



RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Detoxification vs. Withdrawal Management: The Jail Challenge
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Advocates for Human Potential, Inc.

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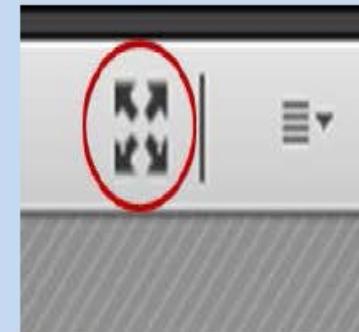
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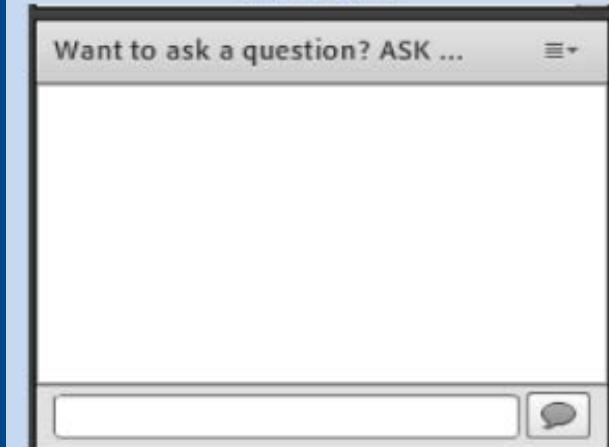
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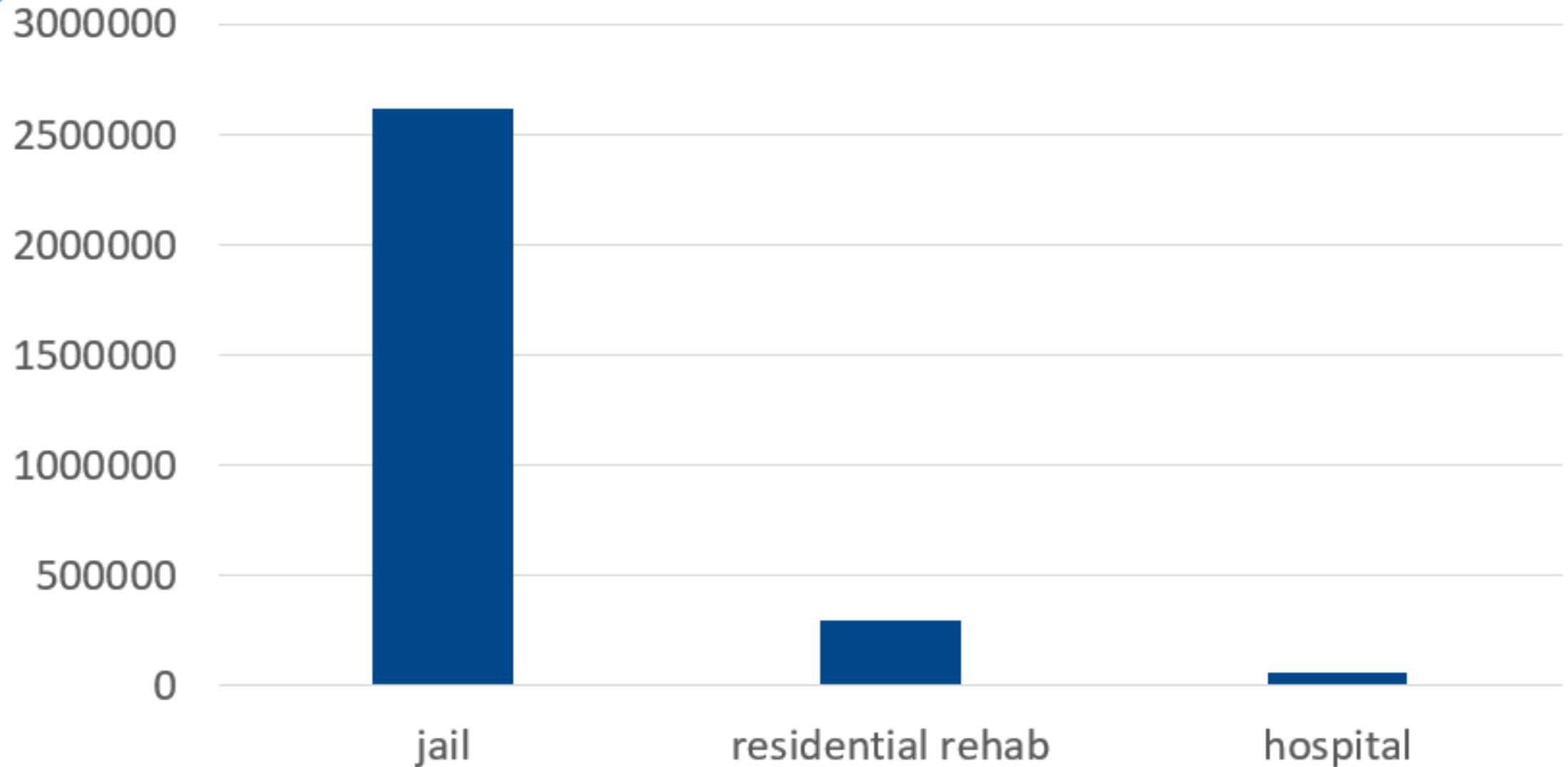
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Learning Objectives:

- Identify the challenges jails and prisons face with increased incarcerated individuals suffering from withdrawal
- Describe treatment options for individuals with SUD's in corrections facilities
- Understand and be able to implement necessary protocols to properly treat incarcerated individuals in need of detoxification services

Opioid Detox (2016)



Detoxification

Opioids: (severe physical withdrawal symptoms)

Alcohol: (severe physical withdrawal symptoms)

Benzodiazepines: (severe physical withdrawal symptoms)

Barbituates: (severe physical withdrawal symptoms)

Methamphetamine (crystal meth): (severe physical withdrawal symptoms)

Cocaine (mostly psychological withdrawal symptoms)

Opioid Withdrawal Syndrome

DSM-5 Criteria:

- A. Either: 1) Cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or 2) administration of an opioid antagonist after a period of opioid use
- B. Three (or more) of the following within minutes to several days after Criterion A: dysphoric mood, nausea or vomiting, muscle aches, lacrimation (abnormal tearing) or rhinorrhea (filling of nasal cavity w/ mucus fluid), pupillary dilation, piloerection (erection of hairs due to the involuntary contraction of small muscles at the base of hair follicles), or sweating, diarrhea, yawning, fever or insomnia

Methadone Withdrawal

Note: Withdrawal from methadone is more dangerous than withdrawal from heroin. Stopping the intake of the drug can lead to breathing difficulties, heart problems or seizures.

Begins 36 hours after last use.

Duration: days to weeks, severe symptoms start declining 10 day.
But emotional symptoms like agitation can begin.

Alcohol Withdrawal Syndrome (AWS)

- Symptoms may develop within 6–24 hours after the abrupt discontinuation or decrease of alcohol consumption.
- Symptoms can vary from autonomic hyperactivity (shortness of breath, rapid heart beat, high heart rate, dry mouth, cold hands, dizziness) and agitation to delirium tremens, hallucinations, high blood pressure and hyperventilation.

Benzodiazepine Withdrawal

- Begins within 24 hours and can last for a few days to several months, even years.
- Symptoms range from slightly uncomfortable to life-threatening, especially for users with severe dependence and those with pre-existing health issues. Symptoms may include one or more of the following : Anxiety, Panic, Irritability, Insomnia, Sweating, Headaches, Muscle pain and stiffness, Poor concentration, Sensory distortions, Nausea, Heart palpitations, High blood pressure, Agitation, & Tremors.
- Serious symptoms can include **Psychosis, Delirious Tremors, and Seizures**.
- Suddenly quitting benzodiazepines may also cause a rebound effect, where ***old symptoms previously treated by the drug return with greater severity***. Users may experience symptoms such as rebound anxiety and insomnia at a level of intensity similar to what was experienced before starting use of the drugs may be progressive, difficult to control, and potentially lethal.

Benzodiazepine Withdrawal (cont.)

- Users with a history of seizures and those who mix benzos with other prescription drugs and/or alcohol may be at higher risk for seizures during withdrawal.
- Some benzodiazepine users may experience a protracted (or prolonged) withdrawal, also known as post-acute withdrawal syndrome, which may last for several months or more. Common symptoms of protracted benzodiazepine withdrawal include: Chronic Anxiety, Depression, & Sleep difficulties

Methamphetamine Withdrawal

- Begin 24 hours after last dose. Fatigue, followed by overwhelming feeling of depression. Some experience paranoia, hallucinations, anxiety, and insomnia during this time.
- Many people who quit using meth experience reduced dopamine receptors in brain resulting in loss of pleasure, called anhedonia. This state can continue for up to two years after a person successfully quits the drug. For many, there are physiological symptoms — anhedonia and the resultant depression.
- The physical symptoms of crystal meth withdrawal are relatively minor as compared to other hard and highly addictive drugs.

Barbiturate Withdrawal

- Begins 8-12 hours after last dose.
- Withdrawal Symptoms: anxiety, muscle twitching, tremor of hands and fingers, weakness, dizziness, distortion in visual perception, nausea, vomiting, insomnia, hypotension, death
- Duration: Symptoms peak in 2-4 days and last 4-7 days for short acting barbiturates and 4-7 and 7-14 for longer acting.

Cocaine Withdrawal

- Begins within hours of last use but worst cravings and withdrawal symptoms appear in first month after quitting.
- Common symptoms: Increased appetite, Fatigue, Depression, Agitation, Restless behavior, Nightmares, Anxiety, Suicidal thoughts
- **Note:** 40% of Cocaine overdose death rates in 2016 involved fentanyl.

Poll Question

Does your facility have a specific protocol for detoxifying entering inmates suffering from withdrawal from opioids, alcohol or benzodiazepine?

- Yes, we have specific detox protocols
- No, but our medical provider provides treatment as needed on a case by case basis.
- Inmates detox cold turkey, unless there are life threatening medical conditions and then they may be sent to hospitals.
- Don't know

People Can Die Withdrawing from Drugs/Alcohol, including Opiates

Myth: Cold turkey withdrawal from opioid is uncomfortable but not dangerous

→ Yes, young healthy patients can tolerate being sick with no lasting problems from withdrawal. ***But*** what about someone who is not healthy to begin with? Someone with asthma or heart disease? Or with underlying sepsis acquired from sharing needles? Or malnourished and dehydrated from not eating? Add physiological stress of withdrawal, “of course they can die.” *Dr. Jeffrey Keller, Jail Medicine*

(127 withdrawal deaths in jails: 94 opioids, 29 alcohol, & 19 benzodiazepines)

Special Risk for Detox of Justice-Involved

Withdrawal from certain substances like opiates as well as alcohol, and benzodiazepines brings increased risks, and these risks are multiplied if the person is on more than one drug. Seizures, for example, do not usually accompany opiate withdrawal, but if the individual is also withdrawing from benzodiazepines, the risk of seizures increases.

J. Galloway (December 6, 2017). U.S. Jails are killing people going through opioid withdrawals, *The Influence*.

Death in a Michigan Jail, 2014

The 32-year-old completed the jail's then standard two-day detoxification program that the facility regularly provided for those withdrawing from opioids. However, the defendant, an opioid addict on prescribed methadone, was also on benzodiazepines prescribed for anxiety. Seeing that his symptoms were not lessening after two days, the defendant was transferred to the jail's mental ward.

Monitored by correctional officers, they notified the jail's medical provider of that they were concerned with the inmate's hallucinations and symptoms, but were reassured that no additional medical intervention was required. The inmate died 16 days later, having lost 50 pounds. The cause of death, "acute withdrawal from chronic benzodiazepine, methadone and opiate medications." The defendant's family suit against the jail and its medical provider, Wellpath and others is on going. The defendant had been jailed for unpaid motor vehicle offense fines of \$772.



Detox Deaths in U.S. Jails

- **Unknown:** Commonly reported as: *Natural Causes, Seizures, Blunt Force Trauma, Suicides*
- **Known:** *109 wrongful death lawsuits pending or recently settled for withdrawal deaths in jails across since 2011*
- *50 settled for more than \$70 million (disclosed)*
- *51 pending*
- *Average award \$1.73 million, range from \$10 million to \$10,000*
- *Awards increasing: all five of major \$4 million settlements in last 3 years*
- *Only 8 dismissed/dropped*

Jail Liability for Inadequate Withdrawal Care

Hernandez v. County of Monterey, 110 F. Supp. 3d 929 (N.D. Ca. 2015).

- Class action filed by former and current inmates against county, jail, and medical provider included inadequate withdrawal medical care.
- Court found for plaintiffs, issued injunction requiring sweeping reforms, including timely withdrawal intake procedures, hospital transfers, the development and implementation of separate detox protocols for opiates, alcohol, and, benzodiazepines, and requirements that the jail continue inmates' prescribed medications when they enter the jail.
- Awarded \$4.8 million to plaintiffs. None of the plaintiffs had died in custody.

Jail Liability

Plaintiff Claim: “deliberate indifference,” based on both actions and inactions

Evidence: Failure to treat withdrawal as serious medical condition

e.g. Tylenol, Pepto-Bismol deemed insufficient for withdrawal symptoms of vomiting, diarrhea, flu-like symptoms and seizures

Another jail protocol to provide “honey and orange juice”

Gatorade provided for woman with severe wait loss due to vomiting, although COs removed her to monitored cell

Jail Liability (cont.).

Lack of medical staff, trained monitors (COs)

- e.g. Wisconsin jail had one nurse for 700 inmates
- Jail contracted with local physician who was also contracted in 21 other county jails, making him sole doctor for 3,500
- Contracted doctor located 300 miles from jail
- Jail had no on-site medical care, relying on nearby hospital, but COs revealed no training to determine who needed hospital care, reluctant to refer due to financial constraints

Jail Liability (cont.)

Existing medical protocols Ignored

- Lack of communications between correctional and medical staff, nurses and physicians
- e.g. Prescription of anti-seizure medication by nurse never provided
- Protocol to provide Clonidine ignored despite severe symptoms, including vomiting and diarrhea
- Communication between jail and contracted medical team found to be “almost non-existent” (\$10 million judgement against Corizon)

Misdiagnosis

- e.g. Seizures, delusions withdrawing from Benzodiazepine seen as symptom of schizophrenia, provided Haldol injection
- Withdrawal symptoms dismissed as fakery or bad behavior

Causes of Death

- **Dehydration**
 - e.g. Inmate lost 50 pounds in 17 days from dehydration before death
- **Blunt Force Trauma**
 - e.g. Inmate seizures result from fall from bunk
- **Suicides**
 - e.g. 7 suicides in 2 years, most during “complex, prolonged” detox provided by jail. Six has expressed no previous suicidal ideation. Report **Report Finding:** Prevalence of suicides to increase due to increasing opioid problem in county

Detoxification vs Withdrawal Management

Street Opioids

vs

Opioid Medications (Methadone, Buprenorphine)

Smith v. Aroostook County & Sheriff Gillen, US Ct

App. 1st Cir. April 30, 2019

- **Facts:** Brenda Smith receive 2x daily dose of buprenorphine prescribed by her doctor for OUD. Due to begin 40-day sentence. Informed jail would not provide medication. Doctor opines prior efforts to take her off medication unsuccessful, continued medication necessary for continued health.
- **Claim:** Forced detox will result in painful symptoms, increase risk of relapse, overdose and death.
- **Demand:** Injunctive relief to compel jail to provide medication
- **Jail Response:** Medication decided on case by case medical assessment (but none planned)
- **District Court:** preliminary injunction ordering jail to provide Smith medication as prescribed while incarcerated

Smith vs Aroostook Cty

Legal Consideration from District Court:

- American with Disabilities Act (542 USC § 12132)
- Potential irreparable harm
- Balance of harm
- Public interest

Appellate Ruling: Preliminary Injunction affirmed, no abuse of discretion by District Court in its assessment of issues that must be balanced.

Amicus Briefs on behalf of Smith

- American Medical Association
- American Society for Addiction Medicine
- Maine Medical Association
- Connecticut Society for Addiction Medicine
- Connecticut State Medical Society
- Maine Association of Psychiatric Physicians
- Massachusetts Medical Society
- Massachusetts Society of Addiction Medicine
- New Hampshire Medical Society
- Northern New England Society for Addiction Medicine
- Rhode Island Medical Society
- Rhode Island Society for Addiction Medicine
- Vermont Medical Society.

Detoxification (illicit opioid) vs Withdrawal Management

- Detoxification vs Withdrawal Management and induction of agonist medication
 - Medically appropriate, accessible post-release (geographically, financially, and medically), resources to administer within institution, desired by patient
- Detoxification followed by antagonist medication (Naltrexone)
 - (same as above)
- Detoxification and release without treatment
 - Relapse, increased risk of overdose deaths (detox =/= treatment)

Detoxification Protocols

Currently, FDA-approved labeling for opioid pain medications, as well as **guidelines** describes the need to gradually reduce the dosage of an opioid medication over time, while monitoring carefully for signs of withdrawal.

CDC Guidelines: Tapering, in general, decrease of 10% of original dose per week reasonable starting point, psychosocial support

Don't reverse the taper, but rate may be slowed or paused

Detoxification Protocols for Jails/Prisons

Short term, uncertain duration of pretrial detention makes CDC Taper guidelines impractical, problematic.

FDA's Center for Drug Evaluation and Research:
“There is no standard opioid tapering schedule suitable for all patients.”

Jail Detox Protocols

1. Cold Turkey
2. Ameliorate symptoms of withdrawal with appropriate medication. i.e. Clonidine, Lofexidine
3. Rapid Taper using agonist medication (methadone/buprenorphine)

American Psychiatric Association

Opioid Detox

- Detoxification treatment options include full opioid agonists (methadone), partial agonists (buprenorphine), opioid antagonists (naltrexone), α_2 agonists (clonidine), and adjunctive medications.
- Treatment choices should be made collaboratively with the patient.
- Buprenorphine is effective for detoxification and maintenance because it is long acting

National practice guideline for the use of medications in the treatment of addiction involving opioid use (American Society of Addiction Medicine)

Methadone Taper: Tapering 20/30 mgs per day within 6-10 days

Buprenorphine Taper: (begin 12-18 hours after last use, 24 to 48 hours after last use of methadone) 4-16 mg dose, tapered for 3-5 days or as long as 30 days or more.

Other medication: Clonidine (off label), max. dose 1.2 mg daily with 0.1 to 0.3 mg every 6-8 hours. . It advises that additional off label medications can also be used for specific symptoms, such as benzodiazepines for anxiety, loperamide for diarrhea, acetaminophen or non-steroidal anti-inflammatory medications for pain, and ondansetron and other agents for nausea.

Lofexidine

First non-opioid medication approved by FDA for opioid withdrawal.

Joshua Lee, MD: “Lofexidine may be superior in terms of better side effect profile and less low pressure, which is the main limitation of the short-term use of clonidine,” and “the biggest issue is if payers and providers will use, or feel they need to use, a new and relatively expensive alpha-2 agonist now FDA-labeled for the non-opioid treatment of opioid withdrawal.”

Alpha2-adrenergic agonists for the management of opioid withdrawal

- To assess the effectiveness of alpha2-adrenergic agonists compared with placebo, reducing doses of methadone, or symptomatic medications for the management of the acute phase of opioid withdrawal.
- Outcomes included the withdrawal syndrome experienced, duration of treatment, occurrence of adverse effects, and completion of treatment.

Findings:

- Moderate-quality evidence: Alpha2-adrenergic agonists (e.g. Clonidine) more effective than placebo in ameliorating withdrawal, likelihood of severe withdrawal.

Research: Gowing, L., Farrell, M., Ali, R., & White, J.M. (2016). Alpha2-adrenergic agonists for the management of opioid withdrawal. *Cochrane Database of Systematic Reviews*, Issue 5.

Growing Findings Continued:

- Moderate-quality evidence: Completion of treatment significantly more likely with alpha2-adrenergic agonists compared with placebo.
- Peak withdrawal severity may be greater with alpha2-adrenergic agonists than with reducing doses of methadone (re likelihood of severe withdrawal and peak withdrawal score), but differences not significant; no significant difference in severity over entire duration of the withdrawal episode.
- The signs and symptoms of withdrawal occurred and resolved earlier with alpha2-adrenergic agonists.
- The duration of treatment was significantly longer with reducing doses of methadone.
- Hypotensive (low blood pressure) or other adverse effects significantly more likely with alpha2-adrenergic agonists, but no significant difference in rates of completion of withdrawal treatment.
- Available data suggest that lofexidine does not reduce blood pressure to the same extent as clonidine but is otherwise like clonidine; not enough studies comparing alpha2-adrenergic agonists

Growing

Conclusion:

Clonidine and lofexidine are more effective than placebo for the management of withdrawal from heroin or methadone. The authors detected no significant difference in efficacy between regimens based on clonidine or lofexidine and those based on reducing doses of methadone over a period of around 10 days, but methadone was associated with fewer adverse effects than clonidine, and lofexidine has a better safety profile than clonidine.

A controlled comparison of buprenorphine and clonidine for acute detoxification from opioids

Compared short-term efficacy of a high-dose, 3-day regimen of buprenorphine to a standard 5-day course of clonidine during rapid detoxification from heroin in 25 men and women admitted to a closed inpatient research ward for this randomized, double-blind, parallel-group trial.

Among the 18 completers, there were no significant differences between the buprenorphine and clonidine groups on five subjective and six physiological measures. However, clonidine lowered blood pressure and buprenorphine provided more effective early relief of withdrawal symptoms.

Research: Cheskin, L. J., Fudala, P. J., & Johnson, R.E. (1994). A controlled comparison of buprenorphine and clonidine for acute detoxification from opioids. *Drug and Alcohol Dependence*. 36(2):115–121.

Three methods of opioid detoxification in a primary care setting: A randomized trial

Compared three detox protocols: clonidine, clonidine and naltrexone, and buprenorphine.

Participants who were assigned to the buprenorphine group experienced less severe withdrawal symptoms than those assigned to the other two groups.

O'Connor, P. G., Carroll, K. M., Shi, J. M., Scottenfeld, R. S., Kosten, T. R., & Rounsaville, B. J. (1997). Three methods of opioid detoxification in a primary care setting: A randomized trial. *Annals of Internal Medicine*. 127:526-530.

A comparison of methadone, buprenorphine and alpha(2) adrenergic agonists for opioid detoxification: A mixed treatment comparison meta-analysis

The aim of this systematic review was to compare the efficacy of methadone, buprenorphine, clonidine and lofexidine for opioid detoxification.

Buprenorpine and methadone appear to be the most effective detoxification treatments. While the analysis suggests buprenorphine is the most effective method of detoxification there is some uncertainty on whether it is more effective than methadone and requires further research to confirm this result.

Meader, N. (2010). A comparison of methadone, buprenorphine and alpha(2) adrenergic agonists for opioid detoxification: A mixed treatment comparison meta-analysis. *Drug and Alcohol Dependence*, (108)1-2: 110-114.

Trend in Jail Detoxification

NaphCare introduces 3-day buprenorphine taper

NaphCare introduced its program through a pilot in 2017 at the Washington County jail in Hillsboro, Oregon. Since then, Kings County and Santa Ana jails in California; Hillsborough County jail in Tampa, Florida; Middlesex County jail in New Jersey; Washoe County jail in Reno, Nevada; Pierce County and Skagit County jails in Washington; and the South Correctional Entity misdemeanor jail in Des Moines, Washington. Then Hamilton County jail in Ohio.

Louisville Metro Department of Corrections

- After being booked, seen by nurse to begin intake process.
- If seen as medically unstable or under influence, nurse assesses to determine if medical stabilization needed at hospital prior to intake. This include unable to stand, cannot maintain own airway, unconscious, intoxicated to point of violence or uncontrollable or threat to others or themselves.
- Intake assessment: Interview, prior record, police report, medical records (patient who deny drug use, but it is suspected, placed in detox monitor only. No medication provided, but assessed by nurses every 8 hrs for 3-5 days or until symptoms abate)
- Instruments: CIWA-AR (Clinical Institute for Withdrawal Assessment-Alcohol Revised) used for Alcohol and Benzodiazepine; COWS (Clinical Institute for Withdrawal Scale) used for opioids

Louisville Metro DOC, cont.

- If identified in need of medical detox, jail classification notified for special housing assignment (not housed alone but with others who can assist them in withdrawal)
- A detox alert entered into jail management system
- Provided with a bottom bunk to prevent falls during seizures/physical weakness
- Provided blue armband to wear during detox period to alert custody and medical staff patient being detoxed should patient need help
- Medications provided at each assessment (every 8 hrs) as needed for nausea, vomiting, diarrhea and body aches
- 8 ounces of Gatorade provided to prevent dehydration with each assessment

Louisville Metro DOC, cont.

- For Benzodiazepine and/or Alcohol withdrawal, tapering dose of Librium provided.
- Louisville does not use agonist taper for opioid withdrawal
- If patient becomes medically unstable, sent to hospital
- Once patient asymptomatic, classification notified for return to general population.
- Detox alert removed, but remains in patient record

Note: On any given day, 40-120 inmates on active detox monitoring. Since detox protocol instituted, no withdrawal deaths compared to several the year before.

Louisville Metro DOC, cont.

- Inmates can refuse medication or have vital signs taken.
- Nurses document what is observed.
- Still placed in detox unit and monitored every 8 hours
- Asked to sign refusal form witnesses by nurse or custody staff. Form kept in patient's medical file.
- If released prior to detox completion, they are referred to treatment. Otherwise will not be released without medical clearance to Home Incarceration, Community Corrections Center, etc.

New Mexico Jails Tested Clonidine

NM jail looked for detoxification alternatives that do not rely on a narcotic taper to see if [clonidine](#), a non-opiate, could be introduced as part of supportive intervention to address acute opioid withdrawal symptoms. 55 inmates (37 male and 18 female) volunteered to test clonidine. Symptoms were assessed with the [Subjective Opiate Withdrawal Scale \(SOWS\)](#) and treated with a standard clonidine protocol. [Clonidine](#) significantly decreased the mean scores at 1 and 4 hours after use. Jail concluded clonidine for opiate withdrawal reduces symptoms when opiate-assisted detoxification is not available.

NCCHC on DETOX

NCCHC: Acute opioid withdrawal is common upon entry into correctional facilities and, untreated, may result in needless suffering, interruption of life-sustaining medical treatments and, rarely, death. National research show significant gaps in quality of care for opioid withdrawal in correctional institutions, including underuse of recommended protocols and low use of drugs approved for detoxification by the Food and Drug Administration. To improve success in reducing substance abuse during and after correctional confinement, the National Commission on Correctional Health Care has issued a new guideline on opioid detoxification in correctional settings.

NCCHC Standards

- Screening. All inmates should be screened for potential opioid withdrawal symptoms within two hours following entry into the facility.
- Evaluation. All inmates who screen positive should be formally assessed for opioid withdrawal within 24 hours.
- Detoxification. All inmates with clinically significant withdrawal should be treated with effective medication.
- Referral for substance abuse treatment. All inmates with opioid withdrawal should be educated about their disease and referred for substance abuse evaluation and treatment.

The American Society of Addictive Medicine

- Criminal justice authorities provide appropriate medical screening so medical needs for alcohol and other drug withdrawal do not go unaddressed during incarceration.
- Drug addicts in jails or prisons receive medical care necessary to manage withdrawal syndromes as for any other acute illnesses or injuries.
- Individuals arrested or detained in correctional facilities be screened by trained personnel for the presence or risk of addiction and withdrawal. When medically necessary, health care professionals should render appropriate detoxification services.
- Jails and prisons revise any policies and procedures that interfere with necessary and appropriate withdrawal management services.

Detox =/= Treatment

- Mass Model: Provide MAT (methadone, buprenorphine or naltrexone) access 30 days before release
 - (**Issue:** Counter FDA advisory to provide methadone or buprenorphine to individuals who are not under the influence of opioids)
- Most jail/prison MAT programs provide injectable naltrexone immediately before release
 - (**Issue:** If patient likely to substitute cocaine or other non-opioid or unlikely to continue on naltrexone, should be advised of alternative agonist medications.)

Questions?

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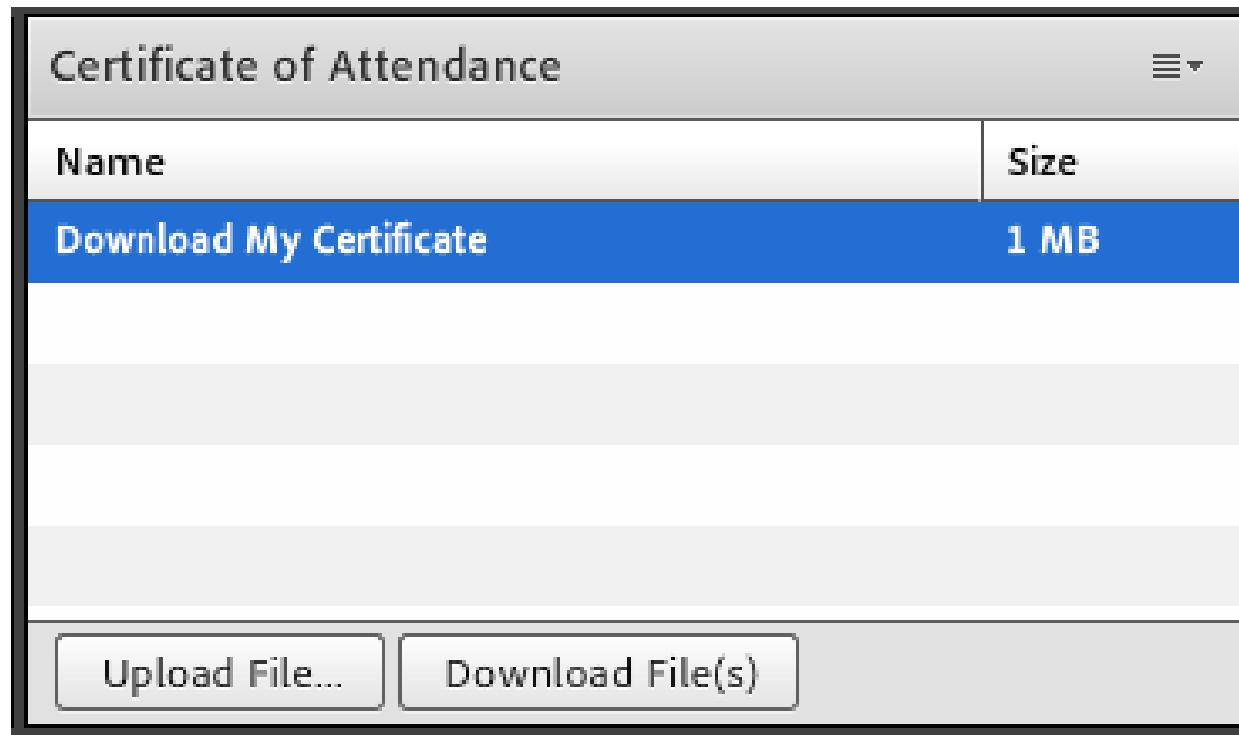
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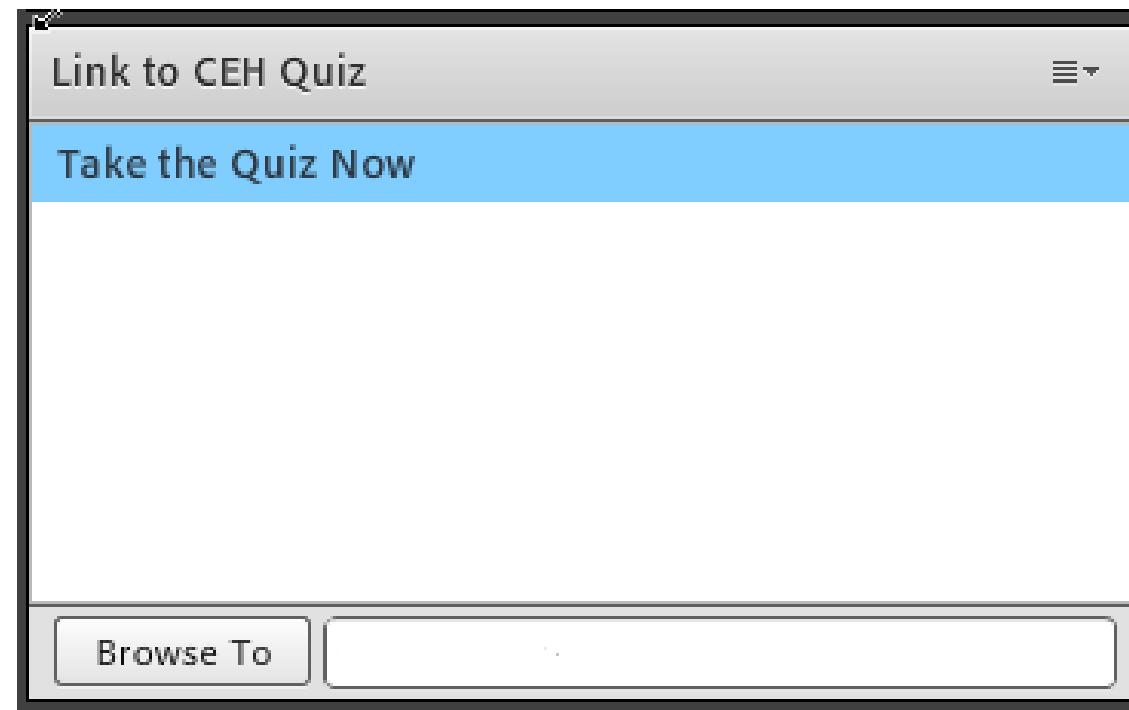
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