National Commission on Correctional Health Care

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Guidance for Disease Management in Correctional Settings

OPIOID DETOXIFICATION

NCCHC issues guidance to assist correctional health care clinicians in evidence-based decision making. This document is meant to supplement—not replace—nationally accepted clinical guidelines issued by organizations such as the Substance Abuse and Mental Health Services Administration, the National Institutes of Health, and the Federal Bureau of Prisons.For specific clinical practice guidelines and recommendations, please see the resources listed on page 3.

Introduction

Although clinical guidelines are important decision support for evidence-based practice, to leverage the potential of guidelines to improve patient outcomes and resource use, NCCHC recommends that health care delivery systems also have components including primary care teams, other decision support at the point of care (such as reminders), disease registries, and patient self-management support. These components have been shown to improve outcomes for patients with chronic conditions. In addition, we recommend establishment of a strategic quality management program that supports ongoing evaluation and improvement activities focused on a set of measures that emphasize outcomes as well as process and practice. For information on the chronic care model and model for improvement, see the resources listed on page 3.

Opioid Detoxification in Corrections

Acute opioid withdrawal is common upon entry into correctional facilities. Untreated withdrawal results in needless suffering, potential interruption of life-sustaining medical treatments, such as HIV treatment, masked symptoms from other life-threatening illness, and, rarely, death. In the absence of systematic screening and assessment, acute opioid withdrawal often goes unrecognized and untreated. National surveys show significant gaps in quality of care for opioid withdrawal in corrections, including underuse of recommended protocols and low use of drugs approved by the Food and Drug Administration (FDA) for detoxification. The general approach to opioid withdrawal comprises four essential components:

- Screening. All inmates should be screened for potential opioid withdrawal symptoms within 2 hours following entry into the facility from the community.
- Evaluation. All inmates who screen positive should be formally assessed for opioid withdrawal using a standardized instrument within 24 hours.
- Detoxification. All inmates with clinically significant withdrawal should be treated with effective medication. Pregnant inmates who use opiates should not undergo detoxification.
- Referral for substance abuse treatment. All inmates with opioid withdrawal should be educated about their disease and referred for substance abuse evaluation and treatment.

Universal Screening

All persons entering correctional facilities from the community should be screened for withdrawal risk during admission. Depending on the half-life of the opioid used, withdrawal symptoms may begin within 24 hours of entry. Screening requires appropriately trained staff and standardized questionnaires. Staff should provide a rationale to the person being screened (e.g., “We ask these questions to identify persons needing treatment for drug or alcohol withdrawal”) before asking about substance use to encourage honest responses. Screening includes questions regarding type, amount, frequency, duration of substance use, and previous withdrawal symptoms. Standardized screening instruments (e.g., Simple

Screening Instrument for Substance Abuse [SSI-SA]) are available. Persons who screen positive or who report heavy regular use of opioids (or alcohol/hypnotics) should be referred for further clinical evaluation.

Evaluation

This includes assessment for substance disorders (including urine drug testing as indicated), withdrawal risk, and medical comorbidity. Checking the state prescription monitoring program registry and confirming opioids doses with community physicians or methadone program is important. In addition, any woman younger than 50 who reports opiate use should be screened for pregnancy. Validated withdrawal assessment instruments such as the Clinical Opiate Withdrawal Scale (COWS) or the Objective Opiate Withdrawal Scale (OOWS) should be used. Withdrawal risk should be stratified into four groups:

- Low risk, asymptomatic: Monitor for symptoms
- Low risk, symptomatic: Immediate treatment needed
- High risk: Intensive monitoring and treatment needed
- Pregnant: Refer to specialist

High-risk patients (e.g., presence of major comorbidity or opioid withdrawal complicated by alcohol/ sedative withdrawal) should be referred to a facility equipped to manage emergencies. Pregnancy also requires separate protocols due to the risk to the fetus of withdrawal and detoxification. Standard of care in pregnancy is opiate substitution therapy with methadone or buprenorphine. Pregnant women who have been receiving medication-assisted treatment prior to confinement should have this continued. For women who are not yet receiving treatment, correctional facilities should consult with a specialist within 6 hours; in some cases this may entail inpatient management.

Acute, potentially life-threatening problems should be addressed first. Inmates who show evidence of moderate to severe sedation, decreased respiration, or hypoxemia should be given intravenous or subcutaneous naloxone 0.4 mg every 1 to 2 minutes and be transferred to a treatment facility equipped to monitor for and manage respiratory arrest. Once the person becomes responsive, monitoring should be done every 15 minutes since relapse into respiratory depression can occur after the effect of naloxone wears off after 45 to 60 minutes.

Detoxification

Standardized withdrawal scales such as the COWS should guide detoxification. Persons scoring < 10 often do not require immediate medication but should be monitored for symptoms. Length of monitoring depends on the half-life of the opioid that has been ingested. Induction often begins with a standard dose of an appropriate medication that is titrated upward, through either a fixed-dose escalation schedule or symptom-triggered treatment. The latter allows the dose to be tailored to the needs of the person (individual needs vary widely), minimizes risk of under- or overdosing, and reduces duration of detoxification. Stabilization refers to the subsiding of withdrawal symptoms. This typically occurs within the first 24 to 48 hours. Then the medication is tapered over a period of 5 to 10 days. The FDA has approved two drugs for opioid detoxification: methadone and buprenorphine. Use of methadone for detoxification (unlike for pain) requires that the correctional facility obtain an opioid license through the Center for Substance Abuse Treatment. Buprenorphine use requires physician certification through completion of an 8-hour course (available online).

Starting doses of methadone or buprenorphine should be based on the severity of dependence. Buprenorphine should be given once withdrawal symptoms are evident (e.g., a COWS score > 10). This is important because buprenorphine is a mixed agonist-antagonist; its use can precipitate acute withdrawal if given before a person develops significant withdrawal symptoms. Adjunctive medications (e.g., nonnarcotic analgesic, antidiarrheal, antiemetic, and anxiolytic) may be needed when detoxification is rapid and/or methadone or buprenorphine are not used. Detoxification is not an FDA-approved use for clonidine.

Substance Abuse Treatment

Detoxification does not treat the underlying disease of addiction. All inmates with opioid dependence should be referred for substance abuse treatment. Depending on expected time of confinement, the inmate should be offered enrollment in drug treatments programs within the facility or referred upon release to comprehensive treatment programs that offer both behavioral and pharmacological treatment. Engagement in community treatment should be done quickly because correctional release often triggers relapse with a high risk of overdose and death.

Quality Improvement Measures

The following quality improvement measures are suggested, but they are not intended to be a complete list necessary to ensure a successful opioid detoxification program in a correctional setting. We recommend that the improvement measures for a patient population be reported at a facility level and at a provider or team level.

- Percentage of new inmates who are screened within 2 hours of entry for risk for opioid withdrawal
- Percentage of new inmates who are referred for evaluation of withdrawal following positive screen
- Percentage of new inmates with acute opioid withdrawal who are assessed using a formal scale (e.g., COWS, OOWS, or SOWS) within 24 hours
- Percentage of new inmates who are identified with acute withdrawal who were not identified through screening
- Percentage of new inmates with acute opioid withdrawal who are detoxed with either methadone or buprenorphine
- Percentage of new inmates with acute opioid withdrawal who are referred for community-based treatment for opioid dependence at time of release
- Percentage of new, pregnant inmates with opiate use disorder who are referred to a specialist within 6 hours
- Percentage of new, pregnant inmates with opiate use disorder who are initiated on methadone or buprenorphine

Recommended Resources to Support Evidence-Based Practice and Quality Improvement

RESOURCE Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol 45 (2006)
SOURCE Substance Abuse and Mental Health Services Administration
URL http://www.ncbi.nlm.nih.gov/books/NBK64115

RESOURCE Substance Abuse Treatment for Adults in the Criminal Justice System. Treatment Improvement Protocol 44 (2005)
SOURCE Substance Abuse and Mental Health Services Administration
URL http://www.ncbi.nlm.nih.gov/books/NBK64137

RESOURCE PCSS-B Training
SOURCE Physicians' Clinical Support System—Buprenorphine
URL http://www.pcssb.org

RESOURCE Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol 40 (September 2004)
SOURCE Substance Abuse and Mental Health Services Administratio
URL http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

RESOURCE	Buprenorphine
SOURCE	CSAT Buprenorphine Information Center
URL	http://buprenorphine.samhsa.gov

RESOURCE	Chronic Care Model (1998)
SOURCE	Developed by Ed Wagner MD, MPH, MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, and the Improving Chronic Illness Care program. Available from the Institute for Healthcare Improvement
URL	http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/

RESOURCE	Model for Improvement (1997)
SOURCE	Associates in Process Improvement. Available from the Institute for Healthcare Improvement
URL	http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove

RESOURCE	Opioid Abuse, Dependence, and Addiction in Pregnancy (2012)
SOURCE	American College of Obstetricians and Gynecologists
URL	http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Opioid_Abuse_Dependence_and_Addiction_in_Pregnancy

RESOURCE	Chronic Care Model (1998)
SOURCE	Based on the model developed by Ed Wagner, MD, MPH, MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, and the Improving Chronic Illness Care program. Available from the Institute for Healthcare Improvement
URL	http://www.ihi.org/knowledge/Pages/Changes/ChangestoImproveChronicCare.aspx

RESOURCE	How to Improve / Model for Improvement
SOURCE	Associates in Process Improvement. Available from the Institute for Healthcare Improvement
URL	http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove

RESOURCE	Measures
SOURCE	Institute for Healthcare Improvement
URL	http://www.ihi.org/knowledge/Pages/Measures

RESOURCE	HEDIS & Performance Measurement
SOURCE	National Committee for Quality Assurance
URL	http://www.ncqa.org/tabid/59/Default.aspx

Last reviewed: October 2014
For the latest version, go to
http://www.ncchc.org/guidance

Appendix 1. DSM-5 Criteria for Substance (Opioid) Disorder

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1. Tolerance to effects
2. Onset of characteristic withdrawal symptoms following cessation of use
3. Opioids are often taken in larger amounts or over a longer period than intended
4. Persistent desire or unsuccessful efforts to cut down or control opioid use
5. A great deal of time is spent on activities necessary to obtain opioids (e.g., stealing property for drug money)
6. Important social, occupational, or recreational activities are given up or reduced because of opioid use
7. Opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids
8. Craving, or a strong desire or urge to use opioids
9. Recurrent opioid use resulting in a failure to fulfill major role obligations
10. Continued opioid use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
11. Recurrent opioid use in situations in which it is physically hazardous.

Adapted from *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). American Psychiatric Association (2013). Available at http://dsm.psychiatryonline.org/content.aspx?bookid=556§ionid=41101782#103441064

Appendix 2. Advantages and Limitations to Use of Buprenorphine and Methadone for Detoxification

Advantages	Limitations
Buprenorphine	
FDA indication for detoxification	Brand name is expensive (generic version cheaper)
Low risk for fatal overdose due to ceiling effect on respiratory depression	Must be administered sublingually, which may require more staff observation time
Lower risk for diversion	Less effective in relieving withdrawal symptoms for heavily dependent persons
Does not require a facility license	Requires physician certification to prescribe
Methadone	
FDA indication for detoxification	Risk for fatal overdose when used inappropriately
Drug is inexpensive	Complex pharmacology
Available as pill or liquid (minimizes diversion risk)	Potential for prolongation of QT interval
Effective regardless of severity of dependence	Clinically significant drug interactions with commonly used medications
	Requires facility opioid license for use

Appendix 3. Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

<table>
<tr><td colspan="2">Patient’s Name________________________________ Date and Time ____/_____/____:__________
Reason for this assessment ____</td></tr>
<tr><td>Resting Pulse Rate ________beats/minute
Measured after patient is sitting or lying for one minute
0 Pulse rate 80 or below
1 Pulse rate 81-100
2 Pulse rate 101-120
4 Pulse rate greater than 120</td><td>GI Upset Over past ½ hour
0 No GI symptoms
1 Stomach cramps
2 Nausea or loose stool
3 Vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting</td></tr>
<tr><td>Sweating Over past ½ hour not accounted for by room temperature or patient activity
0 No report of chills or flushing
1 Subjective report of chills or flushing
2 Flushed or observable moistness on face
3 Beads of sweat on brow or face
4 Sweat streaming off face</td><td>Tremor Observation of outstretched hands
0 No tremor
1 Tremor can be felt but not observed
2 Slight tremor observable
4 Gross tremor or muscle twitching</td></tr>
<tr><td>Restlessness Observation during assessment
0 Able to sit still
1 Reports difficulty sitting still but is able to do so
3 Frequent shifting or extraneous movements of legs/arms
5 Unable to sit still for more than a few seconds</td><td>Yawning Observation during assessment
0 No yawning
1 Yawning once or twice during assessment
2 Yawning three or more times during assessment
4 Yawning several times/minute</td></tr>
<tr><td>Pupil Size
0 Pupils pinned or normal size for room light
1 Pupils possibly larger than normal for room light
2 Pupils moderately dilated
5 Pupils so dilated that only the rim of the iris is visible</td><td>Anxiety or Irritability
0 None
1 Patient reports increasing irritability or anxiousness
2 Patient obviously irritable or anxious
4 Patient so irritable or anxious that participation in the assessment is difficult</td></tr>
<tr><td>Bone or Joint Aches If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored
0 Not present
1 Mild diffuse discomfort
2 Patient reports severe diffuse aching of joints/ muscles
4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort</td><td>Gooseflesh Skin
0 Skin is smooth
3 Piloerection of skin can be felt or hairs standing up on arms
5 Prominent piloerection</td></tr>
<tr><td>Runny Nose or Tearing Not accounted for by cold symptoms or allergies
0 Not present
1 Nasal stuffiness or unusually moist eyes
2 Nose running or tearing
4 Nose constantly running or tears streaming down cheeks</td><td>Total Score (sum of all 11 items) __________
Initials of person completing assessment ____________</td></tr>
<tr><td colspan="2">Score: 5-12 = mild, 13-24 = moderate, 25-36 = moderately severe, More than 36 = severe</td></tr>
</table>