Safe Detox in a Jail Setting: A Corrections Guide

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University of Alabama, Birmingham, 11/09

Supported by the NPHF Scholarship and Award Program though an Educational Grant from Pfizer, Inc.
Jails often arrest people that are addicted to drugs.

Withdrawal occurs 12-96 hours after last use.

Certain drugs can result in death during withdrawal; such as alcohol & benzodiazepines.

Many county jails in Oregon have only alcohol withdrawal protocols including Deschutes County Adult Jail.

Inmates may be housed alone and may not share their addiction history.
Evidence from the Literature
Withdrawal While Incarcerated

* 49% of jails (in a cohort of 500 jails) had no procedures or support services for withdrawal. (Fiscella, Moore, Engerman & Meldrum, 2005).

Sturges (2008) found that a planned approach to care is safer and less stressful for all involved.

* Arrestees in withdrawal often are not acquainted with any form of healthcare, except the emergency room, thus making their health status even more precarious. (Brooks, Pompi, & Nink, 2007)
* Suicidal ideation has been found in 29% of those in withdrawal in the previous 3 months (Mardsen and colleagues, 2000).

* A study by Garcia (2007) found treatment resulted in lower recidivism rates of addiction upon release.

* “Management of withdrawal without medication is difficult, and current assessments do not allow us to predict with confidence who will have life threatening complications” (SAMHSA, TIP 45, 2006).
• There is convincing evidence that treating clients in withdrawal with Evidence Based protocols is safer than dealing with the consequences of untreated detoxification (Fiscella, 2005).

• Addiction medicine is evolving rapidly. NPs in a DNP role are well positioned to take a proactive role in development of this specialty; both in clinical leadership and in training of others.
Detoxification in a Jail

* In a survey of 500 jails, only 28% of jail administrators stated that their facilities ever detoxify inmates (Fiscella, 2005).

* Inmates left to undergo withdrawal without medical supervision can become seriously ill and even die. This is especially true with benzodiazepines and alcohol.
What Do We Mean, “Detox”? 

* During ‘withdrawals’, characteristic mental and physical symptoms occur when drugs of choice are taken away.

* ‘Detox’ is that period of time when abused drugs are taken from the brain, and it becomes unable to regulate itself successfully without them. Long-lasting changes have occurred in the brain’s neuro pathways, and time is necessary to restore them to their former function.
Withdrawal

* When a drug is removed, physical & mental disturbances may occur, depending on drug, amount, chronicity and medical condition of inmate, symptoms can include:
  * Physical symptoms, emotional problems
  * Cognitive & attention deficits
  * Aggressive behavior
  * Hallucinations, seizures
  * Death
Remember.....

• Symptoms of **withdrawal** when abusing depressant substances such as **alcohol**, **opioids**, and **benzodiazepines** often appear to be **opposite** of those symptoms noted when the inmate is moderately intoxicated with these same drugs:

• Anxiety, sympathetic hyperarousal, G-I disturbances, pain, feelings of desperation....
Why Should We Change Current Outdated Practice?

* Withdrawal does not always proceed in a predictable manner.
* A symptom triggered dosing regime is preferred over ‘fixed’ dosing because it is more effective and requires less overall medication.
How will we change current Practice?

We will learn how to use the current standard scoring tools:

The **CIWA** and **COWS**

and base our treatment on evidence-based research used on an individual basis
So, what drug withdrawals will we learn about......?

• Alcohol
• Opiates
• Benzodiazepines........
• The most commonly seen in jail
• The most dangerous for us to manage........especially without an infirmary
Learner Objectives

• **Cognitive Domain**

• #1. Following the presentation.......jail staff will be able to identify 4/7 symptoms that signify an inmate is in alcohol or opiate withdrawal.

• #2. Staff will know the blood alcohol threshold for death.

• #3. Staff will recognize both the CIWA and COWS assessment tools and verbalize why they are a valuable resource for us in corrections.
Learner Objectives, cont.

• Affective Domain

#1. Following the presentation, during discussion...staff will be able to verbalize how the jail will benefit by initiating a symptom-triggered detox regime, and how evidence-based improvements positively affect the facility and staff as well as inmates.
Learner Objectives

• **Psychomotor Domain**

#1. After training, staff will be able to accurately score both a CIWA and COWS assessment tool, and respond per protocol, to that score, with the assistance of the trainer.
Goals:

* To positively affect the health and well being of inmates in withdrawal at DCAJ through individualized treatment.
* To increase knowledge of detoxification through use of evidenced-based scoring tools by staff working with inmates.
* To work synergistically with other providers in county jails, and at the Oregon Police Academy, to increase use of evidence-based care.
CIWA-Ar Scoring Tool

- Clinical Institute Withdrawal Assessment for Alcohol, revised....10 items to score, total score based on symptoms....
- Aids in adjustment of care related to withdrawal severity, and improves staff awareness of the elements of withdrawal....
- Two minutes of observation can be done by deputies or nurses.
- Scoring/interpretation is done by provider, nurses lieutenants, or sergeants.......
How is the CIWA scored?

• The CIWA measures 10 symptom areas of alcohol withdrawal, and structures the severity of symptoms by assigning numerical scores. It is both highly reliable and valid in its interpretation. (max score-67)

• It provides rapid documentation of an inmate’s signs and symptoms, and allows for objective communication among staff as well as appropriate triage of the patient.

• **See handout** of CIWA for further discussion....
## BAC-Effect Relationship

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<thead>
<tr>
<th>BAC (%)</th>
<th>EFFECTS</th>
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<tbody>
<tr>
<td>0.02-0.03</td>
<td>Mood elevation. Muscle relaxation. Behavioral changes</td>
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<tr>
<td>0.05-0.06</td>
<td>Increased reaction time. Decreased fine muscle coordination</td>
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<tr>
<td>0.08-0.09</td>
<td>Impaired balance, speech, vision, hearing, coordination. Euphoria</td>
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<tr>
<td>0.14-0.15</td>
<td>Gross impairment of physical &amp; mental control</td>
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<tr>
<td>0.20-0.30</td>
<td>Memory blackouts. Decreased control of mind or body. Amnesia.</td>
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<tr>
<td>0.40-0.80</td>
<td>Stupor. Unconscious. Deep coma. Decreased V.S. Incontinence. Death</td>
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Ries, R., 2009; SAMSHA TIP 45, 2006
Alcohol Withdrawal Signs & Symptoms

• Tremor
• Agitation
• Changes in blood pressure, pulse temperature
• Seizures
• Sensorium changes (hallucinations, confusion)
Neurological Complications

- **Delirium**: Wernike’s Encephalopathy
- **Dementia**: Koraskoff’s
- **Ventricular Enlargement**: cognitive dysfunction
- **Cerebellar**: ataxia
- **Peripheral**: neuropathy
- **Myopathy**
Wernicke’s Encephalopathy

- Neurological manifestation of **thiamine deficiency**
- Seen in chronic alcoholics
- **Delirium, ophthalmoplegia** (can’t move eyes), ataxic gait progresses to **inability to stand**
- Masked by alcohol withdrawal, can progress to **coma** and **death**
- Treatment: thiamine, early treatment shows improvement within hours to days!
Korsakoff’s Dementia

• Characterized by memory loss and acute confabulations (inability to store or retrieve recent memories)

• Seen in chronic alcoholics, progression from Wernike’s Encephalopathy

• Grossly normal cognition

• Genetic predisposition

• Irreversible

• Other CNS syndromes being researched....
Stage I Withdrawal

• Autonomic hyperactivity (↑ BP ↑ pulse), may begin in first 24 hours
• Lasts up to 5 days, “The Horrors”
• Most (90%) of cases do not progress beyond Stage I
• May also have headache, nausea, vomiting, anxiety
Stage II Withdrawal

• Symptoms of Stage I become increasingly severe
• Results from inadequately treated Stage I
• Hallucinations are present
• Begins approximately 48 hours after last drink
Stage III Withdrawal

• Seen in those inmates with severe alcoholism, medical problems, esp. liver disease. 72-96 hours after last drink

• Delirium Tremens (reversible psychosis) may have 5% mortality, VS decrease

• Disorientation, global confusion, usually 2-5 days (50 days longest)
Withdrawal Seizures

- More common if history of past W/D seizures
- 25% will have additional seizures within 6-12 hours
- Grand mal seizures (Rum Fits)

- Kindling effect noted........
- Benzodiazepines... treatment of choice for both withdrawal and seizures
An excerpt from the “Practice of Medicine” by George B. Wood, 1849, The Pennsylvania Hospital, on alcohol W/D

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<td>•</td>
<td>“a cerebral debility consequent on the cessation of an accustomed excitement”</td>
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<td>•</td>
<td>“Phantoms seem real at night and vanish by daytime.....hobgoblins of all possible shapes.....leering, hissing, and threatening......”</td>
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<td>•</td>
<td>“Each successive one becomes more dangerous”</td>
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<td>•</td>
<td>“At the end of 3-4 days, up to a week, the patient falls into a sound sleep...awakes feeble and pale...but free of illusions”</td>
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What else.........?????

We know that often inmates come to jail intoxicated on a variety of drugs. We will **Detox** inmates from one substance, then another. **Benzodiazepines** are the last to **GO**......
COWS Scoring Tool

• **11 item scale** that best describes the inmate’s symptoms as they **withdrawal from opioids**

• Rated on symptoms just related to the opiate withdrawal ......see **COWS handout** for discussion

• Max score **48**

• **5-12 Mild** withdrawal

• **13-24 Moderate** withdrawal

• **25-36 Moderately Severe** withdrawal

• **More than 36 = Severe** withdrawal
Opioids

Opium
Heroin
Morphine
Codeine
Hydrocodone
Oxycodone
Methadone
Buprenorphine (Suboxone)
Opiate related problems

- Development of **dependence** requires regular use over **months**........1 in 3-4 users become dependent.
- Poor self-care...
- Blood-borne infections; **HIV, HCV, HBV**
- **Incarceration**, cost rises, unable to work
- **Polydrug** use is the **norm**, (benzos & alcohol)
- These combinations are significant
- contributors to **overdose & death** from respiratory depression
Opioid Toxicity?

- If the drug is not “cut” with other detrimental substances, the addict has money to purchase what they need daily, and if self care is maintained, as well as overdose avoided……

- There is little evidence that opiates cause long-term toxic CNS effects if taken perfectly, but.....this is very RARE
Clinical Pearl

- Please keep in mind in your discussions with your fellow deputies and nurses that once an inmate has been detox’ed, their tolerance is lowered for opiates, especially heroin.....

- This means that a dose that was used to get “HIGH” right before arrest is the same dose that may kill them by overdose when they are released and go “back to using”............
• Scores from both the COWS and the CIWA are used to manage the detoxification of each inmate

• The schedule of monitoring depends on the score obtained, the higher the score, the more frequent the monitoring. The lower the score the less frequent the monitoring and less medication needed. This type of care (“symptom-based”) results in less overall medication and a shorter, safer withdrawal....
How long does this go on…..?

* Depending on the substance and the person, withdrawal can range from several days (alcohol), to weeks or months (benzodiazepines).

* Methadone has one of the “roughest” and most drawn out withdrawals and can last weeks. INMATES FEAR withdrawal.

• Simple supportive measures, such as adequate hydration and emotional comfort can ameliorate symptoms and lessen the withdrawal time.
 Last, but unfortunately, not LEAST...

- **BENZODIAZEPINES**
- Often implicated in multi-drug overdose, combination with opiates and alcohol can be **lethal**......
- Used as anxiolytic, sedative, anticonvulsant, muscle relaxer and in alcohol withdrawal
- Difficult to ‘get off’ of, weaning takes **months**
- **If removed too quickly= seizures, possible deaths,** which have been documented in jails
Benzodiazepines

Klonipin
Ativan
Xanax
Valium
Librium

....etc., etc.
Sneaky little pills....

- Developed by Swiss chemists in the 1950’s for its sedative properties..........................  

- One of most **over prescribed** and **abused** drugs today, often used with other drugs  

- Entry level addiction, some people become addicted as they ‘innocently’ take more and more.......inmates often in denial r/t abuse  

- Prescribers are also at fault for inappropriately writing RXs, and being ‘duped’ by seekers
Withdrawal Symptoms

* Benzodiazepines....the “OPIUM of the masses”
Withdrawal symptoms are opposite to intended effect of drug....extreme agitation, tremors, grand mal seizures, psychosis, hypersensitivity, hostile behavior

* Abusers tend to prefer the fast acting varieties, such as Xanax as it gives the user more of a ‘rush’ (shorter ½ life, 6-12 hours), 40% of chronic users will experience withdrawal if abruptly stopped, as with arrest....
Withdrawal from Benzos

*Because benzodiazepines are depressants, withdrawal requires supportive care and pharmacological support for increased blood pressure, pulse rate, and risk of cardiovascular collapse which can lead to DEATH.......

How do we begin??

• We ask arrestees **what** they are **USING**: not to add charges BUT to help them get through possible withdrawal, this is IMPERATIVE….

• Even if they won’t tell you at that time, they will **remember** that you **asked**, and when they begin to detox, they’ll “come clean”……….
What can we do??

• When making scheduled rounds, be alert for those who may be detox’ing........

• Score the CIWA (ALCOHOL) or Cows (OPIATES) as required by medical (remember there is no assessment tool for benzos alone.....)

• For any abrupt changes, CIWA> 10 or COWS>12 contact nurse, or Sergeant will call provider, if no nurse on duty
Case Scenario #1

*28 y/o male, jovial “frequent flyer”,
*Recent foot amputation from ‘camping’ in the snow (homeless),
*Long-term alcoholic with seizure history
* Fifth a day

• **Treatment**
  -corrections staff

  • Have high index of suspicion for seizure potential.....
  • This is an inmate that **should** be on a CIWA protocol
  • Encourage fluids, as symptoms become worse with dehydration
  • If vomiting becomes a problem, until it is controlled, keep observation checks frequent....
  • If sensorium changes, alert medical ASAP!
Case Scenario #2

* 22 y/o female with Classic **Borderline** personality disorder symptoms (“I hate you, I love you....”)
* Worried about weight, **pregnant**, difficult....
* Has been drinking **Vodka** and taking **valium** for sleep

**Treatment**
- corrections staff

* We cannot discount anything she tells us, as her situation is **DIRE!**
* Consultation with the OB/GYN, if is there is one, is paramount...
* She will be watched for both alcohol withdrawal and benzo withdrawal, constant observation may be required, possibly hospitalization.....
Questions?
Thank You


