General Withdrawal

Summary of BJA/NIC Guidelines for Managing Substance Withdrawal in Jails

The Bureau of Justice Assistance (BJA) in conjunction with the National Institute of Corrections (NIC) have published ***Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals***[i] to help correctional facilities establish or enhance processes that appropriately address withdrawal and support custody and health care staff in carrying out their responsibilities.

Why should correctional facilities care about this topic?

- 63% of individuals sentenced to correctional facility have a substance use disorder (SUD) and will undergo withdrawal from that substance (e.g., alcohol, opioids, stimulants) while in custody.
- Insufficient management of withdrawal can lead to poor clinical outcomes for the detained person and increased legal liability for the correctional facility. Appropriate management of withdrawal and SUD treatment can improve outcomes for both the individuals under treatment (e.g., improve rates of recovery) and society (e.g., decrease violence in correctional facilities and crime rates.)

Who should be screened for risk of withdrawal at entry to a correctional facility?

- **Every detained person** should be confidentially screened for risk of withdrawal at entry to a correctional facility using a **validated SUD tool** that includes recent types of substances used; routes; amounts; frequency; most recent use; history of complicated withdrawal; SUD diagnoses; risk of withdrawal; and prescribed medications.

Who should be monitored for continued risk of withdrawal?

- 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exhibiting sign or symptoms of withdrawal including (but not limited to) agitation, tremor, vomiting, or appearing withdrawn.

Who can complete the screening and withdrawal monitoring?

- Health care staff or well-trained custody staff can complete screening and monitor for risk of withdrawal.

What is the frequency of withdrawal monitoring? And how does it trigger clinical assessment?

- A **qualified health care professional** should perform an **immediate clinical assessment** for any detained person who **appears unwell or intoxicated**; is **pregnant and using substances**; reports or is known to have **regular heavy use of alcohol or sedatives;** or **reports using alcohol or sedatives in the past week AND has a history of complicated withdrawal**.
- Withdrawal monitoring is coupled with clinical assessment and the frequency depends on the type of substance and severity of withdrawal as shown in the Table below from G2 and Appendix E in the *Guidelines*.

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Substance	Refer for Immediate Clinical Assessment	Monitor for Withdrawal Signs and Symptoms	Frequency of Withdrawal Monitoring
Alcohol	• Appears unwell to a layperson. • Self-report of ≥8 standard drinks/day for men or ≥6 standard drinks/day for women, ≥4 days a week. • Reports past-week alcohol use and a history of complicated alcohol withdrawal (e.g., withdrawal-related seizures, delirium, hallucinations).	• Self-reported risk for alcohol withdrawal. • Reports recent alcohol use below the threshold specified for immediate clinical assessment AND does not report a history of complicated alcohol withdrawal. **Monitor at least every 6 hours for the first 72 hours from arrival to facility.**	Re-assessment using the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar) at least every 8 hours during alcohol withdrawal management until the CIWA-Ar score remains below 10 for 24 hours. • If the CIWA-Ar is ≥19, repeat the CIWA-Ar at least every 6 hours during alcohol withdrawal management until the score falls below 19, and then continue monitoring with the CIWA-Ar at least every 8 hours until the score remains below 10 for 24 hours.
Sedatives	• Appears unwell to a layperson. • Self-report of daily use or near-daily use, and use within the last 7 days. • Reports past-week sedative use and a history of complicated sedative withdrawal (e.g., withdrawal-related seizures, delirium, hallucinations).	• Self-reported risk for sedative withdrawal. • Reports recent sedative use below the threshold specified for immediate clinical assessment AND does not report a history of complicated sedative withdrawal. **Monitor at least every 6 hours for the first week from arrival to facility.**	• Daily clinical assessment by qualified health care professional for the first week or as condition indicates. • After the first week, re-assessment by a qualified health care professional at least twice per week until withdrawal management is complete.

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Substance	Refer for Immediate Clinical Assessment	Monitor for Withdrawal Signs and Symptoms	Frequency of Withdrawal Monitoring
Opioids	• Appears unwell to a layperson. • Clinical Opioid Withdrawal Score (COWS) ≥3.	• Self-reported risk for opioid withdrawal or reports recent opioid use AND COWS <3. **Monitor at least every 4 hours for the first 72 hours from arrival to facility.**	• Monitoring using the Clinical Opiate Withdrawal Score (COWS) at least every 4 hours for patients who report use of a sport-acting opioid (e.g., heroin, oxycodone, fentanyl). • Monitoring using the COWS at least every 8 hours for patients who report using long-acting opioids (e.g., extended-release formulations, methadone).
Stimulants	• Appears unwell to a layperson. • Signs and symptoms emerge.	Self-reported risk for stimulant withdrawal or reports recent stimulant use. **Monitor at least twice per day for the first 72 hours from arrival to facility.**	• Monitoring, at an interval determined by the treating clinician, for suicide risk, cardiac complications, severe or persistent psychosis, significant agitation, and possible opioid withdrawal (due to potential contamination of stimulant drugs).

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What is the goal of the clinical assessment?

- The qualified health care professional should assess **emergent medical and psychiatric needs**, including **suicidality**; assess risk for **complicated withdrawal**; and determine the **appropriate level of care** which may be outside of the correctional facility. Telehealth can be utilized for assessment and treatment.

When should correctional facilities transfer to a higher level of care?

- Moderate to severe withdrawal with **significant comorbidity or pregnancy.**
- **Overdose** is suspected or **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) ingestion.**

How should correctional facilities clinically manage withdrawal when detained persons do not require transfer to a higher level of care?

- Correctional facilities should consider **housing together individuals at risk of withdrawal.**
- Have **24-hour availability of on-call nursing.**
- Provide supportive environment with access to **hydration, nutrition, and sleep.**
- Ensure **appropriate staff training** for withdrawal monitoring and management.
- Implement **best clinical practices** for withdrawal management based on the substance involved and **start treatment for SUD including medications for alcohol and opioid use disorder if indicated.** See Guidelines for specific recommendations for each substance.

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[i] Bureau of Justice Assistance (BJA) and National Institute of Corrections (NIC). (2023). Guidelines for Managing Substance Withdrawal in Jails. https://bja.ojp.gov/news/new-resource-guidelines-managing-substance-withdrawal-jails