Download Stimulant Withdrawal: Monitoring & Treatment Resource

POLYSUBSTANCE USE

- Individuals with justice involvement have higher rates of polysubstance use than the general public
- More than half (56%) of overdose deaths among individuals who were formerly incarcerated involved polysubstance use
- People who use stimulants may have opioid withdrawal due to fentanyl in stimulant supply
- Opioid withdrawal requires pharmacological treatment
- Treatment of opioid use disorder can lead to decreases in stimulant use long term
- Engage in evidence-based treatments for stimulant use disorder

Sources: Bunting, A., C. Oser, M. Staton, and H. Knudsen (2020) ; Peles E, Kreek MJ, Kellogg S, Adelson M. (2006); Tennant, F. & Shannon, J. (1995)

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

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TIME PERMITTING
LET'S TAKE SOME QUESTIONS

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

REFERENCES AND RESOURCES

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