

GUIDE TO DEVELOPING AND REVISING ALCOHOL AND OPIOID DETOXIFICATION PROTOCOLS

By Kevin Fiscella, MD, MPH

All correctional facilities, regardless of size, should have a system for screening, diagnosis, and appropriate treatment of alcohol, sedative/hypnotic, and opioid withdrawal, and postrelease linkage to treatment.

Introduction

Newly admitted jail detainees and inmates have high rates of alcohol and opioid dependence.¹ Acute withdrawal from these substances is common in correctional facilities.² Unrecognized and untreated alcohol (and chemically related sedative/hypnotic) withdrawal can be fatal.³ Untreated opioid withdrawal results in needless suffering, potential interruption of vital treatments such as antiretroviral treatment for HIV, and masking of symptoms from other life-threatening illness. In the presence of significant chronic illness, untreated opioid withdrawal has resulted in deaths.² Even in healthy patients, untreated opioid withdrawal results in needless suffering, diversion of opioids within the facility, and behavioral challenges for custodial staff.⁴

Inmates receiving opioid treatment in the community prior to arrest should be continued on methadone or buprenorphine treatment during incarceration. Forced detoxification of persons engaged in treatment deters future treatment,^{5,6} and its legality is questionable.⁷ Moreover, continuation of medication-assisted treatment not only avoids detoxification and facilitates reengagement with inmates' community treatment program postrelease, but also minimizes postrelease overdose.

In the absence of systematic screening and assessment, acute withdrawal often goes unrecognized as it commences, often within 12 to 36 hours following last use.⁸ Correctional staff, including health professionals, may mistakenly attribute withdrawal symptoms to other concurrent illness. National surveys indicate that many correctional facilities fail to use standardized, valid instruments for screening and assessing alcohol and drug withdrawal and often fail to employ detoxification protocols that are consistent with current medical practice.^{1,2,9} Only 8% of correctional facilities refer inmates to methadone programs following release despite high rates of postrelease overdose and death.^{10,11}

Implementing safe effective and protocols for detoxification requires that correctional facilities address the following key components: training, identification/referral, risk assessment, use of medically acceptable protocols, an established system for emergency hospitalization of inmates in severe withdrawal, and prerelease linkage to treatment.

Training

Implementation of effective detoxification in correctional facilities requires adequate training of both health care and custodial staff.¹² A training manual is available from the federal Substance Abuse and Mental Health Services Administration.¹³ Training for all correctional staff should focus on appropriate attitudes, knowledge, and skills. Attitudes that are dismissive ("It's no big deal") or punitive ("Addicts get what they deserve") may hinder recognition and early treatment of alcohol and opioid withdrawal.

A key training goal is recognition that substance use disorders are same as any other chronic illness, such as diabetes or schizophrenia. Staff should understand that substance disorders are not hopeless conditions, but can be successfully treated¹⁴⁻¹⁶ and that successful treatment can prevent further arrests.^{15,17} Most importantly, staff should recognize that *they* can make a difference—by actively encouraging inmates to seek treatment. Attitudes are often conveyed verbally or nonverbally. Staff should understand that helpful and responsible expressions (e.g., "You can recover if you commit yourself fully to

it”) can facilitate inmates’ recovery.¹⁸ Punitive attitudes engender bitterness and may increase cravings that undermine inmates’ motivation to seek treatment.¹⁹ Similarly, training should stress that while relapse is not uncommon, that repeated treatment increases chances for success.

All staff should have basic knowledge regarding the course of substance disorders and the availability of effective treatment, including both behavioral and medication-assisted treatment, even if such treatment is not available in the facility. All staff should learn to recognize the signs and symptoms of alcohol, sedative/hypnotic, and opioid withdrawal, including their time course, and be aware of the consequences of inadequate treatment, including potential death.²⁰ The concept of harm reduction as a basic component of drug treatment should be incorporated into the training.²¹

Staff conducting intake screening should be trained to administer screening questions to assess for alcohol and drug use, frequency, quantity, duration of use, and last use, and, most importantly, to obtain any history of prior episodes of withdrawal syndromes.¹² They should also be trained to recognize signs of acute intoxication requiring emergency management.¹²

Health personnel should be trained to obtain an appropriate history that includes details about substance use, past treatment, current medications and allergic reactions, medical and psychiatric comorbidity, and suicidal ideation, and to assess mental status and level of consciousness.²² Records should be obtained from community physicians. Health professionals should be trained to administer standardized withdrawal instruments, and be trained in use of established, evidence-based detoxification protocols. They should understand that detoxification involves appropriate assessment, stabilization of withdrawal symptoms, and then a tapering of the medication used to treat the withdrawal.

Detoxification can be very helpful in fostering readiness for entry into treatment.¹² However, health personnel should also recognize the limitations of detoxification. Training should emphasize that detoxification does not constitute treatment of the underlying substance dependence disorder.²² Thus, health personnel should be trained to link persons with alcohol or opioid treatment following detoxification and to educate inmates and detainees about the need to engage in community-based treatment following release.²² Ideally, health staff should be trained in motivational interviewing, an approach shown to foster entry into treatment.²³ They should recognize that readiness to change varies by circumstances and person and that previous relapse does not imply futility. In addition, they should understand the limitations of urine toxicology testing, including common reasons for false negative and positives. Health personnel must also recognize that opiate detoxification is not appropriate for pregnant women, as discussed below.

Identification, Referral, and Evaluation

Intake screening and assessment of all inmates is critical to a correctional facility’s ability to safely and humanely manage alcohol and opioid withdrawal.¹² Withdrawal from other substances, such as cocaine, amphetamines, hallucinogens, inhalants, and cannabis, does not require specific treatment and usually can be managed with monitoring, psychological support, and symptomatic treatment.¹² The primary exceptions are withdrawal from sedative hypnotics such as barbiturates and benzodiazepines. These should be managed similarly to alcohol.¹²

Optimally, detoxification programs in jails should include the following components:¹²

Universal screening. Upon admission, all detainees/inmates should be screened for substance use disorders and for potential for acute withdrawal. Such screening requires appropriately trained staff to administer standardized questionnaires. Providing a rationale (e.g., “we ask these questions to identify persons needing treatment for alcohol or drug withdrawal”) before asking about substance use encourages more honest response. Inmates should be routinely asked about type of substances, amount, frequency, duration, and previous withdrawal. Standardized screening instruments are available, including the Simple Screening Instrument for Substance Abuse (SSI-SA) and the AUDIT-PC.^{22,24} Persons who screen positive or who report heavy daily or near daily use of alcohol or daily use of opioids should be referred for further clinical evaluation.

Evaluation of those who screen positive. All who screen positive should be assessed for substance dependence and acute withdrawal by trained health professionals using standard diagnostic criteria, such as the DSM-5, and validated withdrawal assessment instruments. These instruments are easy for clinicians to use and identify patients in alcohol or opioid withdrawal who need intensive medical management. Examples of such instruments include the Clinical Institute Withdrawal Assessment – Alcohol Revised (CIWA-AR),^{12,25} the Clinical Opiate Withdrawal Scale (COWS) and the Objective Opiate Withdrawal Scale (OOWS).

Those who screen positive should receive a complete medical and psychiatric evaluation to assess for and treat physical and mental health comorbidity, pregnancy, hydration, and nutritional status (that can complicate management of withdrawal) and a review of current medications. Evaluation includes assessment of level of consciousness and mental status. Acute intoxication requires close monitoring. A significant alteration or decline in level of consciousness suggests need for hospital transfer because both alcohol, and occasionally, opioid intoxication can be fatal. Naloxone (e.g., Narcan®) should be readily available to treat opioid intoxication emergencies. Intoxicated inmates should be closely monitored for the development of withdrawal symptoms that may ensue as blood alcohol or opioid levels decline.¹²

Routine laboratory testing may include a complete blood count (to assess for underlying infection or severe anemia), chemistry (electrolyte disturbance that could increase risk for seizures), liver function (acute or chronic hepatitis from alcohol or viral hepatitis), urine toxicology (to confirm drug use), and pregnancy testing in women (see below). Other testing should be guided by medical indications. Persons undergoing alcohol detoxification routinely receive thiamine and multivitamins.

Risk stratification. Persons at risk for withdrawal should be stratified into three groups: those who do not require immediate medication but do need continue monitoring, those who require immediate medication but lack other risk factors, and those at high risk who require medication and intensive monitoring. High-risk patients are identified using standardized criteria and referred to a facility equipped to manage emergencies. Common risk factors include prior history of delirium tremens, withdrawal-associated seizures, history of traumatic brain injury, advanced age, major medical or psychiatric comorbidity, pregnancy, and a score of 15 or higher on the CIWA-AR.¹² If the correctional facility lacks an infirmary adequately equipped with trained medical staff available around the clock to handle emergencies or if a person is at great risk of developing delirium tremens, then the inmate should be quickly transferred to a hospital.

Detoxification and opiate substitution therapy during pregnancy. Pregnancy requires separate policies and procedures.²⁶ Pregnant detainees/inmates undergoing alcohol, sedative/hypnotic, or opioid withdrawal require specialized treatment that typically involves transfer. Standard of care for pregnant women with opiate dependence is substitution therapy. Detoxification from opiates must be avoided in pregnancy, given the risks to the fetus.²⁶ Many well-designed programs arrange to continue methadone or buprenorphine among pregnant women who have been receiving medication-assisted treatment prior to confinement, and to initiate substitution therapy while in custody.²⁷ For women who are not yet receiving opiate substitution treatment, correctional facilities should consult a specialist within 6 hours.

Detoxification Protocols

Clear and valid criteria are needed for initiation of medical detoxification. Such criteria ensure that all inmates who experience appreciable withdrawal are treated and that those who do not experience such symptoms do not undergo needless treatment. For example, persons scoring < 10 on the CIWA-AR or on the COWS often do not require immediate medication.¹² However, continued monitoring is necessary to determine whether symptoms will worsen and require medication or will continue to abate. Length of monitoring depends on the substance that has been ingested. Substances with longer pharmacologic half-lives result in protracted withdrawal and require longer monitoring of withdrawal symptoms.

Medical detoxification must be conducted under the supervision of a physician or an appropriately licensed health professional. It involves three steps: induction, stabilization, and taper.¹² Induction involves initiation of a substitute medication to treat withdrawal. Induction often begins with a standard dose of an appropriate medication that is titrated upwards. This can be done through either a fixed dose escalation schedule or through symptom-triggered treatment. The latter allows the dose to be tailored to

the individuals' needs (which vary widely), minimizes risk of under- or overdosing, and reduces duration of detoxification.²⁸ Stabilization refers to abatement of signs and symptoms of withdrawal following dose induction. This typically occurs within the first 24 to 48 hours. Once withdrawal symptoms stabilize, medication is tapered over a period of 5 to 10 days.¹²

Detoxification protocols are widely available from various sources, including correctional medicine textbooks,²⁹ the Federal Bureau of Prisons,³⁰ and "Treatment Improvement Protocols" produced by the Substance Abuse and Mental Health Services Administration,¹² among others. Guidelines for alcohol and opioid detoxification in correctional settings are posted on the NCCHC website.

Benzodiazepines such as lorazepam are commonly used.¹² Phenobarbital and selected other anticonvulsants may be used as alternative for alcohol detoxification. Methadone and buprenorphine are FDA approved for opioid withdrawal.¹² Methadone has the longest track record but requires a facility opioid license; it is used primarily during pregnancy.¹⁰ Buprenorphine is being increasingly used in community detoxification because of low risk for overdose.³¹ It requires certification by the prescribing physician following completion of an 8-hour course (available online). Clonidine, an antihypertensive, is not approved by the Food and Drug Administration for opioid detoxification but is widely used in correctional facilities.²⁷ It requires careful monitoring to avoid hypotension (and rebound hypertension, particularly in those with underlying high blood pressure). It is not as effective as methadone or buprenorphine in alleviating pain, anxiety, insomnia, and craving.^{32,33} Medications to treat withdrawal in correctional facilities should be administered under supervision to avoid diversion of these substances. A significant number of correctional facilities fail to treat opioid withdrawal with any of these treatments.²⁷ Such policies are not compatible with current standards, are potentially dangerous, and not consistent with the Hippocratic Oath.³⁴

Treatment Referral Within Facilities

All persons assessed as having a substance use disorder, regardless of whether they required detoxification, should receive education about substance use disorder and be referred for formal treatment for substance use disorders following completion of detoxification. For inmates or detainees who are skeptical that they are drug or alcohol dependent, onset of withdrawal symptoms and provision of detoxification may reduce their denial and enhance their motivation for treatment.

Postrelease Treatment Referral

All persons with substance use disorders should be referred for formal treatment prior to their release.³⁵ Enrolling persons in available health insurance prior to release facilitates access to care.^{36,37} Currently, rates of referral for methadone or buprenorphine treatment from prisons at time of release are low but they steadily increasing.³⁸

Correctional staff should be knowledgeable about treatment options available in the community and coordinate discharge with community treatment facilities. Persons who have undergone opioid detoxification should be counseled regarding the increased risk of lethal overdose following release due to loss of tolerance. Persons who have been detoxed from alcohol should be counseled that repeated alcohol withdrawal is associated with increased risk for delirium tremens and death.³⁹ All persons should be counseled about the availability of evidence-based treatment modalities for substance dependence, including medication-assisted treatment of alcohol and opioid dependence.^{40,41}

Correctional physicians should be encouraged to obtain licenses for the use of methadone and/or buprenorphine in order to continue medications for those receiving treatment in the community, to provide optimal detoxification regimens, and to offer selected detainees the opportunity to begin medication-assisted therapy prior to release. These programs have been found to reduce rates of illicit drugs in correctional facilities and reduce recidivism.^{42,43} Similarly, programs using evidence-based medical treatment of alcoholism with naltrexone (including monthly injections) and/or acamprosate should be encouraged.⁴⁴

Repeated studies have shown that postrelease mortality rates for opioid-dependent persons are extremely high because of accidental overdose secondary to decreased tolerance.^{11,45,46} Programs of

low-dose medication-assisted treatment during or immediately prior to release show promise for decreasing these preventable deaths.⁴⁷⁻⁴⁹ Correctional facilities should consider implementing these programs to reduce minimize postrelease drug use, overdose, and re-arrest and to facilitate entry into community treatment programs.

Contribution

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