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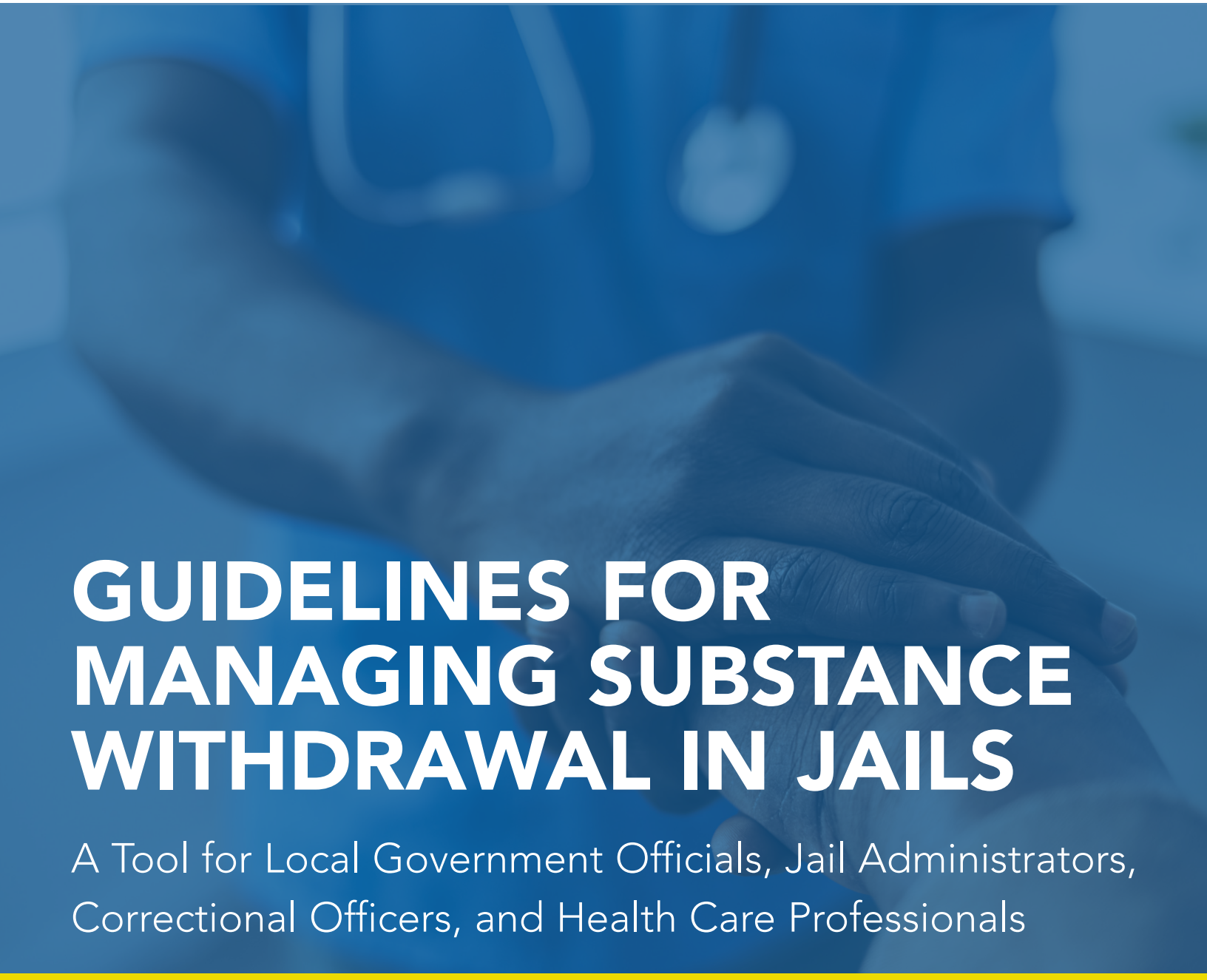

GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS

A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals

June 2023

BJA Bureau of Justice Assistance U.S. Department of Justice
NIC National Institute of Corrections

U.S. Department of Justice
Office of Justice Programs
810 Seventh Street NW
Washington, DC 20531

Amy L. Solomon
Assistant Attorney General

Karhlton F. Moore
Director, Bureau of Justice Assistance

Alix M. McLearen
Acting Director, National Institute of Corrections

Office of Justice Programs
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Endorsing Organizations

The following organizations and their boards of directors endorse the *Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals* published by the U.S. Department of Justice's Bureau of Justice Assistance (BJA) and National Institute of Corrections (NIC).

American Correctional Association (ACA)

American Society of Addiction Medicine (ASAM)

American Jail Association (AJA)

Major County Sheriffs of America (MCSA)

National Association of Counties (NACo)

National Commission on Correctional Health Care (NCCHC)

National Sheriffs' Association (NSA) [but not the NSA Board of Directors]

Small & Rural Law Enforcement Executives Association (SRLEEA)

Foreword

Death and suffering due to withdrawal from opioids, alcohol, and other substances are preventable. Local government officials, jail administrators, correctional officers, and health care professionals have an opportunity to save lives and promote the wellbeing of individuals in jail, an opportunity bound by legal obligations set forth in the Americans with Disabilities Act and various federal civil rights acts.

To help jails and communities establish or enhance policies and procedures that appropriately address withdrawal, as well as support custody and health care staff in carrying out their responsibilities, the Bureau of Justice Assistance (BJA) and the National Institute of Corrections (NIC) are excited to present *Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals*. This groundbreaking document not only responds to urgent requests for guidance from the field but also advances the National Drug Control Strategy of improving access to medication for opioid use disorder for populations who are incarcerated or reentering the community.[1]

We understand that jails have a wide range of medical capabilities and encourage each facility to explore options for implementing the guidelines within their systems and communities. This will involve collaboration between jail administrators and their providers to establish policies and procedures for custody staff and health care professionals. Implementation of the guidelines also calls for collaboration within the community: namely, assessment, planning, and coordination with hospitals, local emergency medical services, opioid treatment providers, county partners, and other entities. BJA and NIC will support implementation efforts of jails and their partners through BJA's Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) Jail Resources, offering a variety of training and technical assistance opportunities, including resources, peer-to-peer learning, and communities of practice.

We profoundly appreciate the time and commitment of the jail administrators, clinicians working in criminal justice settings, and substance use disorder specialists who wholeheartedly shared their expertise, experience, and energy with us to create these guidelines. Many of these experts are now poised to help jails and their partners implement the guidelines through training and technical assistance offered through BJA's COSSUP Jail Resources.

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Together, we can expand access to high-quality and continuous care, thereby preventing deaths from withdrawal and overdose and paving the way toward long-term recovery.

Karhlton F. Moore
Director, Bureau of Justice Assistance

Alix McLearen
Acting Director, National Institute of Corrections

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Federal Champions

- Stephen Amos, National Institute of Corrections, U.S. Department of Justice
- Margaret Chapman, Bureau of Justice Assistance, U.S. Department of Justice
- Ruby Qazilbash, Bureau of Justice Assistance, U.S. Department of Justice

Expert Committee Members

- Jeffrey Alvarez, M.D., CCHP
- Andrew F. Angelino, M.D.
- Oscar Aviles, CPM, CJM, CCE, CCHP
- Chief Deputy Jeff Clark, M.J.A.
- Kevin A. Fiscella, M.D., M.P.H., CCHP
- Carrie Hill, Esq.
- Miriam S. Komaromy, M.D.
- Shannon Robinson, M.D.
- Sandra Springer, M.D.
- Marc F. Stern, M.D., M.P.H.
- Chief Deputy Geoff Stobart
- Donna Strugar-Fritsch, B.S.N., M.P.A., CCHP

Technical Support Team Members

Advocates for Human Potential, Inc.

- Linda Frazier, M.A., RN, MCHES
- Kay S. Peavey, B.A.
- Pam Rainer, M.S.W.
- Deann Rogers, M.S.

American Society of Addiction Medicine

- Maureen Boyle, Ph.D.
- Taleen Safarian, B.A.

National Commission on Correctional Health Care

- Brent Gibson, M.D., M.P.H., CCHP-P
- Wendy Habert, M.B.A., PHR, CCHP
- Laura Lutgen-Nieves, Ph.D.
- Jim Martin, M.P.S.A., CCHP
- Deborah Ross, CCHP
- Jaime Shimkus, CCHP
- Kim Sterling, M.B.A.
- Claire Wolfe, M.A., M.P.H., CCHP

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Table of Contents

Introduction **1**

Purpose 1

Background 2

Development of the Guidelines 2

Content Overview 3

The Withdrawal Management Process **5**

Screening 5

Clinical Assessment 5

Onsite Withdrawal Management Versus External Transfer 6

Pathway to Recovery 6

General Guidance **7**

Screening To Flag Withdrawal Risk 7

Monitoring for Withdrawal Signs and Symptoms 9

Clinical Assessment and Diagnosis 11

Level of Care 13

Withdrawal Management by Qualified Health Care Professionals 14

Monitoring Patients During Withdrawal Management 15

Medications 16

Staffing and Staff Training 17

Quality Assurance 18

Supportive Care 18

Reentry 19
Suicide 21
Pregnancy and Postpartum 21
Older Adults 22
Alcohol Withdrawal 25
Screening 25
Monitoring for Withdrawal Signs and Symptoms 26
Clinical Assessment and Diagnosis 26
Withdrawal Management by Qualified Health Care Professionals 27
Monitoring Patients During Withdrawal Management 27
Level of Care 28
Medications 29
Supportive Care 31
Pregnancy and Postpartum 31
Managing Comorbidities 32
Polysubstance Use Disorder 33
Sedative Withdrawal 35
Screening 35
Monitoring for Withdrawal Signs and Symptoms 35
Clinical Assessment and Diagnosis 36
Level of Care 37
Monitoring Patients During Withdrawal Management 37
Medications 38
Recommendations 38
Supportive Care 39
Pregnancy and Postpartum 39

Opioid Withdrawal **41**
Screening 41
Monitoring for Withdrawal Signs and Symptoms 42
Clinical Assessment and Diagnosis 43
Medications 43
Level of Care 50
Monitoring Patients During Withdrawal Management 50
Supportive Care 51
Pregnancy and Postpartum 51
Reentry 53
Stimulant Withdrawal **55**
Screening 56
Monitoring for Withdrawal Signs and Symptoms 56
Clinical Assessment and Diagnosis 56
Monitoring Patients During Withdrawal Management 57
Medications 57
Level of Care 59
Supportive Care 59
Pregnancy and Postpartum 60
Appendixes **61**
Appendix A: Development Team **63**
Expert Committee 63
Federal Project Champions 64
Technical Support Team 64
Appendix B: Full Methodology **67**
Overview of Approach 67

Task 1: Literature Review 68

Task 2: Identification of Draft Statements and Appropriateness/Feasibility Rating 70

Appendix C: Preferred Terminology 73

Appendix D: ASAM's Principles of Drug Testing During Withdrawal Management 75

Appendix E: Monitoring Patients During Withdrawal Management 77

Appendix F: Withdrawal Pharmacotherapy 79

Appendix G: Indicators of Dehydration 81

Appendix H: Expert Committee Members' Current Industry Relationships 83

Appendix I: Field Reviewers 85

Appendix J: Field Reviewers' Current Industry Relationships 89

Appendix K: Glossary 91

Appendix L: Acronym Glossary 97

Appendix M: Resources 99

Clinical Practice Studies 99

Legislation, Rules, and Regulations 99

Pregnancy and Postpartum 100

Substances 100

Treatment and Medication 101

Reentry 102

Screening and Assessment 103

Telehealth 104

Endnotes 105

Introduction

Purpose

Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals is designed to support jails (including detention, holding, and lockup facilities) and communities in providing effective health care for adults (18 years of age and older) who are sentenced or awaiting sentencing to jail, awaiting court action on a current charge, or being held in custody for other reasons (e.g., violation of terms of probation or parole) and are at risk for or experiencing substance withdrawal. These guidelines will help jail administrators, custody staff, jail-based health care professionals, local government officials, and community providers:

- Unite around a shared understanding of appropriate policies and procedures for responding to individuals at risk for or experiencing withdrawal.
- Understand standards of care for:
    - Managing withdrawal from alcohol, sedative-hypnotics (hereafter referred to as "sedatives" for simplicity), and stimulants.
    - Avoiding or minimizing opioid withdrawal through effective opioid use disorder (OUD) treatment.
- Determine the level of clinical severity that can be managed with the jail's available medical resources, setting thresholds for when individuals need to be transferred to a higher level of care at an external medical facility.

Smaller jails, or jails with fewer internal resources, are expected to meet the same standards of care as larger, better-resourced jails, but how they achieve this will differ. For example, it is expected that shortly after arrival at a jail, all individuals are screened for their risk of substance withdrawal. A well-resourced jail may fulfill this expectation using nurses to screen. A less well-resourced jail may fulfill the expectation by using custody staff who are well-trained and supervised (as defined in the glossary and detailed in Staffing and Staff Training) or through telehealth (see Screening To Flag Withdrawal Risk). The guidance offered herein is intended for all jails, with specific suggestions for jails with fewer resources.

The extent of custody staff training and technical assistance needed to implement these guidelines will vary by jail. Jail Resources, housed on BJA's Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) website, supports jails' efforts to connect individuals to evidence-based withdrawal and substance use disorder (SUD) services and facilitate continuity of care upon community reentry. More specifically, these webpages house comprehensive information on these guidelines, offering resources, tools, online learning (e.g., webinars, courses, videos), and technical assistance to support jails' implementation of these recommendations.

Background

Sixty-three percent of individuals sentenced to jail (compared to 5 percent of adults in the general population) meet diagnostic criteria for SUD.[2] The typical short stays in jail, combined with scant resources for supportive services, present challenges for addressing substance withdrawal and SUD, yet jurisdictions are responsible for the health and well-being of those in custody.

Acute substance withdrawal, left unaddressed, can result in serious health complications and death. The prevalence of such deaths is difficult to determine because they often have been categorized as "illness" or "other" (e.g., aspiration pneumonia due to severe vomiting, profound dehydration) due to lack of a specific reporting category for deaths associated with drug or alcohol withdrawal.[3]

Suicide is the leading single cause of death in jails,[4] but the exact role of substance withdrawal in these deaths is difficult to quantify.[5] Risk for suicidal ideation and attempts is increased among individuals in substance withdrawal and those with an SUD. Notably, individuals with OUD have a threefold higher risk for suicidal behavior than those without OUD.[6]

Wrongful death lawsuits and other litigation for inadequate medical care are resulting in large financial settlements or judgments against counties, jail administrators, staff, and health care providers. *Managing Substance Withdrawal in Jails: A Legal Brief* provides an overview of key legislation and significant court cases related to substance withdrawal, as well as steps for jails and communities seeking to create a comprehensive response to SUD.

Beyond complying with the law, effectively managing withdrawal and SUD has significant potential for individual and societal benefits. For example, patients who received methadone treatment from a community provider prior to entering jail and continued to receive methadone from the same community provider while in jail "were less likely to receive disciplinary tickets while incarcerated and more likely to re-engage in community-based [methadone treatment] after release compared to those who underwent forced withdrawal from methadone."[7] Long-term pharmacotherapy for OUD mitigates opioid withdrawal syndrome *and* minimizes the risk of opioid overdose death, which is significant during the weeks following release from incarceration due to reduced tolerance.

Opioid Withdrawal Considerations

Effective management of opioid withdrawal involves initiation of long-term buprenorphine or methadone. When administered in a timely manner, these medications prevent withdrawal *and* treat OUD. (Naltrexone, another U.S. Food and Drug Administration-approved [FDA] medication for OUD, is not approved for withdrawal management purposes, does not relieve withdrawal symptoms, and may precipitate withdrawal.)

Opioid withdrawal management without ongoing pharmacotherapy does not treat the underlying OUD and leaves the patient at risk for overdose and death.

Development of the Guidelines

Responding to the urgent need for recognition and appropriate management of substance withdrawal, the Bureau of Justice Assistance (BJA), in partnership with the National Institute of Corrections (NIC), formed a collaboration with Advocates for Human Potential, Inc. (AHP), the American Society for Addiction Medicine (ASAM), and the National Commission on Correctional Health Care (NCCHC) to develop guidelines informed by evidence-based medical practice, while accounting for the practical realities of jails and community providers. Collectively, they facilitated the work of an expert committee (EC) to develop these guidelines. Members of the EC included eight clinical experts (including addiction specialists) with experience in criminal justice settings and four experts in jail administration. Appendix A lists members of the EC, as well as the technical support team who carried out the development methodology.

These guidelines were developed using a modified RAND/UCLA Appropriateness Method (RAM). RAM is a systematic approach encompassing review of existing literature, clinical guidelines, and standards; appropriateness ratings; stakeholder comment and reconciliation; and document development.[8] The process combines scientific evidence and clinical knowledge to determine the appropriateness of a set of clinical procedures. The modified RAM used for the development of these guidelines combined the best available scientific evidence with the collective judgment of clinical and jail administration experts weighing both clinical best practices and feasibility in jail settings. (For a full description of the methodology, go to appendix B.)

Content Overview

Following a brief description of the withdrawal management process, the recommendation statements crafted by the EC and supporting narrative are presented in five sections. General Guidance addresses issues that are universal to withdrawal management in jails; the ensuing sections focus on substance-specific considerations for alcohol, sedatives, opioids, and stimulants.[a]

The numbered recommendation statements in each section provide guidance for establishing policies and procedures related to withdrawal management. Some recommendations are included to help clinicians make decisions about services and levels of care for individuals at risk for or experiencing withdrawal. Other recommendations are intended to ground jail administrators, and to some degree health directors, in the basics of withdrawal management to:

- Facilitate effective management of jail resources and foster community partnerships.
- Inform scope-of-work requirements when creating requests for contract proposals and in writing the resulting contracts in jails that outsource health care services.

It is the jurisdiction's responsibility to determine how best to apply these recommendations (e.g., whether additional staff or contracts are needed, updating policies and procedures). Recommendations in this document do not supersede any federal, state, local, or tribal regulations.

A Note on Terminology

Using clinically correct and non-stigmatizing language promotes understanding of SUD as a complex medical condition. "Withdrawal management" is used in this document to describe services to assist a patient's withdrawal from substances, a process involving far more than removing substances from the body (commonly referred to as "detoxification" or "detox"). **The authors have made every effort to incorporate appropriate terminology and encourage readers to use and promote the use of person-first and non-stigmatizing language.** (For more information, go to appendix C.)

Clinical staff are purposely identified throughout this document (e.g., "physician" is used only when a physician is required), with the expectation that clinical staff meet and adhere to the requirements of their position, as well as operate within their scopes of practice. Clinical staff referred to in this document include physician, prescriber, provider, qualified health care professional, qualified health care staff, qualified mental health care professional, and responsible provider. Likewise, the terms "individual" and "patient" are used intentionally: "individual" refers to a person who is not currently being treated for substance withdrawal or SUD, whereas "patient" refers to a person whose substance withdrawal or SUD is being treated. All terms defined in the glossary are hyperlinked to their definition at first use.

[a] Nicotine withdrawal may exacerbate other withdrawal symptoms but is beyond the purview of this document. NCCHC standards include availability of nicotine replacement products when ordered by a physician.

The Withdrawal Management Process

Regular and active observation by custody and health care staff is the foundation for an effective withdrawal management process, which begins upon an individual's arrival to the jail. Diligent observation and structured screening help identify individuals who may be at risk for substance withdrawal.

Individuals who appear unwell are referred for immediate clinical assessment conducted by a qualified health care professional. Broadly defined, "appears unwell" encompasses observed signs and symptoms obvious to a layperson that:

- An individual may be sick (physically or psychologically), which includes signs of or self-reported intoxication or substance withdrawal. Symptoms of the latter may present at any time (including upon arrival to the facility); typically, they emerge within 72 hours of arrival.
- The condition of a patient who has already been assessed by a qualified health care professional is worsening, becoming unstable, or becoming a danger to the patient or others.

Screening

All individuals, regardless of their length of stay in jail, should be screened for risk of withdrawal. Screening is critical to fully understanding and meeting the often acute and complex substance withdrawal-related needs of individuals entering jail. Screening will help identify individuals in need of immediate clinical assessment, including anyone who:

- Reports or is known to have used alcohol or sedatives recently, regularly, and heavily.
- Reports using alcohol or sedatives in the past week and also reports a history of complicated withdrawal.
- Is known to be pregnant and screens positive for alcohol or opioid use.

Otherwise, individuals who screen positive for withdrawal risk and who appear well are monitored by health care staff or well-trained custody staff and referred for immediate clinical assessment upon emergence of withdrawal signs or symptoms.

Clinical Assessment

A major goal of the initial clinical assessment in a jail setting is to address the need for swift action to avoid critical biomedical or psychiatric issues related to intoxication or withdrawal (e.g., acute withdrawal syndromes, overdose, suicidality, and other acute psychiatric symptoms). Findings of the clinical assessment inform whether the patient's needs can be addressed at the jail or require transfer to a higher level of care.

Onsite Withdrawal Management Versus External Transfer

When onsite withdrawal management is appropriate, the treating clinician provides specific guidance regarding ongoing monitoring and care of the patient during withdrawal management. Prescribers may call upon qualified health care staff (or custody staff who are well-trained for the task) to monitor vital signs and assess withdrawal symptoms using structured, objective scales.

Jails have highly variable levels of health care capacity. A qualified health care professional should determine whether the jail has the capacity to safely and effectively manage the anticipated withdrawal syndrome. If not, the patient should be transferred to a higher level of care.

Pathway to Recovery

Ideally, identifying and managing substance withdrawal among individuals who are detained is a component of a more far-reaching approach to helping individuals engage in ongoing SUD treatment and recovery. This approach requires coordination with the greater community to:

- Enable patients who are taking buprenorphine or methadone to treat OUD to continue upon entry to jail.
- Help small, rural, and under-resourced jails explore community partnerships to overcome challenges in providing withdrawal management services (e.g., lack of health care professionals on staff, lack of secure medication storage, etc.).
- Educate patients about community resources, including where to access continuing withdrawal management and SUD care in the community.
- Support effective reentry planning (when feasible), including coordinated referrals to ongoing care for SUD.

General Guidance

Screening To Flag Withdrawal Risk

Individuals who consume alcohol or other drugs may experience withdrawal when they abruptly stop or reduce consumption, with several factors, such as the duration of heavy and regular use, prior episodes of withdrawal, and presence of other medical conditions, influencing the likelihood and severity of withdrawal. Screening is critical for identifying those at risk for withdrawal, allowing custody and health care staff to take appropriate steps to intervene.

A number of brief, standardized screening tools are available to identify recent, regular, or heavy substance use. These tools do not assess signs and symptoms of withdrawal syndromes but can help gauge risk for withdrawal and identify individuals who should be monitored for the emergence of withdrawal signs and symptoms as well as those who should be referred for immediate clinical assessment. Screening usually includes documenting type(s) of substances used; route(s) of use (oral, injection, snorting); amount of substance used; frequency and recency of use; and history of complicated withdrawal.

Confidentiality

Accurate information regarding recent substance use is critical for safe management of the individual's health. However, individuals may be reluctant to share information regarding substance use with custody officers. Staff who conduct screenings for withdrawal risk should be well-trained to inform individuals of confidentiality protections before the screening process begins.

Each jurisdiction may be subject to different laws and regulations governing the confidentiality of health information, which should be considered when the jail develops their policies and procedures regarding the confidentiality and sharing of health information. It is helpful for jail confidentiality policies to limit sharing of self-reported health information for non-health-care purposes to only what needs to be known to protect the health and safety of the individual and others, and to affirm that this information will not be used against the individual.

The screening process also addresses the need for continuation of prescribed medications that may present a risk for withdrawal if not provided in a timely manner. As addressed in G-4, O-25, and O-32, prescribed opioid medications for chronic pain or OUD treatment should be continued upon entering the jail.

Prior to continuing medication, staff should verify the prescription. With monitoring for withdrawal signs and symptoms, it is typically safe to allow up to 24 hours to verify and then administer their prescribed medication. However, if staff are unable to verify the prescription prior to the next scheduled dose of the medication, a provider must be notified. The provider should make a determination whether the medication should be continued pending verification.

Prescription Verification

Medications prescribed for individuals entering jail can often be verified by checking with prescribers, pharmacies, and community databases, such as the Prescription Drug Monitoring Program (PDMP).

- The PDMP tracks controlled substance prescriptions.
- Each state establishes who (e.g., patient, physician, physician-delegate) has access to the PDMP.
- Methadone prescriptions typically cannot be verified through the PDMP or by a pharmacist.

Memoranda of understanding (MOUs) between jails and local methadone treatment providers (e.g., opioid treatment program [OTP]) can facilitate verification by establishing clear procedures, including contact procedures beyond the provider's regular operating hours.

Collecting release of information from individuals on an as-needed, case-by-case basis, rather than as standard practice at intake, is preferred. It is important that individuals entering custody understand what they are signing and are of sound mind to make the decision to sign.

Recommendations

Referral for Immediate Clinical Assessment

As noted in the substance-specific sections, referral for immediate clinical assessment is indicated for individuals who:

- Appear unwell (including those who appear intoxicated).
- Report or are known to have used alcohol or sedatives recently, regularly, and heavily.
- Report using alcohol or sedatives in the past week and also report a history of complicated withdrawal.
- Are known to be pregnant and screen positive for alcohol or opioid use.

Transfer to a higher level of care may be necessary when clinical assessment cannot be immediately provided.

G-1. To safely and effectively identify and treat substance withdrawal, health care and custody staff should be alert to the possibility of SUD, acute intoxication, physiological dependence, and the risk of withdrawal in all new arrivals.

A. Individuals presenting with intoxication should be presumed to be at risk for withdrawal until determined otherwise by a qualified health care professional.

B. Individuals who exhibit potential signs and symptoms of intoxication or withdrawal, or who appear unwell to a layperson, should be referred for immediate clinical assessment.

C. All individuals should be screened for withdrawal risk immediately upon arrival in a jail. The screening administrator should:

i) Review recent substance use using a validated tool.

ii) Ask individuals about current SUD diagnoses.

iii) Ask individuals about their risk for substance withdrawal.

iv) Ask individuals reporting past-week alcohol or sedative use about their history of complicated withdrawal (e.g., seizures, hallucinations, delirium, psychosis).

D. An individual's report of recent, regular substance use (see substance-specific guidance), SUD, or withdrawal risk constitutes a positive screen, even if they are asymptomatic.

G-2. Screening may be conducted by well-trained and supervised custody staff members when health care staff are not available.

A. If the health screening is conducted by custody staff, it should begin with verbal notice that the health screening is beginning and explain the reasons for the questions that will be asked.

B. Jails should establish policies and procedures regarding the confidentiality of information collected during the health screening in accordance with federal, state, and local laws.

C. Staff who conduct screenings for withdrawal risk should be well-trained to inform the individuals that the screening is being conducted for health purposes and to inform them of the confidentiality policies governing the information they share. If confidentiality protection cannot be provided, screening for risk of withdrawal should be conducted by a qualified health care professional.

G-3. Individuals may not be forthright about recent substance use or withdrawal risk. Therefore, custody staff should be alert to emerging signs and symptoms of withdrawal in individuals who initially screen negative, particularly in the first 72 hours after intake.

G-4. For individuals who enter jail while taking prescription medications associated with physiological dependence (e.g., opioids, sedatives, anxiolytics, stimulants), health care staff should first attempt to verify the prescription.

A. Verified medications (including medications for OUD) should be continued unless otherwise ordered by a prescriber based on documented clinical need.

B. If the medication cannot be verified, health care staff should consult with a prescriber to determine how to proceed.

Monitoring for Withdrawal Signs and Symptoms

Individuals who screen positive for substance withdrawal risk, even if they appear well, should be monitored for the emergence of withdrawal indicators (see table G-1).

Table G-1: Possible Indicators of Substance Withdrawal*

• Agitation	• Seeming unaware of who or where they are
• Appearing severely depressed or withdrawn	• Seizure
• Dilated pupils	• Talking about hurting themselves or others
• Incoherent speech	• Diarrhea
• Increasing anxiety or panic	• Tremor
• Marked paranoia	• Vital signs outside of the normal range
• Seeing, hearing, or responding to people or things not present	• Vomiting

*Staff should be alert to any and all indicators of being unwell, not only those listed here.

Attentiveness to any indicator of unwellness is critical because many individuals are unable to fully report what they have ingested due to unknown contamination with other substances.

Housing individuals at risk for or experiencing withdrawal in a dedicated unit(s) has several advantages, such as improved monitoring and care (due to the presence of staff with a focused mission), efficiency of operations (e.g., health care staff can make rounds more quickly), and a lower risk of diversion of treatment medications into the general jail population. These settings may include general housing pods, special observation cells in the health services unit, or other special housing arrangements.

The frequency and duration of monitoring summarized in table G-2 (and detailed in the substance-specific sections) are recommended minimums. The provider may order more frequent monitoring based on the clinical assessment findings. Likewise, qualified health care professionals may use their clinical judgment to provide **more frequent** monitoring. Only a provider, through a patient-specific order, may order less frequent monitoring.

Table G-2: Withdrawal Risk Triage by Substance

Substance	Refer for Immediate Clinical Assessment	Monitor for Withdrawal Signs or Symptoms[b]
Alcohol	• Appears unwell to a layperson. • Self-report of ≥8 standard drinks/day for men or ≥6 standard drinks/day for women, ≥4 days/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.**
Sedatives	• Appears unwell to a layperson. • Self-report of daily or near-daily use, and use within the past 7 days. • Reports past-week sedative use and a history of complicated sedative withdrawal (e.g., withdrawal-related seizures, psychosis, 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.**
Opioids	• Appears unwell to a layperson. • Clinical Opiate 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.**
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.**

Recommendations

G-5. Table G-2 summarizes the substance specific recommendations for triaging individuals at risk for withdrawal. All other individuals who screen positive for withdrawal risk should be monitored regularly for the first 72 hours after intake and immediately referred for immediate clinical assessment and possible withdrawal management protocol if signs or symptoms emerge or if the individual begins to appear unwell to a layperson.

A. Individuals at risk for withdrawal should ideally be housed together in a dedicated unit to facilitate monitoring.

G-6. Monitoring should only be discontinued early based on a patient-specific order from a provider.

G-7. Monitoring may be conducted by a qualified health care professional or well-trained and supervised custody staff (see Staffing and Staff Training).

G-8. Both custody and health care staff should encourage individuals at risk for substance withdrawal to report emerging withdrawal symptoms to staff. If patients report that they are starting to experience withdrawal, they should be referred for immediate clinical assessment.

A. Jails should train all staff to be responsive when an individual self-reports withdrawal symptoms. This should include referral for immediate clinical assessment.

G-9. Individual differences in metabolism, liver function, and kidney function can cause some individuals to take longer to go into withdrawal than expected. If withdrawal-like symptoms emerge after the monitoring period has ended, the individual should be referred for immediate clinical assessment.

[b] For individuals who appear well to a layperson

G-10. Since the supply of illicit drugs is increasingly contaminated or mixed with opioids, some individuals may not be aware that they have been using opioids. Custody staff should be alert to potential opioid withdrawal signs and symptoms that begin within 72 hours of incarceration (see table G-2). Individuals showing these signs or symptoms, or appearing unwell to a layperson, should be referred for immediate clinical assessment.

Clinical Assessment and Diagnosis

Unlike screening, clinical assessment is conducted only by qualified health care professionals, who focus first on establishing substance intoxication or withdrawal as the likely and primary cause of any findings. They collect vital signs, take medical and psychiatric history, and evaluate the individual for signs of other physical or mental health conditions to help determine withdrawal-related risks and risk for complications. For example, the use of more than one substance or underlying psychiatric conditions may complicate management of the withdrawal syndrome. Telehealth may be used to support clinical assessment. Well-trained custody staff can provide support for onsite tasks, such as taking vital signs. The telehealth provider is responsible for determining if telehealth is appropriate or when an in-person visit is needed.

Drug testing may be considered to corroborate self-reported information. Note that toxicology screens may fail to detect all substances consumed. (For example, standard panel drug tests do not detect fentanyl, which may reduce alertness among staff to withdrawal signs and symptoms associated with opioids.). ASAM's Principles of Drug Testing During Withdrawal Management are summarized in appendix D. For more information, review ASAM's *Appropriate Use of Drug Testing in Clinical Addiction Medicine*.

Scope of Practice

Registered nurses are qualified to conduct and document clinical assessments, following physician-approved protocols defining when coordination with an on-call provider must take place, such as in making diagnoses and initiating treatment plans. (Note: Nurse practitioners and physician assistants are allowed to diagnose and initiate treatment.)

Results of the clinical assessment inform the diagnosis (as guided by criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*), the duration and frequency of monitoring, the withdrawal management plan (including medications if needed), and the need for transfer to a higher level of care, as summarized in table G-3.

Table G-3: Assessment and Action

Assess withdrawal risk level based on:
• Current substance use (frequency, dose, duration, route, time of last use, etc.). • Signs and symptoms. • History and severity of prior withdrawal. • Medical and psychiatric comorbidities. • Psychiatric history, including suicidality.
Conduct onsite withdrawal management when:
• The jail can manage the anticipated severity of the withdrawal syndrome and any medical or psychiatric comorbidities. • Medications and monitoring can be carried out per substance-specific clinical orders. • A supportive environment with access to hydration, nutrition, and sleep can be provided.

Table G-3: Assessment and Action (continued)

Consider transfer to a higher level of care when:
• History of severe or complicated withdrawal is identified. • Moderate to severe withdrawal from multiple substances is anticipated. • History of severe psychiatric symptoms is identified. • A pregnant patient may be at risk for alcohol or opioid withdrawal.
Transfer to a higher level of care when:
• Nursing, medical, or psychiatric resources recommended in this guideline are not immediately available. • Overdose is suspected. • Significant signs and symptoms persist despite multiple doses of medication. • Severe signs or symptoms develop during withdrawal management. • Existing medical or psychiatric condition worsens. • Unstable vital signs do not respond to medications. • There is severe or ongoing oversedation. • There is moderate to severe withdrawal with significant comorbidity. • Alcohol or sedative withdrawal is severe. • Complicated symptoms (seizures, delirium, hallucinations) exist. • Wernicke encephalopathy is known or suspected. • A patient cannot take required medication orally, and there is no capacity to provide medication by another route. • Severe psychiatric symptoms are present, and a mental health assessment cannot be immediately provided. • Barbiturate or gamma-hydroxybutyric acid (GHB) withdrawal is known or suspected. • The treatment plan as recommended by a qualified health care professional cannot be adequately or safely managed in the jail. • Acute medical signs or symptoms cannot be safely managed.

Recommendations

G-11. All individuals who are referred for immediate clinical assessment for substance withdrawal should be assessed by a qualified health care professional.

G-12. The initial clinical assessment should:

A. Identify any emergent medical or psychiatric needs.

B. Evaluate current withdrawal signs and symptoms.

C. Evaluate risk for severe or complicated withdrawal.

D. Assess risk for suicide.

E. Determine the appropriate level of care.

G-13. All individuals at risk for withdrawal should be assessed for SUD.

G-14. If patients are unable to engage in the full clinical assessment due to intoxication or withdrawal, they should be assessed for immediate clinical needs. The full assessment should be completed once their intoxication or withdrawal symptoms have resolved.

Level of Care

There is wide variation across jails in onsite medical, mental health, and nursing staffing and capacity to handle serious, complex, and urgent health care needs. Where treatment services and resources are recommended in this guideline, including buprenorphine and methadone treatment, and are not immediately available in the jail, timely transfer to a higher level of care is indicated.

Each facility should establish clear policies on determining when to provide services in-house or to transfer to a facility equipped to provide the necessary level of care. Recommendations involving a higher level of care apply to individuals who are already incarcerated in the jail, as well as those who are newly arriving.

Hospitals are obligated, under the Emergency Medical Treatment and Labor Act, to provide stabilizing treatment for patients with emergency medical conditions. Most individuals, once stabilized, can safely be readmitted to the jail. When this is not the case, clear policy and procedures on readmittance (established with the input of the sheriff or jail director, county administrators, hospital officials, and the jail health authority) will help prevent unsafe and needless transport.

The transferring party (e.g., hospital) and the accepting party (i.e., jail) must agree that the accepting party can provide the required ongoing care. The hospital should not assume jails have the staff capacity to monitor and support proper care for the patient upon discharge. It is important to establish a strong working relationship between hospital and jail; this may be supported through an MOU between the local hospital and the jail. An established relationship should facilitate effective communication regarding the jail's health care capabilities and what the jail needs to safely accept patients who require ongoing care (e.g., documentation, medical orders, access to specialty medications).

If the jail does not have the ability to safely manage care, the patient should be returned to a medical facility. In other words, "clearance" by an external medical authority should not be automatically accepted by the jail when medical or common sense dictate otherwise and should be considered subject to change if the individual's condition changes. Jails are encouraged to seek counsel in developing policies and procedures regarding when to refuse an individual returning from a medical facility.

Clinical needs do not justify loss of privileges. If the physical layout of the jail demands transfer of the patient to a more restrictive area when close clinical monitoring is indicated, the impact on privileges should be carefully considered and minimized.

Recommendations

G-15. The level of care in which withdrawal management is provided should be appropriate for the anticipated severity of the withdrawal syndrome, as well as any medical or psychiatric comorbidities present, and should be adequate to provide the treatment services and monitoring needed to facilitate safe and effective care.

G-16. A patient who presents with severe psychiatric symptoms, including hallucinations, delusions, paranoia, and delirium, should be immediately transferred to a higher level of care unless a physician experienced in differential diagnosis and management of acute changes in mental status is immediately available for clinical assessment and stabilization.

A. If feasible and clinically indicated, medications should be provided to stabilize the patient concurrent with the call for transport.

G-17. See substance-specific guidance regarding frequency of clinical assessments. If health care staff are not available onsite to manage the minimum required frequency of clinical assessments, the patient should be transferred to an appropriate medical facility. (Note that well-trained and supervised custody staff may monitor withdrawal signs and symptoms and administer validated tools, such as the COWS and CIWA-Ar.)

G-18. Where nursing, medical, psychiatric, or urgent care resources are recommended in these guidelines and are not immediately available onsite, the provider should be consulted to determine the necessary timing for transferring the patient to a higher level of care for further assessment and treatment.

A. If a provider is not available, the patient should be immediately transferred to a hospital.

G-19. For management of suspected substance overdose, follow the principles of first aid and cardiopulmonary resuscitation (CPR) and transfer to a local emergency department.

A. If the patient is not breathing, or their breathing is not sufficient, naloxone should be administered.

Withdrawal Management by Qualified Health Care Professionals

Recommendations

G-20. Medical decisions should be independent of the custody level or classification of the patient.

G-21. While comprehensive clinical assessment of the patient is critical for treatment planning, treatment should not be delayed while awaiting completion of all assessments or laboratory testing or results.

G-22. Any protocols or similar guidance used in withdrawal management should reflect current clinical treatment standards and be approved by the responsible provider with input from a physician with withdrawal management expertise as appropriate.

G-23. Some patients may be released from jail prior to completion of withdrawal management. However, treatment should not be delayed based on the potential timeline for release.

G-24. A provider should receive a daily census of all patients being monitored or treated for substance withdrawal and review the status of all patients being monitored for acute withdrawal daily.

G-25. Withdrawal from alcohol, sedatives, and opioids can be dangerous and potentially life-threatening. The intensity of withdrawal cannot always be predicted. Frequent clinical assessments should be conducted by qualified health care professionals based on patient-specific orders from the provider.

A. These clinical assessments should be conducted by qualified health care professionals not less than twice per day, not more than 16 hours apart, unless otherwise stated in the substance-specific guidance in this document.

B. Unless otherwise ordered by the provider, during each clinical assessment, a qualified health care professional should evaluate:

i) General physical condition.

ii) Vital signs.

iii) Hydration.

iv) Orientation.

v) Sleep.

vi) Mental health status including risk for suicide and self-harm.

vii) Fall risk.

viii) Progression of the patient's withdrawal symptoms.

ix) Timing of the next assessment.

G-26. Withdrawal syndromes and the medications used to manage withdrawal can put patients at risk for falls. It is recommended that patients undergoing withdrawal management be assigned lower bunks and housed on lower floors.

G-27. Management of withdrawal does not constitute treatment for SUD. Jails should take proactive steps to engage patients with SUD in ongoing treatment, as described in Reentry.

Monitoring Patients During Withdrawal Management

Regularly monitoring patients helps staff detect destabilizing health, enabling providers' timely modification of treatment plans. Telehealth may be used to provide a broad range of clinical services, depending on what technologies are available and the needs of the patient. It is the provider's responsibility to determine when telehealth is or is not appropriate.

Consider the timing of monitoring to avoid interfering with the normal sleep schedule of the person being assessed, unless specifically ordered otherwise by the qualified health care professional.

Recommendations

G-28. All patients undergoing withdrawal from any substance should be monitored regularly for changes in condition. Monitoring should be conducted by qualified health care professionals or well-trained and supervised custody staff (see Staffing and Staff Training).

G-29. The onset and intensity of withdrawal is variable. The frequency and duration of monitoring should be determined based on the type of substance taken, when it was last taken, and the suspected duration of effect. Frequency of monitoring should be determined by a qualified health care professional.

A. See respective substance-specific section for monitoring intervals (see appendix E for summary of recommendations).

B. The frequency of monitoring and assessment discussed in this document is the minimum recommended for the patients described. Clinical staff should use their judgment to determine when more frequent assessment or monitoring is needed.

C. The frequency of monitoring or assessment should not be decreased or discontinued without a patient-specific order from a physician.

G-30. If qualified health care professionals are not onsite, well-trained and supervised custody staff should monitor patients undergoing withdrawal management based on patient-specific instructions from a provider.

A. Custody staff should not be expected to make decisions about the severity or implications of changes in patient condition. Rather, the patient-specific instructions should describe what should be monitored (e.g., changes in appearance, mental status, behavior, vital signs, score on a validated tool), what changes to look for, and what to do if those changes are noted (e.g., when to contact the on-call qualified health care professional, when to seek emergency medical care).

B. If a patient's condition appears emergent to the layperson, emergency assistance should be obtained immediately.

G-31. Jails should consider housing individuals who will be monitored for withdrawal risk or withdrawal management in a unit dedicated for this purpose.

G-32. In jails without a dedicated housing unit for withdrawal management, an accurate and current log of all patients being monitored for withdrawal risk and withdrawal management should be maintained including, at a minimum, the substance(s) for which monitoring is being conducted and the frequency of monitoring.

G-33. Monitoring may be discontinued when the patient is no longer showing signs or symptoms of withdrawal without medications and a patient-specific order is written by a provider.

Medications

The effectiveness of pharmacotherapy for withdrawal from certain substances is well established, such as benzodiazepines for alcohol withdrawal and buprenorphine or methadone for opioid withdrawal. (For a summary of pharmacotherapy per substance, see appendix F.)

Medication used to manage withdrawal must be ordered by a licensed prescriber for a specific patient. However, a prescriber order is not required to administer naloxone, a medication used to reverse opioid overdose. Correctional and health care staff alike should be well-trained to regard naloxone as a life-saving tool for opioid overdoses, much like automated external defibrillators have become standard features in workplaces to respond to cardiac arrest. Note that multiple doses of naloxone may be needed, and individuals with OUD may experience withdrawal symptoms after receiving naloxone.

Recommendations

G-34. There is significant variation in the timing and intensity of withdrawal, as well as response to medications. This variance is related to both the characteristics of the patient's substance use and individual genetic differences in substance metabolism. Treatment plans, including medications, should be individualized.

G-35. Any prescription medications provided for withdrawal management should be ordered for the patient by a prescriber.

A. This does not preclude the inclusion of prescription medications in a withdrawal protocol or pathway. However, a prescriber must order implementation of a specific withdrawal protocol or pathway for a specific patient.

G-36. Medications for specific withdrawal syndromes are discussed in the relevant sections of this document. Medications may also be provided for common symptoms of withdrawal, as needed, using standard doses unless otherwise contraindicated.

A. Nursing protocols may be used to provide guidance regarding provision of over-the-counter medications.

G-37. Naloxone should be readily available to custody and medical staff for overdose reversal, including in all housing units.

G-38. Jails should consider making naloxone readily available in all housing units to individuals who are in custody.

Staffing and Staff Training

Building a sense of teamwork between custody and health care staff facilitates a unified response to substance withdrawal. Jail administrators can support this relationship by setting clear policies and protocols on the roles and responsibilities of both custody and health care staff and supporting these policies through training. For example, it is not within the purview of custody staff to diagnose or determine the cause of signs or symptoms; qualified health care professionals make these determinations.

Recommendations

G-39. Jails lacking expertise in withdrawal management, SUD, and overdose risk should consider establishing relationships with external experts, including local public health and state substance use treatment authorities, to help establish effective protocols for managing these issues.

G-40. To support management of substance withdrawal, it is recommended that jails, at minimum, have 24-hour, on-call clinical support (at minimum, a registered nurse). This can be accomplished through any combination of onsite health care staff, remote coverage, telehealth services, and/or transfer to facilities that can provide a higher level of care.

G-41. Custody staff should be well-trained to make an immediate referral to medical services when they observe potential signs and symptoms of withdrawal, or an individual otherwise appears unwell, and when an individual reports experiencing withdrawal.

G-42. If custody staff may be called upon to screen for withdrawal risk, they should be well-trained to conduct screenings, to recognize the signs and symptoms of withdrawal, and to follow established protocols to ensure rapid provision of medical services for patients in or at risk for withdrawal.

G-43. Custody staff may be trained to effectively administer withdrawal severity tools (such as the COWS and CIWA-Ar), including collection of vital signs, and to coordinate care with an on-call registered nurse based on established protocols when health care staff are not available.

G-44. Training for custody staff who conduct screening for withdrawal risk or administer withdrawal severity tools should be provided by a qualified health care professional assigned this task by the health services administrator or the responsible provider.

G-45. All staff who conduct screenings or assessments should be assessed at least yearly for competence in performing these tasks.

G-46. The trainer or a supervisor should observe real-patient interviews as part of both initial and refresher training to ensure competency.

G-47. All custody staff should receive training that addresses the misconceptions and stigma regarding SUD, SUD treatment, and the use of medications to treat OUD.

G-48. The jail's first aid course should include training on giving CPR; managing overdose (checking respirations, positioning patient to avoid aspiration, and administering naloxone); and managing seizures (preventing head trauma, positioning the patient to avoid aspiration) while awaiting emergency medical services (EMS).

G-49. All training relevant to these guidelines should be repeated at least every 2 years.

G-50. Policy and procedures for staff training should be reviewed at least every 2 years.

Additional staff training is noted in the substance-specific sections.

Quality Assurance

Quality assurance is essential for effectively implementing these guidelines. Quality assurance should involve both custody and health care staff and include structured procedures. Ideally, meetings would take place to review data and minutes reflecting actions taken.

Recommendation

G-51. Jails should establish a quality assurance process for withdrawal management in their facility.

Supportive Care

Supportive care for withdrawal helps alleviate common physical complications and reassures the patient about what to expect from the process. For example, minimizing environmental stimulation (e.g., dimming lights, reducing noise levels) and housing patients experiencing withdrawal in smaller units (when available) may make withdrawal less physically and emotionally challenging. **Isolating patients who are experiencing withdrawal, however, is not advised, due to the increased risk of self-harm** (see G-63).

In addition, vomiting and diarrhea can occur during withdrawal. Dehydration and electrolyte imbalances can have serious health consequences, including death, so maintaining fluids is essential (see G-54). It is important that custody staff are alert to indicators of dehydration (see appendix G) and well-trained to report concerns about dehydration to health care staff. Qualified health care professionals will monitor for signs and symptoms of dehydration during clinical assessments.

On a broader level, supportive care encompasses all programming and resources that facilitate a patient's journey to recovery from SUD. It is important for patients to understand that treatment of withdrawal is not treatment of SUD.

The length of stay in jail will impact the nature of supportive care and may include Motivational Interviewing and other counseling, stress management strategies, education on making lifestyle changes, and mutual support/peer support programs. Of note, some jails use telehealth to provide individual and group counseling sessions (see Telehealth Resources).[9]

Recommendations

G-52. All patients experiencing withdrawal, regardless of severity, should receive supportive care, which may include nutritional supplementation, intravenous (IV) fluids, glucose, management of electrolyte abnormalities, and periodic clinical reevaluations, as clinically indicated (see Monitoring Patients During Withdrawal Management).

G-53. Patient education regarding the withdrawal process is a necessary component of treatment. Patients experiencing withdrawal should be counseled on:

A. The signs and symptoms of withdrawal.

B. The assessment process.

C. What to expect during treatment and monitoring.

D. What to do if they are released prior to completion of withdrawal management.

E. The patient's role in helping to manage withdrawal (e.g., staying hydrated, communicating with health care and custody staff).

F. The importance of engaging in ongoing SUD treatment to support sustained recovery.

G-54. Unless restricted access is ordered by a provider and the patient is placed under close medical supervision, patients experiencing withdrawal should have unimpeded access to water or electrolyte solution.

A. Both health care and custody staff should encourage patients to stay well-hydrated.

B. Custody staff should notify health care staff if they notice that a patient undergoing withdrawal management has insufficient fluid intake or is refusing to drink.

Reentry

Reentering the community is a challenging time for individuals, especially for those with SUD. Research shows that risk of overdose in the 2 weeks following release from incarceration is extremely high.[10] Patient education on the risks associated with reduced tolerance to substances as a result of withdrawal and how this might lead to overdose and death is important for mitigating these risks. This topic is further discussed in Opioid Withdrawal.

Ideally, individualized reentry plans that address ongoing withdrawal management needs, SUD treatment engagement, overdose prevention, and recovery supports are developed with appropriate input from the health care provider for all patients with SUD. These plans include assertive referrals (i.e., scheduling appointments for community care), as well as strategies for:

- Appropriate sharing of health records (electronic or paper) as authorized by state law.
- Establishing insurance coverage including support for enrollment or re-activation of suspended or terminated Medicaid coverage (if applicable).
- Arranging patient navigator support or collaborating with community substance use treatment, such as providers who are willing to meet people upon release or provide in-reach services to facilitate transition. The value of patient navigators with lived experience in incarceration and SUD may be realized in improved relationships with treatment providers, increased treatment retention, decreased criminal justice involvement, reduced relapse rates, and reduced substance use, among other outcomes.[11]

However, reentry plans may not be possible for patients who are in jail for only a few hours or days. At minimum, all patients treated for withdrawal should be provided information on where they can follow up in the community upon release to obtain withdrawal management or SUD treatment services; when feasible and allowed, they should also

receive a sufficient quantity of medication to sustain them until the next appointment. This is particularly important for patients who are treated with buprenorphine or methadone, which can be difficult to access. Providing a prescription for prepaid medication at a local pharmacy to patients reentering the community may be an option for jurisdictions to explore.

In developing protocols for releasing patients from confinement with ongoing urgent or emergent medical needs who do not have decisionmaking capacity or competency, staff should seek out advice from counsel to ascertain appropriate release protocols in accordance with federal, state, and local laws and regulations.

Recommendations

G-55. As discussed in Withdrawal Management by Qualified Health Care Professionals, some patients may be released from jail prior to completion of withdrawal management. Disruption of treatment could place the patient at risk for serious health consequences and death. At the start of treatment, qualified health care staff should provide patients with information regarding community resources where they can continue withdrawal management services and initiate or continue SUD treatment services.

A. Where time permits, qualified health care professionals should establish a discharge plan that is in place throughout withdrawal management which outlines appropriate care upon release.

G-56. Patient navigation services may be helpful for facilitating engagement in care upon release from jail. Jails and/or partnering community agencies should consider providing well-trained patient navigators prior to release to support patient engagement in community treatment.

A. This is particularly important for patients receiving methadone or buprenorphine for the treatment of opioid withdrawal or OUD as these services can be difficult to access. If provided, navigators should be trained to maintain backup plans and emergency contacts to prevent interruption of post-release treatment.

B. Because patient navigators are often individuals with lived experience with SUD and/or incarceration, jails should review their security protocols to consider allowing individuals with lived experience, who may typically not be permitted to enter the facility, to perform this role, consistent with security protocols.

G-57. When patients who have decision-making capacity are being released with ongoing emergent medical needs, they should be informed of the related medical risks by a qualified health care professional and offered transportation to a hospital.

G-58. When patients who do not have decision-making capacity are released with ongoing emergent medical needs, they should be transferred to an appropriate medical facility in accordance with federal, state, and local laws and regulations.

G-59. Every effort should be made to ensure continuity of care by sharing health records with the patient's community provider(s), in accordance with applicable federal, state, and local laws and regulations.

A. Shared health records should have sufficiently detailed clinical information to allow for continuity of care; a discharge report containing only the patient's medication and problems list is insufficient.

B. If the jail cannot establish communication with the patient's community provider, the jail should provide the patient with either a discharge report with sufficient clinical detail to support continuity of care or instructions on how the patient's community provider can contact health care staff.

C. Jails should have policies and procedures that support continuity of care through sharing of health records and clinical information with community providers.

Suicide

Screening for suicide risk regularly throughout the withdrawal process is advised due to the rapidity at which suicidal ideation can evolve. The instruments available for screening for suicide risk have only been validated in a community setting; no instrument has been validated in a correctional population at the time of this publication. Therefore, caution should be used when interpreting the results. It is important for jails to have policies and protocols regarding the safety of individuals identified as at risk of self-harm and that define the frequency and duration of wellness checks while in custody.

Depression may be a consequence of withdrawal; however, depression that does not improve as the withdrawal syndrome improves may require evidence-based depression treatment.

Recommendations

G-60. The frequency of suicide attempts is substantially higher among patients with SUD, including those without a pre-existing psychiatric condition. Suicide risk, with particular attention to thoughts of self-harm, should be evaluated as part of the initial patient assessment and each subsequent clinical assessment during withdrawal management using a validated tool.

G-61. Management of patients at risk for suicide should include reducing immediate risk, managing underlying factors associated with suicidal intent, and monitoring and follow-up care as directed by a qualified mental health care professional.

G-62. Frequent safety checks should be implemented; the frequency of these checks should be determined by a qualified mental health professional with consideration for increased frequency when signs of depression, shame, guilt, helplessness, worthlessness, or hopelessness are present.

G-63. Isolating patients who are experiencing withdrawal is not recommended due to the increased risk of self-harm.

Pregnancy and Postpartum

Substance withdrawal can pose risks to both the pregnant patient and the fetus, which may necessitate a higher level of care. The substance-specific guidance in this document provides recommendations to guide care, and as discussed further in Opioid Withdrawal, a higher level of care (e.g., a hospital or medically managed residential program with an obstetrical provider) should be considered for pregnant patients during initiation of methadone or buprenorphine.

Medications used to treat withdrawal, including benzodiazepines, can pose risks to the fetus, but the risks of unmanaged withdrawal often outweigh these risks. Pregnant patients should receive a judgment-free explanation of the risks and benefits of available options for withdrawal management (see G-69), while being sensitive to the overlapping stigma and judgment pregnant patients who use substances and are incarcerated face. Pregnant patients may decline medications based on perceived or discussed risk to fetus, but medications that treat withdrawal should not be withheld based on the patient's pregnancy or lactation status.

Some states have laws requiring health care providers to report positive drug test results or to notify child protective services when infants are born affected by prenatal alcohol or drug use (e.g., Child Abuse Prevention and Treatment Act [CAPTA]). Qualified health care professionals should educate pregnant patients regarding these risks and, when

appropriate, obtain informed consent prior to conducting any health care-related drug testing. The intent of the notification is to ensure that the patient understands the requirements without conveying judgment.

Withdrawal during pregnancy is also associated with high rates of return to use,[12] which can lead to harm to the fetus, including the return to alcohol use that can result in fetal alcohol spectrum disorders (FASD), overdoses, and other harms. Efforts should be made to engage all pregnant patients treated for withdrawal in ongoing SUD treatment. For pregnant patients with OUD, the standard of care is ongoing treatment with buprenorphine or methadone.

Jails should establish policies and protocols related to withdrawal management during pregnancy. These policies and protocols should be developed and approved by a physician or physicians with experience in SUD and obstetrics and communicated to all facility and community decision-makers, from arrest through reentry.

Additionally, jails are encouraged to establish policies and procedures for distributing naloxone or providing prescriptions for naloxone to patients, including those who are pregnant or postpartum, as they leave custody to reenter the community.

Recommendations

G-64. All patients of childbearing potential or childbearing age should be assessed for pregnancy and offered pregnancy testing.

G-65. Health care professionals and custody staff should not assume symptoms such as nausea, headache, anxiety, and insomnia are due to pregnancy and should remain vigilant for substance withdrawal.

G-66. When offering medications to pregnant or lactating patients to treat substance withdrawal or medical complications of withdrawal, the prescriber should discuss the risks and benefits of each medication for the patient and the fetus or infant, as well as risks associated with untreated withdrawal and ongoing substance use during pregnancy.

G-67. Initiation and continuation of medication should not be withheld or delayed due to a patient's pregnancy or lactation status.

G-68. Health care professionals should follow the recommendations included in the substance-specific sections on treating withdrawal in pregnant patients.

G-69. Some states have laws that require health care providers to report positive drug test results and impose adverse legal and social consequences on individuals who use substances during pregnancy. Therefore, qualified health care professionals should educate pregnant patients regarding these risks and obtain informed consent prior to conducting any health care-related drug testing.

Older Adults

Approximately 8 percent of adults confined in local jails are age 55 and older,[13] a cohort referred to in this document as "older adults." Fifty-five years is used in this context because heavy substance use, inadequate health care, and the stress of incarceration itself contribute to accelerated aging, which means that individuals may have physical and mental conditions that are typically associated with those who are at least 10 years older.[14] Hypertension, diabetes, angina, heart attacks, arthritis, and hepatitis are more prevalent among individuals in jail custody who are ages 50–65 than those in the same age group who are not incarcerated.[15]

Withdrawal management in older adults can be complicated by the higher prevalence of chronic diseases that impact withdrawal management (e.g., heart disease, lung disease); slower metabolism of medications; blunted physiological responses that can affect the validity of monitoring tools such as the COWS; and misinterpretation of cognitive changes associated with withdrawal as being due to dementia.

In general, the treatments discussed in this guideline are applicable to older adults; however, medications to manage withdrawal should be modified to account for age-related factors, such as increased sensitivity to medications, drug-drug interactions, or co-existing conditions. For example, long-acting benzodiazepines are not necessarily preferred in older patients for managing alcohol withdrawal due to the risk of accumulation leading to oversedation and respiratory depression.[16] Withdrawal may also take longer due to slower metabolism among older adults.

Recommendations

G-70. Management of withdrawal in older adults may require increased monitoring for side effects and/or lower medication dosages.

A. The recommendations presented in this document for management of withdrawal from alcohol, sedatives, opioids, and stimulants are generally applicable to older adults as long as sensitivity to medications and drug interactions are considered.

B. The threshold for transferring an older adult patient to a community facility and/or higher level of care for withdrawal management should be lower than it is for younger adults.

Alcohol Withdrawal

Alcohol withdrawal left undetected, unmonitored, and untreated can lead to seizures, delirium, and death.

Screening

There is no established threshold of alcohol use that confers risk for serious or complicated alcohol withdrawal. The expert committee (EC) reviewed the available research literature and, after finding a lack of conclusive data, drew on their collective professional experience and expertise to recommend a level of alcohol use that should trigger an immediate clinical assessment (see A-2).

A standard drink in the United States is defined as approximately 14 grams of pure alcohol, which is found in 12 fluid ounces of regular beer, 5 fluid ounces of wine, or 1.5 fluid ounces of distilled spirits (see exhibit 1).

For individuals who are unable to provide an alcohol use history, a toxicological test can measure blood alcohol concentration (BAC) or breath alcohol concentration (BrAC), thereby detecting recent use of alcohol. Toxicological testing can also help differentiate between alcohol intoxication and sedative intoxication, which can have a similar presentation (e.g., slurred speech, poor physical coordination). However, it is important to understand that BAC/BrAC results alone do not establish risk for withdrawal. For example, patients can have a negative result and still be at risk for alcohol withdrawal.

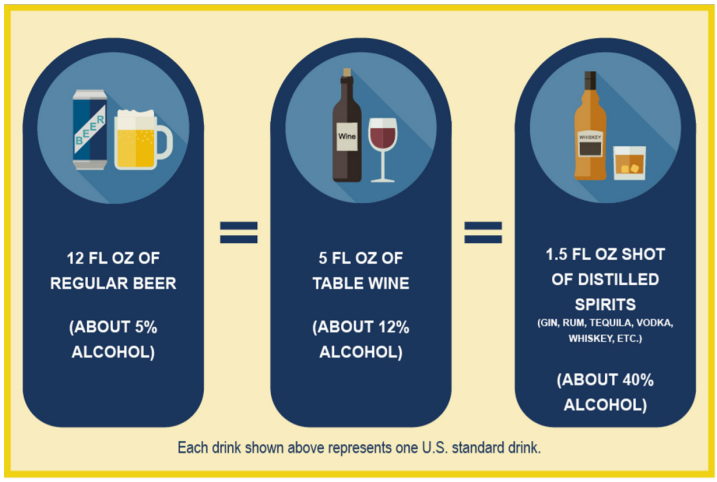

Exhibit 1: U.S. standard drink equivalents (Adapted from National Institute on Alcohol Abuse and Alcoholism)

Recommendations

A-1. If an individual appears intoxicated and/or a corrections-administered breathalyzer test suggests intoxication, the individual should be referred for immediate clinical assessment.

A-2. Individuals reporting or known to be using alcohol recently, regularly, and heavily (eight or more standard drinks per day for men and six or more standard drinks per day for women, 4 or more days per week) should be referred for immediate clinical assessment and possible withdrawal management protocol.

A-3. Individuals who report using any alcohol in the past week and also report a history of complicated withdrawal should be referred for immediate clinical assessment.

Monitoring for Withdrawal Signs and Symptoms

Typically, signs and symptoms of alcohol withdrawal (see table A-1) emerge 6–24 hours after the last drink of alcohol, with more severe indicators starting later, such as alcohol withdrawal delirium (formerly known as "delirium tremens"), which may emerge 72–96 hours after the last drink.[17]

Table A-1: Possible Indicators of Alcohol Withdrawal*[18]

Many conditions listed below are expected responses to incarceration but, when presented as part of a constellation of symptoms, may indicate alcohol withdrawal.	
• Agitation‡	• Loss of appetite
• Anxiety or nervousness	• Mood swings
• Depression	• Nausea and vomiting
• Difficulty thinking clearly	• Nightmares
• Fatigue	• Pallor
• Fever‡	• Rapid heart rate
• Hallucinations‡	• Elevated blood pressure
• Insomnia	• Seizures‡
• Headache	• Severe confusion‡
• Irritability	• Sweating, clammy skin
• Jumpiness or shakiness	• Tremor of the hands or other body parts

*Staff should be alert to any indications that an individual is unwell, not only those listed here.
‡Indicative of alcohol withdrawal delirium

Recommendations

A-4. Individuals who self-report risk for alcohol withdrawal and who report alcohol use below the threshold specified in recommendation statement A-2 should be monitored at least every 6 hours for the emergence of withdrawal signs and symptoms.

A. As discussed in The Withdrawal Management Process, if signs or symptoms emerge or if the individual begins to appear unwell to a layperson, the individual should be referred for immediate clinical assessment.

A-5. Custody staff who perform regular health and wellbeing checks should be alert to the emergence of withdrawal signs and symptoms and well-trained to make immediate referrals for medical care if the individual appears unwell.

Clinical Assessment and Diagnosis

As discussed in *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*, alcohol withdrawal severity assessment scales, such as the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar), are designed to assess withdrawal after a diagnosis has been established. High scores may be indicative of other conditions (e.g., dehydration, fever from infection, Graves' disease).

Recommendations

A-6. The clinical assessment should:

A. Rule out other serious illnesses that can mimic the signs and symptoms of alcohol withdrawal.

B. Determine if the patient is taking medication that can mask the signs and symptoms of alcohol withdrawal.

A-7. Alcohol withdrawal severity assessment scales (including the CIWA-Ar) should not be used as stand-alone diagnostic tools because scores can be influenced by conditions other than alcohol withdrawal.

A-8. Alcohol withdrawal can progress rapidly with serious health consequences. Individuals referred for immediate clinical assessment should be assessed immediately by a qualified health care professional to determine their risk for developing severe and/or complicated alcohol withdrawal or complications from alcohol withdrawal.

A. In addition to signs and symptoms of alcohol withdrawal, the following factors are associated with increased patient risk for complicated withdrawal or complications of withdrawal and should be assessed:

i. History of complicated alcohol withdrawal (e.g., delirium or alcohol withdrawal seizure).

ii. Multiple prior withdrawal episodes.

iii. Comorbid illnesses (especially traumatic brain injury).

iv. Age > 65.

v. Marked autonomic instability on presentation.

vi. Long duration of heavy and regular alcohol consumption.

vii. Seizure(s) during the current withdrawal episode.

viii. Physiological dependence on sedatives such as benzodiazepines or barbiturates.

ix. Positive blood alcohol concentration in the presence of signs or symptoms of withdrawal.

A-9. If a toxicology test (blood, breath, or urine) for alcohol use is used, do not rule out the risk of developing alcohol withdrawal if the test result is negative.

Withdrawal Management by Qualified Health Care Professionals

Historically, alcohol has been administered to prevent withdrawal in some cases. However, administration of oral or IV alcohol has no proven efficacy, no accepted protocols, and can be toxic.

Recommendations

A-10. Oral or IV alcohol should **not** be used for the prevention or treatment of alcohol withdrawal.

Monitoring Patients During Withdrawal Management

During withdrawal management, monitoring typically includes both collection of vital signs and administration of a validated severity assessment scale, such as the CIWA-Ar (see table A-2).

Table A-2: Alcohol Withdrawal Severity[19]

Severity Category	Mild	Moderate	Severe	Complicated
Associated CIWA-Ar Range	< 10	10–18	≥ 19	≥ 19

As alcohol withdrawal is primarily treated with benzodiazepines, which are sedative medications, it is important that staff monitor for and report oversedation.

Recommendations

A-11. Alcohol withdrawal severity should be monitored using a validated tool, such as the CIWA-Ar.

A-12. Use of the CIWA-Ar does not replace a clinical assessment, including collection of the patient's vital signs.

A-13. A clinical assessment including the CIWA-Ar should be conducted ***at least*** every 8 hours during alcohol withdrawal treatment until the CIWA-Ar score remains below 10 for 24 hours.

A. If the CIWA-Ar is > 19, repeat the CIWA-Ar ***at least*** every 6 hours during alcohol withdrawal treatment until the score falls below 19, then continue monitoring with the CIWA-Ar ***at least*** every 8 hours until the score remains below 10 for 24 hours.

B. More frequent monitoring should be conducted if clinically indicated.

A-14. To support management of alcohol withdrawal, a qualified health care professional, or custody staff, who has been well-trained to administer the CIWA-Ar (or another validated tool) should be available at all times.

A-15. Custody staff should be well-trained to identify oversedation and to alert health care staff if a patient appears oversedated.

A-16. Regular clinical assessments should monitor for dehydration. Health care staff should be alerted if the patient reports, or custody staff otherwise become aware, that the patient has stopped drinking, has a significant reduction in urine volume or frequency of urination, or has very dark urine.

Level of Care

Severe alcohol withdrawal can result in serious health consequences, including death. The clinical assessment should inform the determination of whether the predicted severity of withdrawal can be managed in the jail or transfer to a hospital is indicated.

Table A-3: Signs and Symptoms of Wernicke Encephalopathy–Korsakoff Syndrome[20]

Wernicke Encephalopathy	Korsakoff Syndrome
• Confusion or loss of mental activity. • Loss of muscle coordination (ataxia), manifested as leg tremor or wide-based or unsteady gait. • Vision changes: o Abnormal eye movements (back and forth movements called nystagmus). o Double vision.	• Inability to form new memories. • Loss of memory, can be severe. • Making up stories (confabulation).

Recommendations

A-17. Level-of-care determination should be based on a patient's risk for developing severe or complicated alcohol withdrawal, or complications of withdrawal, as well as current signs and symptoms.

A-18. If the patient requires transfer to a higher level of care, treatment for immediate needs should be initiated while awaiting transfer, where feasible.

A-19. While most patients experiencing alcohol withdrawal may be managed in the facility, if the following indications are present, the patient should be transferred to a hospital (unless the jail has hospital-level capacity):

A. Agitation or severe tremor persists despite having received multiple doses of medication.

B. Severe signs or symptoms, such as persistent vomiting, marked agitation, hallucinations, confusion, or seizure, develop.

C. Existing medical or psychiatric condition worsens.

D. Unstable vital signs (low/high blood pressure or heart rate) that are not responsive to medications provided to treat withdrawal.

E. Severe or ongoing oversedation.

F. Patient has moderate or high CIWA-Ar scores and significant comorbidity.

A-20. Patients with severe withdrawal (CIWA ≥ 19) or complicated symptoms (e.g., seizures, delirium, hallucinations) should typically be transferred to a setting with 24-hour medical care available, (e.g., an emergency department or hospital).

A. For patients experiencing less severe alcohol withdrawal (CIWA < 19) who have a history of complicated alcohol withdrawal symptoms, transfer to a setting with 24-hour medical care should be considered.

B. For patients at risk for alcohol withdrawal (but not presenting signs or symptoms) who have a history of complicated withdrawal symptoms, more frequent monitoring should be considered.

A-21. Pregnant patients should typically be transferred to a hospital.

A-22. Patients with known or suspected Wernicke encephalopathy and/or suspected Korsakoff syndrome require immediate administration of parenteral (intravenous or intramuscular) thiamine (vitamin B1) (if unavailable, provide oral thiamine), as well as benzodiazepines and transfer to a hospital.

A-23. Patients actively seizing as a result of alcohol withdrawal or showing signs of alcohol withdrawal delirium should be treated immediately with benzodiazepines and transferred to a hospital.

Medications

Long-acting benzodiazepines are the most commonly used medications for treating alcohol withdrawal.[21] Dosing approaches include front loading, fixed, and symptom-triggered (see below). Symptom severity will help determine the most appropriate dosing regimen, which may be adjusted during the course of treatment. Many jails routinely give one or two doses of benzodiazepine prophylactically (under protocols, with patient-specific orders) to patients at risk for alcohol withdrawal as a low-risk, low-cost, effective preventive measure.

Dosage Regimens

Front loading: An approach where moderate to high doses of a long-acting medication are given frequently at the start of treatment to achieve rapid control of withdrawal signs and symptoms. Front loading can be followed by a symptom-triggered or fixed-dose regimen.

Fixed dosing: An approach where a predetermined dose (which can be determined based on withdrawal severity) is administered at fixed intervals according to a schedule. Doses usually decrease in a gradual taper over several days. Additional medication may be provided if the fixed dose does not adequately control symptoms.

Symptom-triggered dosing: An approach where patients are given medication only when symptoms cross a threshold of severity (e.g., 15 mg oxazepam for CIWA-Ar scores 8–15, 30 mg oxazepam for CIWA-Ar > 15).

WARNING: Symptom-triggered dosing, if used alone, requires highly reliable and dedicated staff to avoid undertreatment of withdrawal and should be used only when there are adequate qualified staff to perform assessments.

Recommendations

A-24. Benzodiazepines are the preferred agent for treating alcohol withdrawal.

A-25. While no particular benzodiazepine agent is more effective than another, long-acting benzodiazepines are the preferred agents due to the clinical benefits of their longer duration of action. Adequate treatment with a long-acting benzodiazepine is effective in preventing withdrawal seizures.

A. See *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management* for more detailed clinical guidance and dosing protocols, including guidance regarding patients with severe liver disease and other significant comorbidities.

A-26. Patients with CIWA-Ar scores < 10 and who are at minimal risk of developing severe or complicated alcohol withdrawal may be provided supportive care alone and monitored.

A. It is also appropriate to use benzodiazepines prophylactically for alcohol withdrawal.

A-27. Patients with CIWA-Ar scores > 10 and patients at risk of developing severe or complicated alcohol withdrawal should receive pharmacotherapy and supportive care.

A-28. Front loading, fixed dosing, and symptom-triggered dosing are all appropriate in jail settings and may be used in combination.

A-29. Front loading is recommended for patients at risk for severe or complicated alcohol withdrawal (e.g., CIWA-Ar ≥ 21). Diazepam and chlordiazepoxide are preferred agents for front loading.

A-30. The patient's signs and symptoms should be monitored, as discussed in Monitoring Patients During Withdrawal Management in General Guidance, regardless of the dosing schedule used.

A-31. Qualified health care staff should monitor patients taking benzodiazepines for signs of oversedation and respiratory depression.

A-32. If a patient's symptoms are not controlled as expected with the dose of benzodiazepine prescribed, the provider should consider increasing the dose.

A-33. Benzodiazepines used to treat alcohol withdrawal should be tapered and discontinued following treatment.

A-34. If the patient has been using sedative substances and alcohol, withdrawal should be handled in the same way as withdrawal from sedatives (see recommendations in Sedative Withdrawal).

A-35. Do not give antiseizure medications prophylactically to prevent alcohol withdrawal unless the patient also has an underlying seizure disorder.

A-36. Alcohol use disorder (AUD) is a chronic medical condition. Patients should be provided with information about the range of evidence-based treatments, including medications for AUD, and recovery support services available in the community.

A. The provider should offer to initiate evidence-based treatment for AUD, including medications and regular follow-up visits at clinically appropriate intervals. Follow-up visits may include monitoring for return to use, Motivational Interviewing to encourage engagement in AUD treatment, psychoeducation, and management of medications for AUD.

A-37. If a patient entering jail is taking prescribed medication for AUD, the medication should be continued unless otherwise ordered by a prescriber based on documented clinical need.

Supportive Care

Inadequate nutrition associated with heavy alcohol use can lead to conditions that can typically be prevented through supportive care. For example, thiamine can reduce the risk for Wernicke encephalopathy.

Recommendations

A-38. As discussed in General Guidance, supportive care is appropriate for all levels of alcohol withdrawal severity and may include nutritional supplementation, IV fluids, glucose, management of electrolyte abnormalities, and periodic clinical reassessments, as clinically indicated (see Monitoring Patients During Withdrawal Management).

A. If dehydration is an ongoing concern and the jail does not have the capacity to manage IV fluids, the patient should be transferred to a facility that does.

A-39. Alcohol use can be associated with vitamin and mineral deficiencies.

A. To reduce the risk of encephalopathy, all patients with suspected AUD should be treated with thiamine, 100 mg daily, either orally or intramuscularly for 3–5 days.

B. Other vitamin and mineral supplementation (e.g., magnesium, folate) should be considered, as determined by the treating provider.

Pregnancy and Postpartum

Alcohol withdrawal presents significant risks during pregnancy, often requiring care at a hospital with expertise in managing high risk obstetrical cases and with fetal monitoring available.

Recommendations

A-40. Pregnant patients should typically be transferred to a setting with 24-hour medical care available (e.g., emergency department, hospital).

A-41. If managing the patient's alcohol withdrawal in the jail, consult with a provider experienced in obstetrical care.

A. Specialty consultation should not delay initiation or titration of treatment.

A-42. Benzodiazepines are the preferred medication for treatment of pregnant patients with alcohol withdrawal. While there is a risk of teratogenicity during the first trimester, the risk appears small and balanced in view of the risk for FASD and consequences to the mother and fetus should severe maternal alcohol withdrawal develop.

A-43. For patients at risk for preterm delivery or in the late third trimester, use of a short-acting benzodiazepine is recommended. This minimizes the risk for neonatal benzodiazepine sedation given shorter onset and duration of action.

A-44. Given the risk of FASD, pregnant patients with alcohol withdrawal should be educated on the importance of treatment for AUD.

A-45. Pregnant patients should be informed of all wraparound services that will assist them in addressing newborn needs (including food, shelter, and pediatric clinics for inoculations) and programs that will help with developmental or physical issues that the newborn may experience as a result of in-utero alcohol exposure.

A-46. Qualified health care professionals should understand and follow their state laws regarding definitions of child abuse and neglect, reporting requirements, and plans of safe care for newborns with in-utero alcohol exposure.

Managing Comorbidities

Co-occurring medical and psychiatric conditions can complicate the management of alcohol withdrawal and should be considered when developing the treatment plan.

Recommendations

A-47. For patients with medical comorbidities, consult with specialists as needed to modify the medication and/or protocol used for treating alcohol withdrawal.

A-48. Hallucinations that develop in the context of alcohol withdrawal may indicate an alcohol-induced psychotic disorder. A patient who develops hallucinations should be transferred to a higher level of care for treatment.

A. Benzodiazepine medication should be given concurrently with the call for transport, if feasible.

B. Antipsychotic medication can be considered, concurrent with the call for transport, if feasible and needed to manage severe psychotic symptoms.

A-49. For patients with medical conditions that prevent the use of oral medication, provide IV or intramuscular medications as necessary.

A. If the jail does not have the capacity to provide medication in these forms, the patient should be transferred to a higher level of care.

Polysubstance Use Disorder

Benzodiazepines or other sedative medications increase the risk for respiratory depression in patients who are taking opioids, including methadone or buprenorphine for the treatment of OUD. While the combined use of these medications increases this risk, the harm caused by untreated opioid withdrawal, OUD, or alcohol withdrawal outweighs these risks. Consulting with an addiction specialist physician may be helpful in determining an appropriate approach to complex polysubstance use withdrawal.

Recommendations

A-50. Patients who are taking opioid medication for OUD or pain should be monitored closely when benzodiazepines are prescribed due to the increased risk of respiratory depression.

A. Patients with concurrent opioid and benzodiazepine withdrawal syndrome should be stabilized on buprenorphine or methadone and a benzodiazepine, prior to tapering benzodiazepines.

A-51. For patients with co-occurring alcohol withdrawal and OUD, stabilize the OUD (e.g., with methadone or buprenorphine) concomitantly with alcohol withdrawal management.

Sedative Withdrawal

Sedatives depress the central nervous system. Benzodiazepines are currently the sedative drug most often encountered in the context of withdrawal risk, but others include barbiturates, GHB, and nonbenzodiazepine hypnotics (Z-drugs). The following recommendations generally apply to all sedatives, although important differences in the management of withdrawal from barbiturates and GHB are discussed.

Like alcohol withdrawal, abrupt cessation of prescribed and illicitly used sedatives can result in serious health consequences and death.[22] As noted in G-4, patients entering jails who have been prescribed benzodiazepines or other sedatives (e.g., gabapentinoids for epilepsy or nerve pain, baclofen for treating muscle stiffness) should continue receiving the medication unless there is a documented clinical reason for discontinuing the prescription. It is not safe to abruptly discontinue benzodiazepines or other sedatives prescribed for medical purposes; proper tapering can take months.[23]

Screening

Screening for sedative withdrawal risk considers frequency and recency of use, as well as history of complicated sedative withdrawal. Although barbiturates are becoming less available in the United States due to increased federal controls to safeguard against dependence and overdose, screening for withdrawal risk remains critical. Barbiturate withdrawal can be deadly, and patients should be treated in a hospital setting (see SH-9).

Recommendations

SH-1. Individuals who report recent, regular use of sedatives (daily or near daily use and use within the past 7 days) should be referred for immediate clinical assessment. [Note that this does not apply to use of prescription sedatives taken as prescribed, as the patient should have continued access to the medication.]

SH-2. Individuals reporting any past-week use of sedatives and a history of complicated sedative withdrawal (e.g., seizures, psychosis, hallucinations) should be referred for immediate clinical assessment.

Monitoring for Withdrawal Signs and Symptoms

Individuals reporting less regular (i.e., less than daily or near daily) use of sedatives should also be monitored for signs and symptoms of withdrawal. Since different sedatives vary in the length of time they are active in the body, the appearance of withdrawal may vary (table SH-1). Short-acting benzodiazepines are processed and leave the body quickly, which leads to a higher risk of withdrawal symptoms developing sooner and escalating quickly. Long-acting benzodiazepines are processed more slowly by the body; therefore, withdrawal symptoms may emerge over a longer period.

Table SH-1: Development of Sedative Withdrawal Symptoms

Duration of Action	Examples	Timeframe
Short-acting	alprazolam, lorazepam	First 24 hours after cessation of use
Long-acting	clonazepam, diazepam	24–48 hours after cessation of use

Some indicators of sedative withdrawal (table SH-2) may be misattributed to other causes, highlighting the importance of referring any individual who appears unwell for immediate clinical assessment.

Table SH-2: Possible Indicators of Sedative Withdrawal*[24,25,26]

- Abdominal cramping, nausea, and vomiting
- Anxiety
- Circulatory failure
- Delirium (including disorientation and hallucinations)
- Hyperthermia and sweating
- Increased heart rate and blood pressure
- Insomnia
- Occasional psychotic thoughts
- Restlessness
- Seizures
- Tremors
- Unease

*Staff should be alert to any indicators that the individual is unwell, not only those listed here.

Recommendations

SH-3. Individuals who self-report risk for sedative withdrawal and those who report sedative use below the threshold specified in SH-1 (daily or near daily and within past 7 days) should be monitored at least every 6 hours for at least the first week for emergence of withdrawal signs and symptoms.

SH-4. Although a few benzodiazepine withdrawal scales have been developed, there is no single scale that has been well validated and replicated. As discussed in General Guidance, if signs or symptoms emerge or if the individual begins to appear unwell to a layperson, they should be referred for immediate clinical assessment.

Clinical Assessment and Diagnosis

All sedative withdrawal should be treated, regardless of length of jail stay. Clinical assessment will determine the type and intensity of care required to address the patient's needs.

No validated scales for assessing sedative withdrawal exist. The Clinical Institute Withdrawal Assessment Scale – Benzodiazepines (CIWA-B) is a 22-item instrument for assessing and monitoring symptoms of benzodiazepine withdrawal, but its validity and reliability have not been fully determined.[27]

Recommendations

SH-5. As with all withdrawal, a patient history and physical exam including vital signs should be done to assess withdrawal severity and inform treatment.

SH-6. Do not use the CIWA-Ar for assessing sedative withdrawal.

SH-7. Because of the high risk of delirium, seizures, and death, sedative withdrawal should always be treated.

Level of Care

Withdrawal from barbiturates and GHB is complex and requires hospital-level care, as does severe or complicated withdrawal from benzodiazepines. Patients should be transferred to a hospital, preferably (when possible) a hospital with expertise in treating sedative withdrawal. Use of GHB is typically determined by patient history due to its short-acting nature. If the patient is intoxicated, obtaining this history may be difficult; however, witnesses (law enforcement, family, friends) may be able to provide information about GHB use.

Recommendations

SH-8. For sedative withdrawal, hospitalization is suggested for patients showing signs of severe or complicated withdrawal.

A. These signs may include:

i) Delirium.

ii) Hallucinations.

iii) Changes in consciousness.

iv) Profound agitation.

v) Autonomic instability (when heart rate, blood pressure, and sweating and other nonvoluntary body functions fluctuate).

vi) Seizures.

B. For patients experiencing less severe sedative withdrawal who have a history of complicated sedative withdrawal symptoms, transfer to a setting with 24-hour medical care should be considered.

C. For patients at risk for sedative withdrawal (but not presenting with signs or symptoms) who have a history of complicated withdrawal symptoms, more frequent monitoring should be considered.

SH-9. Hospitalization is recommended for patients experiencing barbiturate withdrawal, unless the jail has hospital-level capacity (i.e., telemetry [including cardiac monitoring] and full-code response including intubation/ventilation support).

SH-10. GHB withdrawal is complex and technically more difficult than other sedative withdrawal. Transfer to a hospital is recommended. When possible, the patient should be transferred to a hospital with experience treating complex sedative withdrawal.

Monitoring Patients During Withdrawal Management

Recommendations

SH-11. Patients treated for sedative withdrawal should have a daily clinical assessment by a qualified health care professional for at least the first week, or as their condition indicates.

A. After the first week, patients should be assessed by a qualified health care professional at least two times per week until the taper is complete (see SH-14).

Medications

For most patients, treatment for benzodiazepine withdrawal involves pharmacotherapy with a long-acting benzodiazepine to stabilize withdrawal symptoms before slowly tapering by 10–25 percent per week. It is important that tapering be no more rapid than 25 percent per week. In circumstances where initial tapering requires unusually high doses of benzodiazepines, providers may consider transferring the patient to a hospital with expertise in sedative withdrawal.

Tapers extending beyond the time of custody will require a prescription for the long-acting benzodiazepine initiated for tapering, as well as linkage to ongoing care at the time of release.

Recommendations

SH-12. Treatment should not be delayed based on the potential timeline for release.

SH-13. Patients who have been taking sedatives should be converted to an equivalent dose of long-acting benzodiazepine.

A. Clonazepam has a long half-life and is well-tolerated and easy to administer. It is the preferred medication for treatment of benzodiazepine withdrawal for most patients.

B. Individuals metabolize clonazepam at different rates; therefore, the dose equivalencies will not hold for all patients and must be individualized according to the patient's response. Adequate dosing of clonazepam will control sedative withdrawal symptoms, including increased heart rate, sweating, and hand tremor.

SH-14. Benzodiazepines should be tapered over a period of weeks or months. Taper duration should be based on the patient's agent of choice, dose, frequency and duration of use, comorbid physical or mental health conditions, and treatment setting.

A. In patients who are not hospitalized, the medication should not be tapered any more rapidly than 25 percent per week.

B. As the taper nears the end, it may be necessary to taper more slowly if anxiety or insomnia develop. These symptoms can continue for many months.

C. Comorbid conditions should be monitored throughout withdrawal to inform the taper schedule.

SH-15. If withdrawal symptoms increase, medication dosage should be stabilized or even increased for a period of days.

SH-16. Signs and symptoms of sedative withdrawal (e.g., insomnia and anxiety) may last beyond the period of acute withdrawal. These symptoms may take months or years to resolve and should be treated with evidence-based interventions.

SH-17. If the patient is experiencing both sedative and opioid withdrawal, provide methadone or buprenorphine to stabilize withdrawal from opioids before tapering the dose of the sedative.

SH-18. If the patient has been using multiple sedative substances or a sedative and alcohol, withdrawal should be handled by using an equivalent or longer-acting agent than the longest-acting agent used by the patient.

SH-19. Do not give antiseizure medications prophylactically to prevent sedative withdrawal unless the patient also has an underlying seizure disorder.

Supportive Care

Sedative withdrawal can cause a number of side effects, including insomnia and anxiety, that may be relieved through supportive care (when possible).

Recommendations

SH-20. In addition to the recommendations in General Guidance, supportive care for patients in sedative withdrawal may include cognitive behavioral therapy (except during acute withdrawal), stress management, sleep hygiene, and relaxation training, which may be helpful both during and after taper.

Pregnancy and Postpartum

Treating sedative withdrawal can be safely managed in pregnancy, following the guidelines described above.

Recommendations

SH-21. Pregnant patients should undergo withdrawal management slowly and in consultation with an obstetrician.

SH-22. The principles of withdrawal management from sedatives are the same for pregnant and non-pregnant patients.

Opioid Withdrawal

Opioids include illicit drugs (e.g., heroin, illicitly manufactured fentanyl, and its analogues) and prescription pain relievers, such as oxycodone (Percocet or Oxycontin), hydrocodone (Vicodin), methadone, and morphine. Individuals who are physiologically dependent on opioids, including those who regularly use either illicit or prescription opioids, are at risk for opioid withdrawal.

Dangerous Changes in Drug Composition

Individuals may not always know that they have been using opioids or which opioids they have been using. Increasingly, individuals are consuming counterfeit pills or drugs containing fentanyl.[28,29] Given the high potency of fentanyl mixed in with the drug supply, multiple doses of naloxone may be necessary to reverse an overdose.[30]

It is important for qualified health care professionals to understand the regional drug supply, remain current on clinical guidance, and regularly revisit response protocols. For example, the veterinary tranquilizer xylazine, which is currently added to fentanyl and other illicit opioids, has been linked to many overdose deaths in the Northeast. Naloxone may be less effective in cases of overdoses involving opioids mixed with xylazine.[31]

Opioid withdrawal syndrome can be medically complex and, in the absence of appropriate management, life-threatening. For example, vomiting and diarrhea associated with opioid withdrawal can lead to electrolyte imbalances and cardiac arrythmias, and the high blood pressure and rapid pulse characteristic of opioid withdrawal can exacerbate underlying cardiac illness. Monitoring for and treating opioid withdrawal can prevent serious health outcomes, including death.

Many jails currently subject individuals to opioid withdrawal by either not offering buprenorphine or methadone treatment or not initiating it in a timely manner, such that individuals are subject to withdrawal before treatment is initiated or they are released. These practices put individuals at significant medical risk during their stay in jail and increase likelihood of overdose if they resume opioid use upon return to the community, due to reduced tolerance. In addition, as discussed in *The ASAM National Practice Guideline* [NPG] *for the Treatment of Opioid Use Disorder* [OUD], "opioid withdrawal management on its own, without ongoing pharmacotherapy, is not a treatment method for opioid use disorder and is not recommended."[32]

For these reasons, it is recommended that individuals with OUD who are at risk for opioid withdrawal be offered initiation of long-term pharmacotherapy for OUD, which should be initiated in a timely manner as discussed in the recommendations below. If the patient declines long-term treatment with medication for OUD or prefers to initiate naltrexone to prevent return to use, the patient should be offered buprenorphine or methadone treatment to treat opioid withdrawal.

Screening

As discussed in General Guidance, all individuals should be screened for recent substance use using a validated screening tool and asked if they are at risk for opioid withdrawal.

Recommendation

O-1. Anyone who reports regular use of opioids (including prescription opioid misuse), OUD, or opioid withdrawal risk should be considered at risk for opioid withdrawal. [Note that this does not apply to use of prescription opioids taken as prescribed, as the patient should have continued access to the medication.]

A. If prescription opioids are discontinued, based on a patient-specific order from a provider (see G-4), the patient should be considered at risk for opioid withdrawal.

Monitoring for Withdrawal Signs and Symptoms

Opioid withdrawal syndrome refers to the wide range of symptoms that occur when individuals who regularly take opioids, either illicit or prescribed, stop or reduce their use. Regular monitoring for signs and symptoms of withdrawal supports rapid identification and referral for clinical assessment.

Some individuals may initially screen negative for withdrawal risk but later exhibit signs or symptoms of withdrawal (tables O-1 and O-2). Custody staff should be well-trained to refer all individuals who appear unwell for immediate clinical assessment (see G-44), regardless of initial screening results.

Table O-1: Opioid Withdrawal Symptom Emergence and Duration[33]

	Emergence	**Duration**
Short-acting opioids (e.g., heroin, oxycodone)	Within 12 hours of last use and peaking within 24–48 hours	3–5 days
Long-acting opioids (e.g., methadone)	Within 30 hours of last use	Up to 10 days

Table O-2: Possible Indicators of Opioid Withdrawal*[34]

- Agitation
- Anxiety
- Abdominal cramping
- Diarrhea
- Dilated pupils
- Increased tearing
- Insomnia
- Muscle aches
- Nausea
- Piloerection ("goose bumps")
- Runny nose
- Sweating
- Vomiting
- Yawning

* Staff should be alert to any indicators that the individual is unwell, not only those listed here.

Recommendations

O-2. Individuals may be considered at risk for opioid withdrawal even if they do not meet the clinical criteria for an OUD.

O-3. Individuals who report regular opioid use (including prescription opioid misuse) or screen positive for current OUD should be monitored for signs and symptoms of opioid withdrawal at least every 4 hours for the first 72 hours of incarceration.

A. As discussed in General Guidance, individuals at risk for withdrawal should ideally be housed together in a dedicated unit to facilitate monitoring.

B. Patients who appear unwell to a layperson or score ≥ 3 on the COWS should be referred for immediate clinical assessment.

Clinical Assessment and Diagnosis

The initial clinical assessment, conducted by a qualified health care professional, focuses on identifying any medical risks that would necessitate a higher level of care or a full medical evaluation. Validated assessment tools, such as the COWS, allow for methodical collection of information about withdrawal signs and symptoms at assessment and during monitoring.

Recommendations

O-4. The initial clinical assessment should focus on identifying signs and symptoms of opioid withdrawal, as well as overdose and withdrawal risk.

A. Assessment of withdrawal risk should focus on the types of opioids used, route of use, length of time used, symptoms when use has stopped or decreased, and details of last use (when, how much, and what type).

O-5. If a patient treated with buprenorphine or methadone for presumed opioid withdrawal does not respond to treatment, the qualified health care professional should consider whether the dose needs to be increased or if the patient may have been misdiagnosed.

A. Differential diagnosis should include serious illnesses that can mimic the signs and symptoms of opioid withdrawal including withdrawal from other substances, myocardial infarction, pulmonary embolus, respiratory infection, severe abdominal infection, diabetic ketoacidosis, sepsis, and thyrotoxicosis, among others.

Medications

Initiating ongoing treatment for OUD with buprenorphine or methadone will prevent severe opioid withdrawal, as well as alleviate cravings that can result in return to use, overdose, and overdose death when patients regain access to opioids. To establish reliable access to medication, jails should have formal relationships with providers of methadone and buprenorphine treatment. Regarding the latter, the Substance Abuse and Mental Health Services Administration (SAMHSA) states, "All practitioners who have a current [Drug Enforcement administration (DEA)] registration that includes Schedule III authority may now prescribe buprenorphine for opioid use disorder in their practice if permitted by applicable state law."[35] Mobile narcotic treatment programs registered with the DEA are allowed to operate at correctional facilities when doing so does not conflict with applicable federal, state, tribal, or local laws and regulations;[36] such programs may expand jail capacity for offering medications. Local public health authorities and state substance use treatment authorities should be able to provide guidance to support jails that lack expertise in this area.

Jail administrators are encouraged to consider barriers to accessing buprenorphine and methadone in the community. If there are no methadone treatment providers, patients will be unable to continue methadone treatment, in which case buprenorphine may be the preferred option. For more information on reentry, go to General Guidance.

It is important that the patient's treatment plan, including choice of medication for OUD management and need for psychosocial treatment, be based on individual clinical needs and informed choice and not policy decisions that disincentivize medications for OUD.

WARNING

- Concurrent use of methadone or buprenorphine with alcohol or benzodiazepines increases respiratory depression risk. However, concurrent treatment with benzodiazepines (e.g., for co-occurring alcohol or sedative withdrawal) should not be a reason to withhold treatment with buprenorphine or methadone. Increased monitoring may be appropriate.
- Naltrexone is not approved by the FDA for withdrawal management purposes and does not relieve withdrawal symptoms. It cannot be administered until patients are free of short-acting opioids for at least 7–10 days or 10–14 days for long-acting opioids. Failing to observe these wait periods may cause precipitated withdrawal.
- Anesthesia-assisted opioid detoxification or ultra-rapid opioid detoxification, which involves large doses of naloxone, anesthesia, and a diuretic, has been associated with serious complications (including cardiac arrest and death) and is not recommended.

Recommendations

O-6. Buprenorphine and methadone are first-line treatments for opioid withdrawal and OUD.

A. All patients at risk for opioid withdrawal should have rapid access to treatment with these medications.

O-7. Because opioid withdrawal management without ongoing OUD treatment increases the risk for overdose and overdose death, the appropriate clinical strategy is to prevent opioid withdrawal by initiating **ongoing treatment** for OUD with buprenorphine or methadone.

O-8. Naltrexone is not a treatment for opioid withdrawal. Extended-release naltrexone is a treatment option for OUD in patients who are no longer physiologically dependent on opioids. However, this medication will exacerbate withdrawal in patients who are dependent on opioids.

O-9. Initiation of medications should not be delayed in patients experiencing or at risk for opioid withdrawal. As noted in General Guidance, completion of the full assessment is NOT required before initiating medication for opioid withdrawal or OUD.

O-10. Once the diagnosis of OUD or opioid withdrawal is confirmed, treatment should be initiated immediately, without regard for the expected duration of incarceration.

O-11. All jails should have a plan for providing same-day access (or access within 24 hours of entry) to buprenorphine and methadone.

O-12. With the expansion of eligibility to prescribe buprenorphine, all jails should be able to provide access to buprenorphine treatment. However, jails lacking the capacity to manage opioid withdrawal with buprenorphine or methadone should have protocols in place to ensure that patients experiencing opioid withdrawal can be rapidly transferred to an appropriate treatment setting that can provide one of these medications.

O-13. Polysubstance use is not a contraindication for treating opioid withdrawal or OUD with medication.

A. Urine drug screen results should not be used to deny patients access to medications for opioid withdrawal or OUD.

O-14. The use of benzodiazepines and other sedatives should not be a reason to withhold or suspend treatment with methadone or buprenorphine. While the combined use of these medications increases the risk of serious side effects, the harm caused by untreated OUD can outweigh these risks. A risk-benefit analysis should be conducted, and greater support should be provided, including careful medication management to reduce risks.

O-15. If individuals entering jail are experiencing symptoms of moderate to severe opioid withdrawal, they should be referred for immediate clinical assessment by a provider who can initiate buprenorphine or methadone or transferred to a facility that can provide buprenorphine or methadone if indicated.

O-16. Even if the patient may not be able to maintain treatment in the community, buprenorphine or methadone should still be initiated.

O-17. Patients undergoing withdrawal management should be advised of the risk of returning to use, overdose, and overdose death if they choose not to engage in ongoing medication treatment.

O-18. Jails that do not have prescribers onsite 24 hours per day, 7 days per week should consider using telehealth to support access to buprenorphine and methadone treatment.

O-19. Opioid withdrawal management is not necessary if the patient is immediately initiated on methadone or buprenorphine upon intake to the jail. However, if opioid withdrawal management is clinically indicated or if the patient declines ongoing treatment with medications for OUD, buprenorphine or methadone are also recommended for withdrawal management (see *The ASAM NPG for the Treatment of OUD* for tapering guidance).

O-20. For protocols for initiating medications for OUD, refer to *The ASAM NPG for the Treatment of OUD*.

O-21. Jails should establish mechanisms for rapidly initiating methadone or buprenorphine treatment when the provider is off-site.

O-22. Adjunctive medications (e.g., clonidine, anti-nausea medication) should not be necessary if buprenorphine or methadone is provided in adequate doses (typically ≥ 16 mg/day of buprenorphine; see *The ASAM NPG for the Treatment of OUD* for methadone-dosing recommendations) and should not be used in the place of an adequate dosage of buprenorphine or methadone.

A. Patient discomfort during opioid withdrawal management may indicate the dose of buprenorphine or methadone is too low.

O-23. Policy decisions disallowing or disincentivizing FDA-approved medications for opioid withdrawal or OUD are not clinically appropriate.

O-24. Jails should consider offering psychosocial treatment to patients with OUD (based on an assessment of their psychosocial needs), in addition to pharmacotherapy. However, **a patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment.**

O-25. Patients entering the jail who take prescribed opioid medications for chronic pain treatment should be permitted to continue these medications. (See also G-4 and supporting narrative.)

A. If a provider determines and documents that continuation of opioid analgesic medications is clinically inappropriate, the medication should be tapered slowly according to current clinical guidelines (see guidance from the U.S. Department of Health and Human Services), and the patient should be monitored for signs and symptoms of withdrawal.

Buprenorphine

Buprenorphine is an effective medication for treating both opioid withdrawal and OUD. Recent changes in federal legislation allow buprenorphine to be prescribed by any prescriber with a DEA registration to prescribe controlled substances. However, some states may limit buprenorphine-prescribing authority.

Buprenorphine should be initiated when the patient shows objective signs or symptoms of withdrawal (e.g., pupil dilation, goose bumps, gastrointestinal discomfort). **In a patient at risk for opioid withdrawal, if buprenorphine is initiated (using standard protocols) before the patient is showing signs of withdrawal, the patient may experience precipitated withdrawal, resulting in a higher COWS score, and severe symptoms, such as vomiting and diarrhea.** As determined by clinical consensus in the absence of data, the patient should be monitored by a qualified health care professional for at least 30 minutes after the initial administration of buprenorphine, as precipitated withdrawal will require immediate treatment and may require a higher level of care. Due to the rapid pace at which clinical practice is changing, jails should collaborate closely with community providers and hospitals on evolving protocols for buprenorphine initiation (including low dose initiation protocols).[37]

The COWS assessment can be helpful in determining if patients are experiencing mild to moderate withdrawal. In community settings, a score of 11–12 is typically indicative of sufficient withdrawal to initiate buprenorphine. However, the EC has observed underscoring of the COWS in jail settings such that some jails initiate buprenorphine with a COWS score of 6 or more. Use of COWS will be more effective when jails periodically evaluate how often patients are experiencing significant withdrawal signs/symptoms (e.g., vomiting or diarrhea) and how often patients are experiencing precipitated withdrawal, adjusting threshold protocols accordingly. If patients are experiencing significant withdrawal before buprenorphine is initiated, initiation should be triggered by a lower COWS score. If the initiation protocols are leading to precipitated withdrawal, initiation should be triggered by a higher COWS score.

The ASAM NPG for the Treatment of OUD provides recommendations for standard dosing protocols. Recent studies have reported successful buprenorphine initiation using alternative dosing protocols including micro-dosing strategies and high-dose buprenorphine initiation, which may be considered (see Resources). For administration during incarceration (and assuming administration is monitored by custody staff), any buprenorphine formulation may be considered.

Table O-3: Buprenorphine Formulations[38]

Name	Route of Administration (Dosing)	For the Treatment of	Comments
For all formulations: • Titration is advised during the first 1–3 weeks of treatment. • Standing orders for dose initiation are not advised.			
Generic: Buprenorphine **Brand:** Generic versions available similar to Subutex	Sublingual tablets (daily)	Opioid withdrawal and OUD.	While there is a higher risk for misuse of the buprenorphine-only product in the community, that risk may be lower in the jail because administration is observed.
Generic: Buprenorphine and naloxone **Brand:** Generic versions available in addition to Suboxone, Cassipa, Zubsolv	Sublingual tablets and film (daily)		Opioid withdrawal and OUD.

Table O-3: Buprenorphine Formulations (continued)

Name	Route of Administration (Dosing)	For the Treatment of	Comments
Generic: Buprenorphine extended-release **Brand:** Sublocade	Extended-release injection (monthly)	Moderate to severe OUD in patients who have initiated treatment with transmucosal forms, followed by dose adjustment for a minimum of 7 days.	• No risk for patient diversion or misuse. • Requires patients to be on a stable dose of transmucosal buprenorphine for at least 7 days. • Less fluctuation in buprenorphine levels (compared to daily doses).
Generic: Buprenorphine extended-release **Brand:** Brixadi	Extended-release injection (weekly or monthly)	Moderate to severe OUD in patients after a single dose of transmucosal buprenorphine or who are already being treated with buprenorphine.	• No risk for patient diversion or misuse. • Only a single prior dose of transmucosal buprenorphine required prior to initiation. • Less fluctuation in buprenorphine levels (compared to daily doses).

Recommendation

O-26. Buprenorphine should be initiated when the patient shows objective signs of opioid withdrawal.

A. The patient should be monitored for precipitated withdrawal for at least 30 minutes after the initial administration of buprenorphine.[c]

B. If a patient is experiencing precipitated withdrawal and a prescriber is not immediately available to conduct an assessment, the patient should be transferred to a hospital.

Methadone

Methadone, a long-acting full opioid agonist, is an effective treatment for opioid withdrawal syndrome and OUD. With the exception of access under the 72-hour emergency rule, methadone for the treatment of OUD is currently only available through federally registered opioid treatment programs (OTPs).

72-Hour Emergency Rule

Under this rule, a physician outside of an OTP is allowed to administer (but not prescribe) methadone to a patient to relieve acute withdrawal symptoms while arranging for the patient's referral for treatment, for up to 72 hours. This may not be renewed or extended, nor may more than 1 day's medication may be administered or given to a patient at one time.[39]

Jails can either become a certified OTP[40] or establish an MOU with an external methadone treatment provider detailing roles, responsibilities, payment, and security concerns, such as:

- Transport of patients to the methadone treatment provider.
- Transport of methadone to the jail by methadone treatment provider, jail medical, or jail custody staff.
- Guest dosing for patients who are established with a different methadone treatment provider.

As noted above, properly registered mobile narcotic treatment providers provide another treatment option for correctional facilities, which may be especially useful in rural communities.

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[c] Note: Buprenorphine may be initiated prior to the emergence of objective signs of withdrawal when using a low-dose buprenorphine initiation protocol. See ASAM's "Treatment of Opioid Use Disorder with Buprenorphine: Clinical Consideration for Treatment of Individuals with OUD using High Potency Opioids" (submitted March 23).

Methadone can be difficult to access, and discontinuation of this medication puts the patient at risk of returning to use, so reentry planning upon initiation of methadone is essential.

Table O-4: Methadone Formulations[41]

Name	Route of Administration (Dosing)	For the Treatment of	Comments
Generic: Methadone **Brand:** Methadose, Dolophine	• Liquid concentrate, tablet, oral solution of powder, or dispersible tablet (daily). • Injection for temporary treatment of opioid dependence in patients unable to take oral medication.[42]	Opioid withdrawal and OUD	• Federal law mandates that the initial dose cannot exceed 30 mg, and the total dosage on the first day cannot exceed 40 mg. • Methadone may cause respiratory depression, particularly during initial dosing. • Titration is advised during the first 1–3 weeks of treatment. • Standing orders for dose initiation are not advised.

Recommendations

O-27. Jails should consider obtaining certification from SAMHSA to administer and dispense methadone or partnering with a local methadone treatment provider to provide access to methadone and support seamless transitions of care on entry and release.

O-28. Methadone treatment must be managed by a methadone treatment provider, except when using the 72-hour emergency prescribing authority. The dose (or taper schedule when clinically indicated or preferred by the patient) should be determined by the methadone treatment provider, not by custody staff or policies.

O-29. If using methadone to treat OUD or opioid withdrawal, follow *The ASAM NPG for the Treatment of OUD* for medication initiation and dosages.

O-30. Patients do not need to experience withdrawal symptoms before methadone treatment is initiated.

Treating Patients Currently Receiving Buprenorphine or Methadone

As explained in The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery, patients in treatment for OUD who are not engaging in illegal drug use, including those who are prescribed medication to treat their OUD, are protected from discrimination. By law, patients meeting these criteria who enter jail should be allowed to continue medications for SUD treatment in consultation with clinical providers.[43] Furthermore, continuation of treatment while incarcerated lowers the odds of reincarceration and increases the odds of remaining in treatment.[44] Methadone withdrawal in particular is a painful experience, and the fear of experiencing this again can make patients reluctant to restart the medication.[45]

Partnerships between jails and a methadone treatment provider in the region can facilitate continued access to methadone for patients who were in methadone treatment prior to incarceration.

It may be necessary or appropriate for patients to transition from one OUD medication to another, such as when they cannot tolerate side effects. The transition from methadone to buprenorphine can be medically complex because of the long duration of action of methadone and the risk for precipitated withdrawal. (Transitioning from buprenorphine to methadone does not pose a risk of precipitated withdrawal.) In the rare instances where discontinuation of methadone or buprenorphine is clinically indicated, the complexity of discontinuation requires the services of a medical provider with SUD treatment expertise (board certified or with 2 or more years of experience in specialty SUD treatment).

Recommendations

O-31. It is not appropriate to require a change in or discontinuation of OUD medication for nonclinical reasons (e.g., conditions of custody, release).

O-32. Discontinuing OUD medication puts the individual at risk for opioid withdrawal, and increases the risk for returning to use, overdose, and overdose death. Jails should continue treatment for patients who, upon arrival, are taking medication for treatment for OUD. (See also recommendation statement G-4 and supporting narrative.)

O-33. Patients should not be required to transition from opioid agonist (methadone or buprenorphine) to opioid antagonist (naltrexone) treatment.

O-34. In the absence of a methadone treatment provider or a provider authorized to prescribe buprenorphine (in states that restrict buprenorphine prescribing), jails should use the 72-hour emergency prescribing authority to provide methadone or state emergency access provisions to provide buprenorphine while they make arrangements for ongoing treatment.

A. The 72-hour emergency prescribing authority (and, typically, other emergency access provisions) cannot be renewed during the individual's stay in jail and should not be used in place of establishing access to buprenorphine and methadone.

O-35. Transitioning patients currently in methadone treatment to buprenorphine is clinically complex and should be managed by, or in consultation with, a provider experienced in managing this transition.

O-36. Discontinuation of methadone or buprenorphine is clinically complex and should be done only when clinically indicated and by a medical provider with SUD treatment expertise.

O-37. Tapering methadone takes longer in patients who are in methadone treatment compared to those initiated on methadone to treat withdrawal. Jails should not attempt to manage this process without the oversight of a methadone treatment provider.

Alpha-2 Adrenergic Agonists (Second-line Treatment)

Alpha-2 adrenergic agonists (FDA-approved lofexidine and off-label use of clonidine) can be used to treat withdrawal when patients choose to taper off buprenorphine or methadone, and in preparation for initiation of extended-release naltrexone. These medications are a second-line option, because they do not relieve opioid withdrawal symptoms as effectively as buprenorphine and methadone and can cause low blood pressure. This risk is increased when patients are not adequately hydrated. In addition, there can be dangerous elevations in blood pressure when this medication is stopped in patients with existing hypertension. When used, these medications are often combined with other medications targeting specific opioid withdrawal symptoms, such as benzodiazepines for anxiety, loperamide or bismuth salicylate for diarrhea, acetaminophen or nonsteroidal anti-inflammatory medications (NSAIDs) for pain, various medications for insomnia, and ondansetron for nausea.

Recommendations

O-38. Lofexidine or clonidine may also be appropriate to manage opioid withdrawal in the rare situations where complete opioid withdrawal management is clinically indicated, including when the patient declines treatment with buprenorphine or methadone.

A. Alpha-2 adrenergic agonists are contraindicated in patients with low blood pressure. As these medications can cause hypotension, blood pressure should be monitored regularly in patients prescribed these medications by personnel well-trained in blood pressure measurement.

B. See *The ASAM NPG for the Treatment of OUD* and SAMHSA's *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, Treatment Improvement Protocol (TIP) 43)* for dosage recommendations.

Level of Care

As discussed in General Guidance, the level of care should be appropriate for the anticipated severity of the withdrawal syndrome, as well as any medical or psychiatric comorbidities present. Where treatment services and resources are recommended in this section, including buprenorphine and methadone treatment, and are not immediately available in the jail, timely transfer to a higher level of care is indicated.

Monitoring Patients During Withdrawal Management

The withdrawal severity score should gradually decrease following medication initiation. An increasing score following buprenorphine initiation may indicate precipitated withdrawal and should trigger an immediate medical assessment. As mentioned in G-33, monitoring should only be discontinued upon a patient-specific order from the prescriber based on clinical evaluation and determination that it is safe to do so.

Recommendations

O-39. Opioid withdrawal symptom severity should be monitored with a validated tool, such as the COWS.

O-40. To support management of opioid use, it is recommended that jails, at minimum, have:

A. Staff who are well-trained to administer the COWS (or another validated tool) available at all times.

B. A provider authorized to prescribe buprenorphine on staff, under contract, or under a memorandum of understanding.

C. When feasible, direct affiliation with a methadone treatment provider to provide access to methadone.

O-41. Custody staff may be trained to effectively administer the COWS, including collection of vital signs.

O-42. The onset and severity of opioid withdrawal is dependent on the type of drug taken, when it was last taken, and how long it lasts in the person's body. Monitoring intervals should be determined by a qualified health care professional based on the anticipated timing and severity of withdrawal for the individual patient.

A. Patients who report use of a short-acting opioid (e.g., heroin, oxycodone, fentanyl) should be monitored using the COWS at least every 4 hours.

B. Patients who report using long-acting opioids (e.g., extended-release formulations, methadone) should be monitored using the COWS at least every 8 hours.

O-43. In patients with concurrent sedative use disorder or withdrawal, methadone or buprenorphine should be used to stabilize withdrawal from opioids.

A. Once opioid withdrawal is stabilized, it is appropriate to begin tapering the dose of the sedative as discussed in Sedative Withdrawal.

O-44. Concurrent stimulant use disorder is not a reason to delay or deny medication for OUD or opioid withdrawal. The patient should be offered evidence-based psychosocial treatment for the stimulant use disorder. However, if psychosocial treatment is not available or the patient declines, this should not preclude or delay pharmacological treatment of OUD or opioid withdrawal.

O-45. Treatment for opioid withdrawal or OUD should not be delayed in patients with comorbid mental illness (e.g., depression, anxiety, psychosis).

A. Withdrawal can exacerbate symptoms of depression and anxiety, and treatment of opioid withdrawal or OUD with medication can often improve these symptoms. The patient's mental health should be reassessed once they are on a stable dose of medication or after they are no longer in withdrawal.

Supportive Care

Recommendations

O-46. In addition to the items discussed in Supportive Care in General Guidance, patients treated for opioid withdrawal or OUD should be educated on:

A. The risk of overdose after withdrawal and strategies to mitigate the risk.

B. The effectiveness of medications for treating OUD and reducing overdose risk.

O-47. Vomiting or diarrhea may indicate opioid withdrawal has not been adequately treated (e.g., the dose of buprenorphine or methadone is too low) and the patient may be at risk of dehydration. The provider should be alerted if vomiting, diarrhea, or indicators of dehydration arise.

A. If inadequate opioid withdrawal treatment is suspected, the provider should consider increasing the dose of medication while managing the risk for dehydration.

B. If the jail does not have the capacity to safely and effectively manage fluid loss and replacement in a patient with vomiting and/or diarrhea, the patient should be transferred to a facility that does.

Pregnancy and Postpartum

Opioid misuse in pregnancy is associated with several complications (including preeclampsia, miscarriage, premature delivery, fetal growth restriction, and fetal death),[46] many of which can be ameliorated with prenatal care and medication for OUD. It is difficult to establish the extent to which these problems are due to opioid use, withdrawal, or co-occurring use of other drugs. Opioid withdrawal, without ongoing medication treatment, during pregnancy and the postpartum period is also associated with high return-to-use rates and associated risk for overdose and overdose death.[47]

The standard of care for pregnant and postpartum patients with OUD is ongoing treatment with buprenorphine or methadone. Barring other medical contraindications, breastfeeding is safe for people receiving methadone or buprenorphine for OUD and provides important maternal and fetal benefits, especially for infants born to women receiving this medication.[48]

Recommendations

O-48. Psychosocial treatment alone or withdrawal management alone are not appropriate for pregnant or postpartum patients with OUD. Pregnant and postpartum patients who are physically dependent on opioids should receive ongoing treatment with methadone or buprenorphine to prevent harm to the patient and fetus.

O-49. Methadone or buprenorphine treatment should be initiated as early as possible during pregnancy since opioid withdrawal can increase the risk of miscarriage or premature delivery.

A. Transfer to the hospital is likely to be needed for appropriate management, especially in the third trimester of pregnancy.

O-50. Opioid withdrawal risk in pregnant patients should be treated with urgency. If the jail does not have the capacity to initiate methadone or buprenorphine, the patient should be immediately transferred to a health care facility with this capacity.

O-51. Care for pregnant patients at risk for opioid withdrawal should be managed by providers experienced in obstetrical care and the treatment of OUD. If the jail does not have obstetric capabilities or expertise, they should consult with an obstetrical care provider or transfer the patient to a facility with this expertise.

A. Specialty consultation should not delay initiation or titration of treatment.

O-52. Pregnant patients should be counseled on the clear evidence of safety and efficacy of buprenorphine and methadone for preventing opioid withdrawal and treating OUD during pregnancy. These medications are the safest treatment options for the pregnant patient and the fetus.

O-53. All staff should be educated on the clear evidence of safety and efficacy of buprenorphine and methadone for preventing opioid withdrawal and treating OUD during pregnancy.

O-54. Qualified health care professionals should be aware that the pharmacokinetics of buprenorphine and methadone are affected by pregnancy. With advancing gestational age, plasma levels of these medications progressively decrease and clearance increases. Beginning in the second trimester, pregnant patients should be regularly evaluated for responses to these medications and encouraged to alert the medical team if cravings or signs and symptoms of withdrawal emerge. Increased and/or split doses should be offered when clinically indicated.

O-55. After the pregnancy has ended, the patient should continue with medications for SUD treatment. Doses may need to be reduced if there is evidence of oversedation, with consideration of patient input.

O-56. Engagement and retention in methadone or buprenorphine treatment should be supported. There should be no punitive consequences to engagement in methadone or buprenorphine treatment.

A. Treatment with medication should never increase the patient's risk for losing custody of their children, prevent access to drug court, or compromise release.

O-57. Jails should establish linkages with community programs to ensure smooth transitions of care for patients with OUD throughout pregnancy, delivery, and postpartum care when they return to their communities.

O-58. Naloxone should be administered to pregnant patients in cases of opioid overdose.

Reentry

Most patients who require opioid withdrawal management will have OUD. Numerous studies have demonstrated that treatment with medications for OUD during incarceration and reentry significantly reduces the risk for overdose and overdose death.[49] These studies also found that treatment for OUD with medication reduces illicit opioid use, increases engagement in OUD treatment in the community, and reduces risks of reincarceration.

If methadone or buprenorphine are abruptly reduced or discontinued upon reentry, patients will be at risk of withdrawal, as well as at risk for overdose and death.

Recommendations

O-59. Individuals who are being treated with buprenorphine or methadone should continue the medication while in jail, and the jail should assist with transfer to community-based treatment upon release.

O-60. Qualified health care professionals should ensure the patient has access to an adequate supply of buprenorphine or methadone to prevent interruption of dosing when the patient transitions to the community.

A. Backup plans are vital in the event the community appointment cannot be completed. Bridging clinics and telehealth can be very helpful.

O-61. Naloxone or a prescription for naloxone should be made available to all patients with OUD upon release.

A. Jails should consider providing naloxone or a prescription for naloxone to all patients with SUD.

B. Jails should consider making naloxone or a prescription for naloxone available to friends and family members of patients with SUD.

Stimulant Withdrawal

Approximately 10 percent of the criminal justice population surveyed used methamphetamine or cocaine or misused prescription stimulants (e.g., nonmedical use of amphetamine products for treating attention-deficit/hyperactivity disorder) at the time of the offense for which they were incarcerated.[50]

Stimulant intoxication is marked by multiple indicators (see table S-1), which often present during withdrawal, as well. In addition, the behavioral signs of intoxication, such as psychosis, hallucinations, and delusions, can be difficult to distinguish from mental illness.[51] Diagnosing stimulant intoxication or withdrawal, or stimulant-induced psychosis, requires qualified health care professionals.

The Substance Abuse and Mental Health Services Administration (SAMHSA) singles out self-harm as the greatest risk among patients who are withdrawing from stimulants because of the intensity of depression during withdrawal. The duration of this depression is longer for individuals who stopped using high doses of methamphetamine than those who stopped using cocaine.[52]

Table S-1: Possible Indicators of Acute Stimulant Intoxication[53]

- Euphoria, heightened sense of self.
- Increased vigor, giddiness, and sense of enhanced mental acuity and performance.
- Agitation, restlessness, irritability.
- Increased alertness.
- Increased sexual libido.
- Poor concentration, although some individuals may report improved concentration.
- Grandiosity, exaggerated self-esteem, egocentricity.
- Hypervigilance.
- Fearlessness.
- Suspiciousness, psychotic symptoms (e.g., paranoia, hallucinations).
- Clarity (not usually disoriented).
- Emotional instability, perceptions of persecution.
- Nausea and vomiting.
- Abnormal body movements.
- Teeth grinding.
- Insomnia.
- Tremors.
- Headache (occasionally).
- Dilated pupils.
- Profuse sweating, often with chills.
- High blood pressure.
- Increased heart rate, with or without an irregular heartbeat and chest pain.
- Elevated temperature.
- Suppressed appetite, weight loss.

Source: Adapted from SAMHSA, 2021, *Treatment for Stimulant Use Disorders, Treatment Improvement Protocol (TIP) Series 33*.

Screening

Recommendation

S-1. Anyone who reports regular stimulant use (including prescription stimulant misuse), stimulant use disorder, or stimulant withdrawal risk should be considered at risk for stimulant withdrawal.

Monitoring for Withdrawal Signs and Symptoms

As discussed in The Withdrawal Management Process, signs and symptoms of stimulant withdrawal (see table S-2) typically emerge within 72 hours of incarceration.

Table S-2: Possible Indicators of Stimulant Withdrawal*[54]

- Agitation
- Anxiety
- Dysphoria/depression
- Intense desire for sleep, often accompanied by insomnia
- Psychotic symptoms
- Strong cravings
- Suicidality/impulsive self-harm

* Staff should be alert to any indicators that the individual is unwell, not only those listed here.

Recommendation

S-2. Custody staff should monitor individuals at risk for stimulant withdrawal at least twice per day for the first 72 hours from intake.

A. If an individual appears unwell to a layperson, they should be referred for immediate clinical assessment.

Clinical Assessment and Diagnosis

Currently, there are no validated clinical assessment tools for stimulant withdrawal. Individuals who appear unwell to a layperson should be evaluated by a qualified health care professional to determine the types and intensities of treatment that may be needed.

Health care staff should also be aware of the potential risk for opioid withdrawal. Stimulant drugs may be contaminated with opioids, including powerful synthetic opioids such as fentanyl. Individuals may not be aware of everything they have taken and, thus, may not report opioid use or opioid withdrawal risk. If opioid use is suspected, the individual should be monitored for signs and symptoms of opioid withdrawal and, when necessary, referred for an immediate clinical assessment.

Recommendations

S-3. The clinical assessment of withdrawal risk should evaluate:

A. Stimulant use in the past 48 hours:

i) Amount used.

ii) Type used (e.g., methamphetamine, amphetamine, cocaine).

iii) Route of administration (intranasal, intravenous, oral, inhalation).

B. Frequency of use (regular daily or binge pattern).

C. Duration of the current period of regular use.

D. Concurrent use of other substances.

E. Psychiatric signs and symptoms.

F. Comorbid psychiatric illness.

S-4. Stimulant withdrawal is not usually associated with medical complications. However, long-term use of stimulants and stimulant intoxication are risk factors for cardiac complications. Health care and custody staff should be alert to chest pain and other cardiac symptoms in patients with suspected stimulant withdrawal.

S-5. Health care staff should also monitor for signs and symptoms of opioid withdrawal because the supply of stimulant drugs is increasingly contaminated or mixed with opioids, and some individuals may not be aware that they have been using opioids.

Monitoring Patients During Withdrawal Management

Recommendation

S-6. Substance withdrawal is a risk factor for severe depression and suicidality. This risk is particularly high in patients undergoing stimulant withdrawal. Custody staff should be alert to signs and symptoms of depression in these patients.

Table S-3: Possible Indicators of Depression[55]

- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment.
- Appetite and/or weight changes.
- Decreased energy or fatigue.
- Difficulty concentrating, remembering, or making decisions.
- Difficulty sleeping, early-morning awakening, or oversleeping.
- Feelings of guilt, worthlessness, or helplessness.
- Feeling restless or having trouble sitting still.
- Feelings of hopelessness or pessimism.
- Irritability.
- Loss of interest or pleasure in activities.
- Moving or talking more slowly.
- Persistent sad, anxious, or "empty" mood.
- Thoughts of death or suicide, or suicide attempts.

Medications

Treatment for stimulant withdrawal typically consists of behavioral management strategies and, when necessary, medications for symptom relief. Patients may present with mental health symptoms such as depression, agitation, suicidality, or stimulant-induced psychosis requiring medical management. For more information on suicide and SUD withdrawal, see Suicide in General Guidance.

Behavioral strategies, including providing an environment with reduced stimulation with dimmed lights, less noise, and minimal exposure to other people, can often reduce or prevent agitation. Care should be taken to encourage calm interactions and avoid situations that may become confrontational during the acute withdrawal phase. This may be challenging in a jail environment but can provide significant benefits, including reduced violence. Of note, the use of physical restraints can pose specific health risks in patients experiencing stimulant withdrawal.

Recommendations

S-7. No medications have been proven effective for the treatment of withdrawal from stimulants. However, it may be appropriate to use medications to relieve symptoms (e.g., agitation, sleep disturbances) during the period of the withdrawal syndrome.

S-8. The use of medications should be limited to short-term treatment of withdrawal symptoms and to treat accurately and appropriately diagnosed comorbid conditions.

S-9. If psychosis (beyond mild paranoia) manifests during stimulant withdrawal, it should be treated.

A. Care should be managed in consultation with a qualified mental health care professional.

B. Antipsychotic medication may be required.

C. If psychosis persists or is severe, an immediate assessment by a physician experienced in differential diagnosis and management of acute changes in mental status is indicated, and general psychosis management and treatment principles should be applied.

S-10. Patients experiencing agitation that does not immediately respond to behavioral management strategies (e.g., minimizing environmental stimulation [e.g., noise, bright lights, crowding]; speaking calmly to the patient; taking time to listen to and address concerns where appropriate and feasible) should receive an immediate medical evaluation.

A. Medications for sedation (typically benzodiazepines) may be necessary.

B. Patients whose agitation is not adequately treated with oral medication should be transferred to a hospital setting.

C. If medications are not available onsite to manage significant agitation, custody staff should transfer the patient to a medical setting where medications can be provided.

S-11. Benzodiazepines should be avoided unless required for concomitant alcohol or sedative detoxification, or severe agitation as discussed in the preceding recommendation.

S-12. While depression is common during stimulant withdrawal, it is often secondary to withdrawal and may not constitute a primary diagnosis. The patient should be monitored to determine if the depression symptoms improve as the withdrawal syndrome improves.

A. If depression symptoms do not improve, it is appropriate to initiate evidence-based depression treatment.

B. If the patient has a history of depressive disorder, it may be appropriate to initiate antidepressant medication sooner.

Level of Care

Withdrawal from stimulants that is not complicated by other conditions can typically be safely managed in jails. However, ongoing or worsening severe depression and other psychiatric complications, as well as acute medical conditions (e.g., cardiac issues), may require transfer to a higher level of care.

Recommendations

S-13. As discussed in General Guidance, patients who present with severe psychiatric symptoms including hallucinations, delusions, paranoia, and delirium, should be immediately transferred to a higher level of care unless a physician experienced in differential diagnosis of acute changes in mental status is immediately available for clinical assessment and stabilization.

A. If feasible, medications may be appropriate to stabilize the patient concurrent with the call for transport.

S-14. Transfer to a higher level of care should occur when:

A. The patient displays significant psychiatric complications, and a mental health assessment cannot be provided immediately.

B. The patient displays significant psychiatric complications (e.g., psychosis, severe depression, suicidal ideation), and the treatment plan as recommended by a qualified mental health care professional cannot be adequately or safely managed in the jail setting.

C. The patient presents with acute medical signs or symptoms that cannot safely be managed in the jail (e.g., chest pain, markedly elevated or rapidly increasing body temperature, uncontrolled hypertension, seizures).

S-15. Stimulant withdrawal can be managed in a jail setting when the following criteria are met:

A. There are no medical, psychiatric, or behavioral complications requiring a level of medical monitoring or management that is not available in the facility.

B. The jail has the capacity to safely manage the treatment plan for the patient's psychiatric complications, as recommended by a qualified mental health care professional.

Supportive Care

Supportive care may include nutritional supplementation, such as extra food or nutritional shakes, for patients experiencing stimulant withdrawal (see G-55).

Recommendations

S-16. Withdrawal from stimulants is best undertaken in a calm environment where the patient can rest. Jails should provide a quiet, non-stimulating environment for patients undergoing stimulant withdrawal, if feasible.

S-17. Often patients undergoing stimulant withdrawal report insomnia and sleep disturbances. Patients should generally be allowed to sleep for as long they can, unless otherwise ordered by a provider.

A. If the patient has ongoing difficulty sleeping, medications may be necessary.

S-18. Due to the high rates of returning to use following treatment of stimulant withdrawal, psychosocial interventions should be offered as stimulant withdrawal symptoms wane.

A. An approach focused on improving patient functioning that combines entry into SUD treatment with support, education, and changes in lifestyle is recommended.

S-19. Any psychological and other supportive therapies initiated during withdrawal should aim to assist the patient to safely complete withdrawal and to engage in stimulant use disorder treatment following withdrawal.

S-20. As stimulants suppress appetite, patients may have nutritional deficits. A qualified health care professional should assess patients for nutritional deficits and order nutritional supplementation as needed.

Pregnancy and Postpartum

As discussed in General Guidance, pregnant patients should be counseled on substance use in pregnancy and offered appropriate treatment.

Recommendation

S-21. Stimulant use is associated with a variety of adverse pregnancy outcomes and neonatal complications. Care for pregnant patients should be managed in consultation with providers experienced with obstetrical care in high-risk patients and SUD treatment.

Appendixes

Appendix A: Development Team

Appendix B: Full Methodology

Appendix C: Preferred Terminology

Appendix D: ASAM's Principles of Drug Testing During Withdrawal Management

Appendix E: Monitoring Patients During Withdrawal Management

Appendix F: Withdrawal Pharmacotherapy

Appendix G: Indicators of Dehydration

Appendix H: Expert Committee Members' Current Industry Relationships

Appendix I: Field Reviewers

Appendix J: Field Reviewers' Current Industry Relationships

Appendix K: Glossary

Appendix L: Acronym Glossary

Appendix M: Resources

Appendix A: Development Team

Expert Committee

Clinical Experts

Jeffrey Alvarez, M.D., CCHP
Chief Medical Officer, NaphCare

Andrew F. Angelino, M.D.
Associate Professor of Psychiatry and Behavioral Sciences, Johns Hopkins University of Medicine

Kevin A. Fiscella, M.D., M.P.H.
Addiction Medicine Physician, Jordan Health

Miriam S. Komaromy, M.D.
Medical Director, Grayken Center for Addiction at Boston Medical Center

Shannon Robinson, M.D.
Principal, Health Management Associates (HMA)

Sandra Springer, M.D.
Associate Professor of Medicine in the Department of Internal Medicine,
Section of Infectious Diseases Yale School of Medicine

Marc F. Stern, M.D., M.P.H.
Affiliate Assistant Professor, School of Public Health, University of Washington
Faculty, School of Public Health University at Albany
Chief Medical Advisor for the National Sheriffs' Association (NSA), American Jail Association (AJA),
and Washington Association of Sheriffs and Police Chiefs

Donna Strugar-Fritsch, B.S.N., M.P.A., CCHP
Correctional Health Care Consultant

Experts in Jail Administration

Oscar Aviles, CPM, CJM, CCE, CCHP
Assistant County Administrator, Hudson County (New Jersey)

Jeff Clark, M.J.A.
Undersheriff, Washoe County Sheriff's Office

Carrie Hill, Esq.
Executive Director, Massachusetts Sheriffs' Association
Chief Jail Advisor, NSA

Geoff Stobart
Chief Deputy of Research, Development, and Major Projects for the Franklin County Sheriff's Office (Columbus, Ohio)

Federal Project Champions

Stephen Amos, M.S.
National Institute of Corrections (NIC) Technical Lead
Chief, Jails Division
NIC, U.S. Department of Justice (DOJ)

Margaret Chapman, M.A.
Bureau of Justice Assistance Project Manager
Policy Advisor
BJA, DOJ

Ruby Qazilbash, M.P.A.
BJA Assistance Technical Lead
Deputy Director
BJA, DOJ

Technical Support Team

Maureen Boyle, B.A., Ph.D.
Executive Scientific Lead
Chief Quality and Science Officer, ASAM

Linda Frazier, B.S., M.A., RN, MCHES
Clinical Liaison
Director, Addictions Initiatives, Advocates for Human Potential, Inc. (AHP)

Brent Gibson, M.D., M.P.H., CCHP-P
Former Chief Health Officer
National Commission on Correctional Health Care (NCCHC)

Wendy Habert, M.B.A., PHR, CCHP
Director of Accreditation, NCCHC

Laura Lutgen-Nieves, Ph.D.
Literature Review Author
Assistant Professor, Department of Criminal Justice, University of Southern Indiana

Jim Martin
Team Project Manager
Vice President of Program Development, NCCHC

Kay S. Peavey
Lead Writer
Deputy Director, Technical Writing, AHP

Pam Rainer, M.S.W.
Corporate Lead
Senior Program Director, AHP

Deann Rogers, M.S.
Project Management Lead
Director, Technical Writing, AHP

Deborah Ross
Project Oversight
Chief Executive Officer (CEO), NCCHC

Taleen Safarian
Project Support
Senior Manager, Science & Dissemination, ASAM

Jaime Shimkus
Communications Support
Former Vice President of Communication, NCCHC

Kim Sterling
Marketing/Communications Support
Vice President of Professional Services, NCCHC

Claire Wolfe
Project Management Associate
Research Associate, NCCHC

Appendix B: Full Methodology

Overview of Approach

These guidelines were developed using a modified RAND/UCLA Appropriateness Method (RAM). The RAM process is a deliberate approach encompassing review of existing clinical guidelines and standards, literature reviews, appropriateness and feasibility ratings, stakeholder comment and reconciliation, and document development. The process typically combines scientific evidence and clinical knowledge to determine the appropriateness of a set of clinical procedures. This process was modified for the development of these guidelines to incorporate the input of jail administration experts and others with legal expertise regarding implementation of guidelines and procedures in jail settings.

RAM is particularly appropriate for the matter at hand for two reasons. First, there are few randomized clinical trials (RCTs) directly addressing the implementation of withdrawal management in criminal justice settings. Second, evidence supporting the efficacy of treatments for different withdrawal syndromes reflects varying years of research and varying levels of evidence (e.g., nonrandomized studies, retrospective studies). The RCT is the gold standard for evidence-based medicine. When data are lacking from RCTs, other methods (i.e., reviewing second-tier research and using a delphi process for consensus development) are used to help health care professionals make the best choices. In addition, individuals in the criminal justice system are often excluded from RCTs, requiring clinical expertise to interpret available studies in the context of a jail setting and population. The modified RAM process used for the development of these guidelines combined the best available scientific evidence with the collective judgment of clinical and jail administration experts to yield statements about the appropriateness and feasibility of specific procedures that can be applied to implementation of withdrawal management in jail settings.

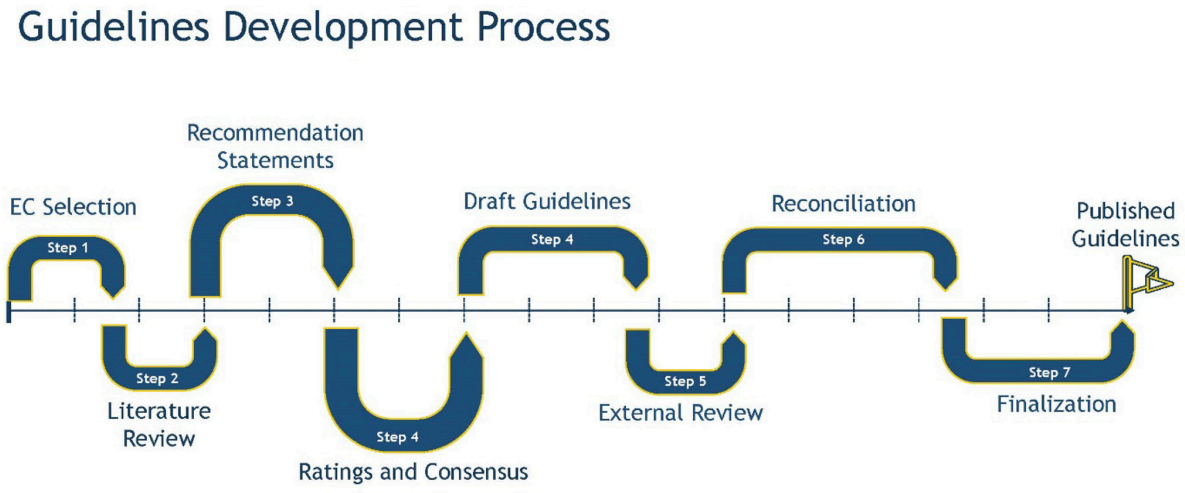

Exhibit B-1

The Bureau of Justice Assistance (BJA), National Institute of Corrections (NIC), Advocates for Human Potential, Inc. (AHP), National Commission on Correctional Health Care (NCCHC), and American Society of Addiction Medicine (ASAM) provided oversight for guideline development, including the selection of expert committee (EC) members. To avoid actual, potential, or perceived conflicts of interest that may arise because of relationships with industry and other entities, EC members were required to disclose all current related relationships (see appendix H). All field reviewers (see appendix I) of these guidelines were also asked to disclose all current related relationships (see appendix J).

Briefly, a structured literature review (see Task 1) was conducted to identify the most up-to-date evidence on the clinical management of substance withdrawal and implementation of withdrawal management in criminal justice settings, including published and unpublished clinical guidelines. This evidence was used by the EC to inform the development of draft recommendation statements.

The clinical experts on the EC then rated the appropriateness of the draft recommendation statements on a 9-point scale, while the jail administration experts rated the feasibility of the draft recommendation statements on a 9-point scale. The ratings were analyzed for consensus or discordance. Statements for which there was a divergence of appropriateness ratings were discussed by the EC. In addition, items flagged for feasibility challenges were discussed by the EC to determine if there were ways to amend the statements to provide additional flexibility to support implementation without undermining patient safety. After each meeting, the information gathered was used to revise several of the statements, and the EC was asked to re-rate these.

All the identified draft statements and supporting research were incorporated into an outline defining each specific section to be included in the document, as well as narrative setting the stage for the statements. A draft document included three rounds of review and comment: the first round to internal reviewers, a revised version sent to EC members, and the third round involving solicitation of field reviewer feedback. All external feedback collected was catalogued, reviewed, tracked, and addressed, discussing any issues raised during this feedback reconciliation process with the EC through several meetings. Recommendation statements and narrative content were then revised based on the committee's feedback, securing EC approval on all revised and new recommendation statements through rounds of appropriateness and feasibility ratings and discussion, as well as internal reviewer feedback (BJA/NIC/AHP/ASAM/NCCHC/EC), to produce the final draft.

Task 1: Literature Review

Scientific Literature Review

To review the most up-to-date evidence on the clinical management of substance withdrawal, a structured literature review was conducted. The literature review included clinical studies with randomized and nonrandom assignment and excluded case studies. Articles were identified through searches conducted in PubMed using predefined search terms and selection criteria. Additional articles were identified through forward and reverse citation search of key articles.

To develop recommendations for management of opioid and alcohol withdrawal in jails, The *ASAM National Practice Guideline for the Treatment of Opioid Use Disorder* and *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*, both released in 2020 with literature reviews completed in late 2018, were used as foundational clinical standards. The literature review for opioid and alcohol withdrawal, therefore, focused on studies addressing criminal justice-specific implementations published in the 10-year period from 2011 to 2021.

To develop recommendations for the management of sedative and stimulant withdrawal, SAMHSA's *Detoxification and Substance Abuse Treatment, Treatment Improvement Protocol (TIP) 45* was used as the foundational clinical standard. A search for literature on management of withdrawal from these substances was conducted for the past 10 years (from

2011 to January 2021), to account for research published during development of this guidance, last published in 2015. Targeted searches were also conducted for studies examining the implementation of withdrawal management in criminal justice settings.

Searches included all fields (e.g., titles, abstracts, keywords). Titles and abstracts were reviewed for inclusion by a senior member of the research team. Articles were restricted to English language and human participants. If an article reflected a secondary analysis of data from a relevant study, the original report was included in the literature review.

The literature search yielded 2,833 articles. The titles and abstracts were reviewed to determine if the study met the inclusion/exclusion criteria, and those that did not, or could not be obtained, were removed (n = 2,403). The remaining 430 articles were then reviewed for inclusion, and 172 articles were ultimately retained for use in the literature review, as the others did not meet the predetermined inclusion/exclusion criteria. Key data were extracted from these articles and presented to the EC.

Gray Literature Review

A targeted internet search of gray literature (literature not available through traditional commercial or academic publications) was also conducted, including published and unpublished clinical guidelines and prominent systematic reviews related to withdrawal management or suicide prevention. The following websites were searched using the onsite search engines:

- Substance Abuse and Mental Health Services Administration
- U.S. Department of Veterans Affairs
- The Indian Health Service
- The World Health Organization
- The Agency for Healthcare Research and Quality
- The National Academies of Sciences, Engineering, and Medicine
- Guideline Central
- Cochrane Reviews

A general internet search was also conducted to identify international clinical guidelines related to withdrawal management or suicide prevention. The gray literature search was not time limited, but where recommending bodies had published updates of guidelines, only the most recent was included. Search terms for the gray literature search were withdrawal-related terms including, but not limited to, "detoxification" and "withdrawal." In total, 83 guidelines were identified.

The aim of this exercise was not to re-review all the research literature, but to identify within the existing clinical guidelines common questions or considerations health care professionals are likely to have with regard to the management of withdrawal and prevention of suicide, with a specific focus on practical management within jail settings.

The six guidelines listed below represented high quality clinical guidance addressing the broad clinical issues related to management of withdrawal from alcohol, opioids, sedative/hypnotics, and stimulants, and addressing management of withdrawal in closed settings flagged for EC members.

- *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update* (2020)
- *Detoxification and Substance Abuse Treatment: Treatment Improvement Protocol (TIP) 45* (2015), from SAMHSA
- *Medically Supervised Withdrawal for Inmates with Substance Use Disorders* (2020), from the Federal Bureau of Prisons
- *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management* (2020)
- *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings* (2009), from the World Health Organization
- *Models of Intervention and Care for Psychostimulant Users* (2004), from the Australian Government Department of Health and Ageing

These clinical documents were each developed using standard methodologies incorporating structured literature reviews and formal expert consensus development processes. They were used as the foundation for the development of draft recommendation statements (discussed below).

The EC was provided with the literature review summary, tables of key abstracted information from the scientific literature, and the guidelines identified in the gray literature search. This information was used by the EC to inform their discussion and judgments in Task 2.

Task 2: Identification of Draft Statements and Appropriateness/ Feasibility Rating

The next step in the RAM was to develop a set of draft recommendation statements, which were derived from the guideline analysis and informed by the literature review and EC's collective expertise. Each member of the EC reviewed the guidelines and literature review. The EC worked with the technical support team to draft recommendation statements. The EC then independently rated the 744 draft recommendation statements on a 9-point scale. The clinical experts on the committee rated the statements for appropriateness, and the jail administration experts rated the statements for feasibility within a jail setting.

A statement was considered appropriate if the expected health benefit (e.g., increased life expectancy, relief of pain, reduction in anxiety, improved functional capacity) exceeded the expected negative consequences (e.g., mortality, morbidity, anxiety, pain) by such a sufficiently wide margin that the recommendation is worth following, exclusive of cost. These appropriateness ratings were meant to identify consensus, or a lack thereof, in existing guidance and research literature. A statement was considered feasible if there was reasonable likelihood that it could be implemented in the context of an average patient presenting to an average jail. Administrators were instructed to consider the literature review as well as their own best judgment, considering relevant factors (e.g., economic, technical, legal, workforce).

Guideline Committee Meetings

Upon completion of the individual committee member ratings, the rating results were analyzed for consensus or discordance. Statements for which there was a divergence of rating scores were discussed by the EC. Items flagged for feasibility challenges were also discussed by the entire committee to determine if there were ways to amend the statements to provide additional flexibility supporting implementation without undermining patient safety. After each meeting, the information and decisions gathered were used to revise many of the statements, and the committee was asked to re-rate the revised statements.

Creation and Revision of Outline

All identified appropriate hypothetical statements and supporting research were incorporated into an outline defining each specific section to be included in these guidelines. The draft outline was sent to all committee members for review and comment prior to finalization.

Creation and Revision of Draft

The outline served as a framework for the narrative that supports the statements to create the first draft. As described above, through many discussions with the EC, rounds of ratings, multiple internal reviews, a field review, and draft revisions, a final version of these guidelines was created.

Appendix C: Preferred Terminology

Use of person-first language and preferred terminology, which is reflected throughout these guidelines, reduces stigma, negative bias, and the perpetuation of stereotypes when speaking about or to individuals experiencing withdrawal or with substance use disorder (SUD).

Use ...	Instead of ...	Because ...
• Individuals who are detained in jail • Individuals who enter jail • Person who has criminal justice system involvement • Person who was formerly incarcerated	• Inmate • Criminal • Offender • Justice-involved person • Felon	• Recognizes that people are not their crimes or criminal history. • Advances language that is accurate and not prejudicial.
• Substance use disorder • Substance use	• Substance abuse • Drug habit	• Avoids negative connotations and the undermining of SUD as a serious health condition.
• Person with a substance (opioid, alcohol, stimulant) use disorder • Individuals who exhibit signs of withdrawal or withdrawal symptoms • Individuals who report using substances (alcohol, opioids, stimulants) • Pregnant person with an opioid use disorder	• Addict • Drug or substance user • User • Dope addict • Alcoholic • Drug addict • Pregnant opiate addict	• Reflects an accurate, science-based understanding that the person has a medical condition. • Recognizes that the person has a disorder, rather than "is the disorder." • Avoids negative associations, punitive attitudes, individual blame, judgment, and misinformation about SUD. • Reinforces use of the same terminology as with other medical conditions. • Encompasses the recovery process of improved health versus the implication that the person was "dirty" before recovery.
• Individuals who screen negative/positive (e.g., withdrawal, suicide risk) • Positive/negative screen result	• Dirty/clean screen • Dirty results • Failing drug screen/test	
• Person in recovery • Person in long-term recovery • Person who has maintained recovery	• Former addict • Former drug user • Former alcoholic • Person who "stayed clean"	
• Return to use • Experienced a recurrence • Resumed drinking or using drugs	• Relapsed • Slipped • Chronic relapser	• Advances language that is medically accurate and non- stigmatizing.

Compiled from the Bureau of Justice Assistance, the National Institute on Drug Abuse, the Justice Community Opioid Innovation Network, and the National Council for Mental Wellbeing.[56]

Appendix D: ASAM's Principles of Drug Testing During Withdrawal Management

1. Drug tests can be used to help inform clinical decisionmaking for patients with substance use disorder (SUD) or at risk for substance withdrawal.

2. Drug tests can neither diagnose SUD nor rule out SUD.

3. Drug test results should be used in combination with the patient history, physical exam, and psychosocial assessment to determine care plan.

4. Drug testing can be an important supplement to patient self-report because patients may not be aware of the composition of the substances they have used.

5. Test selection should be individualized based on specific patients and clinical scenarios. Before choosing the type of test and matrix, the provider should determine the questions they are seeking to answer and consider the benefits and limitations of each test and matrix (e.g., urine, blood, saliva, hair, etc.). The methods used will impact the interpretation of the results:

    a. Each matrix has advantages and disadvantages (e.g., ease of collection, window of detection, susceptibility to tampering, etc.).

    b. Tests are designed to measure whether specific substances have been used within particular windows of time.

    c. Drug testing panel selection should be based on the patient's self-reported use, prescribed medications, and drugs commonly used in the geographic area and in the patient's peer group.

        i. Note that many drug test panels do not detect fentanyl, fentanyl analogs, methadone, buprenorphine, norbuprenorphine, and many other commonly used and/or misused substances.

    d. It is important to understand the difference between presumptive drug tests (routinely used for point-of-care testing) and definitive tests (used to confirm results of presumptive tests and rule out false positives).

        i. Definitive tests are laboratory tests that are conducted in Clinical Laboratory Improvement Amendments-certified laboratories.

6. Definitive testing should be used when the results inform clinical decisions with major clinical or non-clinical implications for the patient (e.g., changes in medications, changes in legal status).

7. Drug test results should be interpreted by a provider whose scope of practice includes ordering and interpreting drug test results, who will consider the limitations of the specific test used.

8. Discrepancies between the patient self-report and the drug tests should be discussed with the patient.

9. Providers should keep test results ordered by health care staff confidential to the extent permitted by law.

10. Providers should be aware of the adverse legal and social consequences of detecting substance use in pregnant patients. The patient should be made aware of local/state reporting requirements and provide consent before tests are conducted.

For more information, go to ASAM's *Appropriate Use of Drug Testing in Clinical Addiction Medicine*.

Appendix E: Monitoring Patients During Withdrawal Management

WARNING: Supply patterns across the country show that drugs used in the community are often mixed with illicitly manufactured fentanyl and other drugs, such as xylazine. The most frequent monitoring noted is the minimum expectation, but providers may need to increase monitoring, based on their best clinical judgment and knowledge of local drug-use trends.

Substance	Minimum Frequency and Use of Withdrawal Symptom Assessment Scale*
Alcohol	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	• Daily clinical assessment by a qualified health care professional for at least the first week or as condition indicates. • After the first week, re-assessment by a qualified health care professional at least two times per week until withdrawal management is complete.
Opioids	• Monitoring using the Clinical Opiate Withdrawal Score (COWS) at least every 4 hours for patients who report use of a short-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	• 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).

*As noted in G-25, clinical assessments should be conducted by qualified health care professionals not less than twice per day, not more than 16 hours apart (unless otherwise stated in the substance-specific guidance in this document and summarized in table 1 above).

Appendix F: Withdrawal Pharmacotherapy

No medications have been approved by the FDA to treat stimulant withdrawal; therefore, that section describes behavioral management strategies as first-line treatment. Stocking medications for symptom relief is also recommended.

Table 2: Withdrawal Pharmacotherapy

Substance	Recommended Pharmacotherapy	For More Information
Alcohol	Benzodiazepines, long-acting preferred (i.e., diazepam or chlordiazepoxide), except for older adults or individuals with impaired liver function	*The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management*
Opioid	Methadone or buprenorphine	*The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*
Sedatives	Long-acting benzodiazepine (e.g., clonazepam)	*Detoxification and Substance Abuse Treatment*, Treatment Improvement Protocol (TIP) Series, No. 45

Appendix G: Indicators of Dehydration

Table 3: Indicators of Dehydration[57]

Mild Dehydration	Life-threatening Dehydration
• Feeling very thirsty • Dry mouth • Urinating and sweating less than usual • Dark-colored urine • Dry skin • Feeling tired • Dizziness	• Confusion • Fainting • Lack of urination • Rapid heartbeat • Rapid breathing • Shock

Appendix H: Expert Committee Members' Current Industry Relationships

Expert Committee Member	Salary	Consultant	Expert Witness	Ownership, Partnership, or Principal	Institution, Organization, or Other Financial Benefit
Jeffrey Alvarez, M.D., CCHP-P, CCHP-A	NaphCare, Inc.	None	None	None	None
Andrew F. Angelino, M.D.	Johns Hopkins School of Medicine	None	Administrative Law Hearings - Involuntary Commitment	None	None
Oscar Aviles, CPM, CJM, CCE, CCHP	Hudson County Administrator's Office	None	Correctional Employment Litigation	None	None
Jeff Clark	Washoe County Sheriff's Office	None	None	None	None
Kevin Fiscella, M.D., M.P.H., CCHP	University of Rochester	None	None	None	NCCHC Board Member
Carrie Hill, Esq.	Massachusetts Sheriff's Association	National Correctional Law, Training, Policy Consulting NSI II training for NIC/ JJSC	Deliberate indifference regarding medical care Use of force	None	Justice Community Opioid Innovation Network Practitioner's Board Member NSA, Chief Jail Advisor
Miriam Komaromy, M.D.	Boston Medical Center, Boston University	None	None	None	ASAM Board of Directors Member
Shannon Robinson, M.D., CAP	HMA	None	None	None	Harm Reduction Solutions (domestic partner)
Sandra Springer, M.D.	Yale School of Medicine	Alkermes, Inc.	None	None	NIH-funded research and U.S. Department of Veterans Affairs (VA)-sponsored research; Indivior (in-kind donation)
Marc Stern, M.D., M.P.H.	Consultant	Consultant	Correctional Health Care	None	None
Donna Strugar-Fritsch, B.S.N., M.P.A., CCHP	Consultant	Consultant	None	None	Former employee of HMA
Geoff Stobart	Franklin County Sheriff's Office	None	None	None	None

Appendix I: Field Reviewers

American Academy of Addiction Psychiatry (AAAP)
Elie G. Aoun, M.D., MRO, FAPA
General, Addictions and Forensic Psychiatrist
Assistant Professor of Clinical Psychiatry, Columbia University, Division of Law, Ethics, and Psychiatry
Co-chair, AAAP Committee on Law and Addiction

Laurence M. Westreich, M.D.
Addiction and Forensic Psychiatry
Co-chair, AAAP Committee on Law and Addiction
Associate Professor of Clinical Psychiatry
Department of Psychiatry, New York University School of Medicine

American College of Academic Addiction Medicine (ACAAM)
Marsha J. Wunsch, M.D., FAAP DFASAM
Past President, ACAAM, Addiction Medicine Consultant
Alameda County Santa Rita Jail

American College of Medical Toxicology (ACMT)
Joseph Carpenter, M.D.
ACMT Addiction Medicine Committee, Communication Subcommittee Chair
Assistant Professor of Emergency Medicine, Emory University School of Medicine

Leslie R. Dye, M.D., FACMT, FASAM, FACCT
ACMT Addiction Toxicology Committee Chair and Past-President
Addiction Medicine Section Editor and former Editor-in-Chief, *Journal of Medical Toxicology*

Ashley Haynes, M.D.
ACMT Addiction Medicine Committee, Practice Subcommittee Chair
Program Physician, Wichita Comprehensive Treatment Center

American College of Obstetricians and Gynecologists (ACOG)
Carolyn Sufrin, M.D., Ph.D.
Associate Professor of Gynecology and Obstetrics, Johns Hopkins School of Medicine

Tricia Wright, M.D., M.S., FACOG DFASAM
Professor of Clinical Medicine, University of California San Francisco

Christopher M. Zahn, M.D.
Chief, Clinical Practice and Health Equity and Quality, ACOG

American Correctional Association (ACA)
Jeffrey Washington
Deputy Executive Director, ACA

American Jail Association (AJA)
Diana L. Knapp
Director, Jackson County Sheriff's Office

Henry Reyes, M.A.M., M.P.A., CJM, CCE, NCCE
Chief Deputy, Detention Bureau/Housing, Tarrant County Sheriff's Office

Darren Sieger, M.S., CJM
Director—Administration, Broward Sheriff's Office, Department of Detention

Marsha Travis, CJM, CCM, CBHC
Director of Standards and Accountability, Nashville-Davidson County Sheriff's Office

American Osteopathic Academy of Addiction Medicine (AOAAM)
Jon Lepley, D.O., FASAM, FAOAAM, CCHP
Medical Director, Addiction Medicine, Penn Medicine Lancaster General Health

American Psychiatric Association (APA)
Smita Das, M.D., Ph.D., M.P.H.
Clinical Associate Professor, Stanford University School of Medicine

Dionne Hart, M.D., DFAPA, FASAM
Medical Director, Care From The Hart
AMA Representative to NCCHC

American Society of Addiction Medicine (ASAM)
Margaret A. E. Jarvis, M.D., DFASAM
Chief, Addiction Services, Geisinger Health System

Hendree Jones, Ph.D.
Executive Director, University of North Carolina at Chapel Hill Horizons

Kelly S. Ramsey, M.D., M.P.H., M.A., FACP, DFASAM
Associate Chief of Addiction Medicine, New York State Office of Addiction Services and Supports

Mishka Terplan, M.D., M.P.H., FACOG, DFASAM
Medical Director/Senior Research Scientist, Friends Research Institute

R. Corey Waller, M.D., M.S., FACEP, DFASAM
Chief Medical Officer, Brightview Health

Aleksandra Zgierska, M.D., Ph.D., DFASAM
Professor and Vice-chair of Research, Penn State College of Medicine

Community Oriented Correctional Health Services (COCHS)
Michael DuBose
Chief Operating Officer

Daniel Mistak
Director of Health Care Initiatives for Justice-involved Populations

Major County Sheriffs of America (MCSA)
Laura Bedard, Ph.D.
Chief of Corrections, Seminole County Sheriff's Office

Kyle Prichard
Mental Health Specialist, Seminole County Sheriff's Office

Vincent Wasilewski
Chief Custody Deputy, Santa Barbara Sheriff's Office

National Association of Addiction Treatment Providers (NAATP)
Mark Dunn
Director of Public Policy

National Association of Counties (NACo)
Brett Mattson
Legislative Director, Justice & Public Safety, Gulf States Counties & Parishes Caucus

Nastassia Walsch
Director of Programs and Operations

National Council for Mental Wellbeing (National Council)
Aaron Williams, M.A.
Senior Advisor, Practice Improvement & Consulting

National Sheriffs' Association (NSA)
Christopher L. Barnes, J.D.
Legal Advisor, Collin County Sheriff's Office

Small & Rural Law Enforcement Executives Association (SRLEEA)
Chief John W. Thompson, Ret.
Executive Vice President

Appendix J: Field Reviewers' Current Industry Relationships

External Reviewer	Representing	Salary	Consultant	Expert Witness	Ownership, Partnership, or Principal	Institution, Organization, or Other Financial Benefit
Elie G. Aoun, M.D., MRO, FAPA	AAAP	Columbia University	None	opioids, correctional mental health treatment, divorce, custody, criminal matters	None	None
Laura Bedard, Ph.D.	MCSA	Seminole County Sheriff's Office	Consulted on Tennessee case	Spouse	None	None
Joseph Carpenter, M.D	ACMT	Emory University School of Medicine	None	None	None	None
Smita Das, M.D., Ph.D., M.P.H.	APA*	Lyra Health	None	None	None	None
Michael DuBose	COCHS	COCHS	None	None	None	None
Dionne Hart, M.D., DFAPA, FASAM	APA	DOJ, Bureau of Prisons	None	Civil commitment hearing, testimony regarding patient's current mental health status	None	AMA rep. to NCCHC
Ashley Haynes, M.D.	ACMT	Wichita Comprehensive Treatment Center	None	None	None	None
Margaret A. E. Jarvis, M.D., DFASAM	ASAM	Geisinger Health System	None	Legal cases & American Board for Preventive Medicine	None	ABPM
Hendree Jones Ph.D.	ASAM	UNC Horizons	None	None	None	None
Diana L. Knapp	AJA	Jackson County Sheriff's Office	None	None	None	None
Jon Lepley, D.O., FASAM, FAOAAM, CCHP	AOAAM	Penn Medicine Lancaster General Health	None	None	None	None
Daniel Mistak	COCHS	COCHS	None	None	None	None
Kelly S. Ramsey, M.D., M.P.H., M.A., FACP, DFASAM	ASAM	NYS OASAS	None	None	None	None
Henry Reyes, M.A.M., M.P.A., CJM, CCE, NCCE	AJA	Detention Bureau Tarrant County Sheriff's Office	None	None	None	None

External Reviewer	Representing	Salary	Consultant	Expert Witness	Ownership, Partnership, or Principal	Institution, Organization, or Other Financial Benefit
Darren Sieger, M.S., CJM	AJA	Broward Sheriff's Office, Department of Detention	None	None	None	None
Carolyn Sufrin, M.D., Ph.D.	ACOG	Johns Hopkins School of Medicine	None	None	None	NCCHC Board of Directors
Mishka Terplan M.D., M.P.H., FACOG, DFASAM	ASAM	Friends Research Institute	None	None	None	Foundation for Opioid Response Efforts Scientific Advisory Committee, AAPM's SUD Shared Interest Group Co-Chair
Marsha Travis, CJM, CCM, CBHC	AJA	Nashville-Davidson County Sheriff's Office	None	None	None	None
Chief Custody Deputy Vincent Wasilewski	MCSA	Santa Barbara Sheriff's Office	None	None	None	None
Laurence M. Westreich, M.D.	AAAP	New York University School of Medicine	Baseball Commissioner (consultant)	None	None	Major League Baseball
R. Corey Waller, M.D., M.S., FACEP DFASAM	ASAM	Brightview Health	None	None	None	None
Aaron Williams	National Council	National Council for Mental Wellbeing	None	None	None	None
Tricia Wright, M.D., M.S., FACOG DFASAM	ACOG	University of California San Francisco	McKesson	McKesson Opioid lawsuit	None	None
Martha J. Wunsch, M.D., FAAP DFASAM	ACAAM	Alameda County Santa Rita Jail	None	None	None	None
Christopher M. Zahn, M.D.	ACOG	ACOG	None	None	None	None
Aleksandra Zgierska, M.D., Ph.D., DFASAM	ASAM	Penn State College of Medicine				Federal & local research grants awarded institution for the projects led by me, Member of the Data and Safety Monitoring Board (DSMB) for three NIDA-funded studies

Conflicts of interest were not collected from federal field reviewers.

Appendix K: Glossary

Definitions in this glossary were largely derived and adapted from evidence-based guidance documents and other reputable, field-accepted sources, as well as input from clinical and criminal justice experts.

Alcohol use disorder: A substance use disorder involving alcohol.[58]

Alcohol withdrawal delirium (formerly known as delirium tremens): A severe manifestation of alcohol withdrawal involving sudden and severe mental or nervous system changes. Clinical features include hallucinations, acute disorientation and confusion, autonomic instability, agitation, and paranoia.[59, 60]

Alpha-2 adrenergic agonists: A class of drugs (FDA-approved lofexidine and off-label clonidine) that activate alpha-2 adrenoceptors. These medications are often used to treat anxiety and hypertension and may also be used to help manage withdrawal symptoms when clinically appropriate.[61, 62]

Anxiolytics: A class of medications that help reduce the symptoms of anxiety.[63]

Appears unwell: Observed signs, symptoms, or indications by a layperson that (1) an individual may be sick (physically or psychologically); or, (2) in the case of a patient who has already been assessed by a qualified health care professional, the patient's condition is worsening, becoming unstable, or becoming a danger to self or others. This term is applied throughout to encourage a layperson to err on the side of caution when determining whether to refer an individual to a qualified health care professional.

Asymptomatic: Showing no symptoms.[64]

Ataxia: Lack of muscle control or coordination.[65]

Autonomic instability: Fluctuation of heart rate, blood pressure, sweating, and other nonvoluntary body functions.[66]

Barbiturates: A class of sedative and sleep-inducing drugs derived from barbituric acid,[67] primarily used to treat seizure disorder, anxiety, and insomnia. They are known on the street by various names (e.g., phennies, reds and blues, tooies, yellow jackets).[68]

Benzodiazepines: Sedative drugs commonly prescribed for anxiety or to help with insomnia.[69] Long-acting benzodiazepines are the most commonly used and preferred pharmacotherapy agents for treating alcohol and sedative withdrawal. Commonly prescribed benzodiazepines include alprazolam (Xanax®), lorazepam (Ativan®), clonazepam (Klonopin®), diazepam (Valium®), and temazepam (Restoril®).[70] Benzodiazepines are commonly referred to as Xanbars, downers, never pills, tranks, and benzos.

Clinical assessment: An evaluation conducted through a clinical encounter by a qualified health care professional who is either licensed or certified and may include psychological, laboratory, or other testing and compilation of collateral information from others who are in close proximity to the individual.[71]

Comorbidity: Concurrent substance use and physical or mental disorders.[72]

Complicated withdrawal: Severe withdrawal symptoms involving seizures, hallucinations, delirium, or psychosis, which require more frequent monitoring and may require hospital-level care.

Cravings: Desire to use substances or engage in addictive behaviors, experienced as a physical or emotional need for reward and/or relief.[73]

Custodial facility: Refers to confines such as jail, detention, holding, or lockup facilities.

Custody staff: Line security, as well as correctional administration.[74]

Delirium: A mental state in which a patient is confused, disoriented, and not able to think or remember clearly. It usually starts suddenly and is often temporary and treatable.[75]

Differential diagnosis: Consideration of possible disorders that could be causing symptoms. It often involves several tests to rule out conditions and/or determine if a patient needs more testing. It is used to help differentiate physical or mental health disorders that cause similar symptoms.[76]

Emergent: Arising suddenly and unexpectedly, calling for quick judgment and prompt action.[77]

Fetal alcohol spectrum disorder: An umbrella term referring to a range of effects caused by prenatal exposure to alcohol.[78]

Fixed dosing: An approach where a predetermined dose (which can be determined based on withdrawal severity) is administered at fixed intervals according to a schedule. Doses usually decrease in a gradual taper over several days. Additional medication may be provided if the fixed-dose does not adequately control symptoms.[79]

Front loading: An approach where moderate to high doses of a long-acting medication are given frequently at the start of treatment to achieve rapid control of withdrawal signs and symptoms. Front loading can be followed by a symptom-triggered or fixed-dose regimen.[80]

Gamma-hydroxybutyric acid (GHB): Sodium oxybate, which is prescribed for daytime sleepiness and muscle weakness associated with sleep disorders. Also produced illegally for illicit use, it is commonly known as "liquid ecstasy" and the "date rape drug," the latter for its enhanced effect and undetectable presence when mixed with alcohol.[81, 82]

Injection: Administering a liquid medication or substance within the body through a needle and syringe (intravenous, subcutaneous, intramuscular).

Intoxication: A clinical state marked by dysfunctional changes in physiological functioning, psychological functioning, mood state, cognitive process, or all of these, as a consequence of consumption of a psychoactive substance.[83]

Korsakoff syndrome: Chronic changes in mental status and memory that often follow an episode of Wernicke encephalopathy; occurs primarily in cases of severe, chronic alcoholism and is caused by thiamine (vitamin B1) deficiency and damage to the mammillary bodies (small, spherical nuclei at the base of the brain).[84, 85]

Layperson: A person with no certification, licensure, specific health care training, or professional or specialized knowledge in health care.

Level of care: Distinct clinical and environmental support services of various intensities available in a variety of settings.[86]

Licensed prescriber: A nurse practitioner, physician assistant, physician, or other health care provider licensed to prescribe medications. Note that state laws may vary with regard to prescribing authorities.

Methadone treatment provider: Authorized provider of methadone (e.g., opioid treatment programs are certified by SAMHSA to treat patients with opioid use disorder using methadone).

Micro-dosing: Administration of buprenorphine–naloxone in a small initial dose with incremental increases to both dose and frequency over time.[87]

Misuse: Misuse of prescription drugs means taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to "get high").[88]

Monitoring: Regular and active surveillance to detect changes in physical or mental status that may indicate health problems, which facilitates appropriate interventions and ensures patient safety.[89, 90]

Narcotic treatment program: The Controlled Substances Act and U.S. Drug Enforcement Administration (DEA) regulations refer to opioid treatment programs as narcotic treatment programs, which are registered with the DEA.[91]

Older adult: Individuals who are 55 years and older.[92]

Opioid: Any psychoactive chemical resembling morphine in pharmacological effects, including opiates and synthetic/semisynthetic agents.[93]

Opioid agonist: A medication that occupies and activates opioid receptors in the body.[94]

Opioid antagonist: A medication that occupies opioid receptors in the body but does not activate the receptors. This effectively blocks the receptor, preventing the brain from responding to other opioids. The result is that further use of opioids does not produce analgesia, euphoria, or intoxication.[95]

Opioid use disorder: A substance use disorder involving opioids.[96]

Opioid withdrawal syndrome: The wide range of symptoms occurring when individuals who regularly take opioids, either illicit or prescribed, stop or reduce their use.[97]

Patient: As used in this document, a person whose substance withdrawal or SUD is being treated.[98]

Patient navigator: A person whose role is to help individuals who are transitioning to new circumstances understand system processes and how to effectively navigate systems to obtain services needed and access resources; for purposes of this document, this transition is from jail to the community. Often, patient navigators have lived experience with a substance use disorder and/or involvement with the criminal justice system.[99]

Pharmacokinetics: The study of how pharmacological agents are processed within a biological system, including factors that influence the absorption, distribution, metabolism, and elimination of a substance or its metabolic products.[100]

Pharmacotherapy: Therapy (medical treatment) using pharmaceutical drugs.[101]

Physician: A designated doctor of medicine or osteopathy who has the final authority at a given facility regarding clinical issues.

Physiological dependence: Adaptation of a body to a substance, requiring more of it to achieve a certain effect (tolerance) and eliciting substance-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal).[102]

Precipitated withdrawal: A condition that occurs when an opioid agonist is displaced from the opioid receptors by an antagonist or partial agonist in an individual who is dependent on opioids. Precipitated withdrawal results in rapidly escalating and severe opioid withdrawal symptoms that require immediate treatment.[103]

Prescriber: A nurse practitioner, physician assistant, or physician licensed to prescribe medications and with the authority to prescribe the medication under discussion. Note that state laws may vary with regard to prescribing authorities.

Provider: A physician, nurse practitioner, or physician assistant.

Psychiatric complications: Acute mental health signs and symptoms, such as psychosis, severe depression, and suicidal ideation, that complicate withdrawal management.

Psychosis: An abnormal mental state involving significant problems with reality testing; characterized by serious impairments or disruptions in the most fundamental higher brain functions—perception, cognition and cognitive processing, and emotions or affect—as manifested in behavioral phenomena, such as delusions, hallucinations, and significantly disorganized speech.[104]

Qualified health care professional: A physician, physician assistant, nurse, nurse practitioner, or another who by virtue of their education, credentials, experience, and licensure can competently and legally execute the clinical activity at hand.

Qualified health care staff: All full-time, part-time, and per diem qualified health care professionals, as well as administrative and support staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, clerical workers), who are appropriately trained and, where required, credentialed, for the task at hand.

Qualified mental health care professional: A psychiatrist, psychologist, psychiatric social worker, psychiatric nurse, or another who by their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients for the task at hand.[105]

Responsible provider: An individual qualified and authorized to practice medicine (i.e., physician, nurse practitioner, or physician assistant) who has the final authority at a given facility regarding clinical issues.

Screening: A brief, routine process designed to identify indicators, or "red flags," for the presence of mental health, substance use, or other issues that reflect an individual's need for treatment.[106]

Sedative-hypnotics (sedatives): Drugs that depress the central nervous system, including benzodiazepines, barbiturates, GHB, and Z-drugs.[107]

Standard drink: In the United States, roughly 14 grams of pure alcohol, which is found in 12 ounces of regular beer, 5 ounces of wine, or 1.5 ounces of distilled spirits.[108]

Standards of care: Treatment that is accepted by medical experts as a proper treatment for a certain medical condition and is widely used by health care professionals.[109]

Stimulant: Substances that speed up the body's systems, including prescription drugs (amphetamines, methylphenidate, diet aids) and other illicitly used drugs, such as methamphetamine, cocaine, methcathinone, and other synthetic cathinones commonly sold under the guise of "bath salts."[110]

Stimulant use disorder: A substance use disorder involving stimulants.[111]

Substance use disorder: A cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)* provides diagnostic criteria.[112]

Suicidal ideation: A range of contemplations of, wishes for, and preoccupations with death and suicide.[113]

Supportive care: Treatment to prevent, control, or relieve complications and side effects and to improve the patient's comfort, quality of life, and safety.[114] It may include hydration, nutritional supplementation, management of electrolyte abnormalities, and periodic clinical reevaluations, as clinically indicated.

Symptom-triggered dosing: An approach where patients receive medication only when symptoms cross a threshold of severity.[115]

Taper: Gradual reduction of medications over time under the supervision of a qualified health care professional to properly manage and substantively mitigate symptoms of withdrawal. Drugs that produce physiological dependence (e.g., opiates, benzodiazepines) must be tapered to prevent a withdrawal syndrome.[116, 117]

Telehealth: Use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care.[118]

Titration: Monitoring response to dosage and adjusting accordingly to safely maximize the benefit of a medication.[119]

Transmucosal: Relating to, being, or supplying a medication that enters through or across a mucous membrane (as of the mouth).[120]

Tremor: An uncontrollable and rhythmic shaking movement in one or more parts of the body due to muscle contractions.[121]

Validated: Having demonstrated empirical evidence for reliability and validity.[122]

Well-trained: Having completed training designed and delivered by appropriate clinical professionals for the task at hand and including the training recommendations described in Staffing and Staff Training.

Wernicke encephalopathy: A neurological disorder caused by a deficiency of vitamin B1 (thiamine). The principal symptoms are confusion, oculomotor abnormalities (gaze palsy and nystagmus), and ataxia. The disorder is most frequently associated with chronic alcoholism but is also found in cases of pernicious anemia, gastric cancer, and malnutrition.[123] (See Korsakoff syndrome)

Withdrawal management: Services to assist a patient's withdrawal from substances. (Sometimes less accurately referred to as "detoxification." The distinction is that the liver detoxifies; qualified health care professionals manage withdrawal.)[124]

Withdrawal syndrome: The onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a psychoactive substance.[125]

Z-drugs: Nonbenzodiazepine sedative-hypnotics (e.g., zaleplon (Sonata®), zolpidem (Ambien®), and zopiclone (Imovane®) often prescribed to treat insomnia.[126] Withdrawal symptoms are noted upon abrupt discontinuation of Z-drug use, especially among patients with SUD.[127]

Appendix L: Acronym Glossary

AAAP	American Academy of Addiction Psychiatry
ACA	American Correctional Association
ACAAM	American College of Academic Addiction Medicine
ACMT	American College of Medical Toxicology
ACOG	American College of Obstetricians and Gynecologists
AHP	Advocates for Human Potential, Inc.
AJA	American Jail Association
AOAAM	American Osteopathic Academy of Addiction Medicine
ASAM	American Society of Addiction Medicine
AUD	Alcohol use disorder
BAC	Blood alcohol concentration
BJA	Bureau of Justice Assistance
BrAC	Breath alcohol concentration
CAPTA	Child Abuse Prevention and Treatment Act
CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised
COCHS	Community Oriented Correctional Health Services
COPS	Office of Community Oriented Policing Services
COSSUP	BJA's Comprehensive Opioid, Stimulant, and Substance Use Program
COWS	Clinical Opiate Withdrawal Score
CPR	Cardiopulmonary resuscitation
CRD	Civil Rights Division
DEA	U.S. Drug Enforcement Administration
EC	Expert committee
EMS	Emergency medical services
FASD	Fetal alcohol spectrum disorder
FDA	U.S. Food and Drug Administration
GHB	Gamma-hydroxybutyric acid
HMA	Health Management Associates

IV	Intravenous
MCSA	Major County Sheriffs of America
MOU	Memorandum of understanding
NAATP	National Association of Addiction Treatment Providers
NACo	National Association of Counties
NCCHC	National Commission on Correctional Health Care
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NLM	National Library of Medicine
NPG	National Practice Guideline
NSA	National Sheriffs' Association
NSAID	Nonsteroidal anti-inflammatory medication (drug)
OTP	Opioid treatment program
OUD	Opioid use disorder
PDMP	Prescription Drug Monitoring Program
RAM	RAND/UCLA Appropriateness Method
RCT	Randomized clinical trial
SAMHSA	Substance Abuse Mental Health Services Administration
SRLEEA	Small & Rural Law Enforcement Executives Association
SUD	Substance use disorder
TIP	Treatment Improvement Protocol
VA	U.S. Department of Veterans Affairs

Appendix M: Resources

To navigate to various sections of this resource list, click on the corresponding hyperlink.

Clinical Practice Studies
Legislation, Rules, and Regulations
Pregnancy and Postpartum
Substances
Treatment and Medication
Reentry
Screening and Assessment
Suicide
Telehealth

Clinical Practice Studies

"Microinduction of Buprenorphine/Naloxone: A Review of the Literature"—review of existing literature to help clinicians better understand the approaches to micro-dosing of buprenorphine in various clinical settings and populations. (*American Journal on Addictions*)

"Review Article: Rapid Review of the Emergency Department-initiated Buprenorphine for Opioid Use Disorder"—investigation of the effectiveness of initiating buprenorphine in the emergency department setting. (*Emergency Medicine Australasia*)

Treatment for Pregnant People with Opioid Use Disorder in Jail—study focusing on jails, recognizing that these facilities are embedded in communities and pregnant persons with opioid use disorder (OUD) entering jails need appropriate care and linkages to services when returning to the community. (Advocacy and Research on Reproductive Wellness of Incarcerated People at Johns Hopkins School of Medicine)

Legislation, Rules, and Regulations

Dying Inside: To End Deaths of Despair, Address the Crisis in Local Jails—the legal framework on the right to adequate medical, mental health, and substance use disorder (SUD) care and treatment in jails. (O'Neill Institute for National and Global Health Law)

Find Your Nurse Practice Act—online tool to locate each state's Nurse Practice Act, as well as rules and regulations. (National Council of State Boards of Nursing)

How to Use the DEA "72-Hour Emergency Rule" for Methadone in Jails—how jails' physicians may use this rule to continue methadone without interruption while the jail establishes a longer-term plan for continuation. (Health Management Associates)

Managing Substance Withdrawal in Jails: A Legal Brief—the scope of challenge, overview of key legislation and court cases related to substance withdrawal, and steps to create a comprehensive response for people with SUD. (Bureau of Justice Assistance [BJA], National Institute of Corrections)

Pregnancy and Postpartum

Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants—comprehensive guidance for optimal management of pregnant and parenting people with OUD and their infants. (Substance Abuse and Mental Health Services Administration [SAMHSA])

Opioid Use and Opioid Use Disorder in Pregnancy—recommendations for identification of and treatment for pregnant persons with SUD. (The American College of Obstetricians and Gynecologists [ACOG])

Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals—how obstetricians-gynecologists and other practitioners can support efforts to improve health care for pregnant, postpartum, and non-pregnant persons who are incarcerated. (ACOG)

Substance Abuse Reporting and Pregnancy: Role of the Obstetrician-Gynecologist—discussion of reporting requirements related to SUD that an obstetrician-gynecologist should be aware of within their state. (ACOG)

Substance Use and Pregnancy – Part 1: Current State Policies on Mandatory Reporting and Implementing Plans of Self Care to Support Pregnant Persons with Substance Use Disorders—examination of state-level policies supporting or inhibiting pregnant and postpartum persons' access to long-term recovery from OUD. (BJA's Comprehensive Opioid, Stimulant, and Substance Use Program [COSSUP])

Substance Use During Pregnancy and Family Care Plans—fact sheet on substance use during pregnancy and family planning. (Legislative Analysis and Public Policy Association with funding from the Office of National Drug Control Policy)

Substances

Barbiturates—fact sheet on barbiturates. (Drug Enforcement Administration [DEA])

Benzodiazepines—description of benzodiazepines, including its licit and illicit uses. (DEA)

Chlordiazepoxide—description of chlordiazepoxide and its uses. (National Library of Medicine's [NLM's] MedlinePlus)

Clonazepam—description of clonazepam and its uses. (NLM's Medline Plus)

Diazepam—description of diazepam and its uses. (NLM's MedlinePlus)

Drug Fact Sheets—descriptions of various medications, as well as illicit drugs. (DEA)

Facts About Fentanyl—information about fentanyl. (DEA)

Gamma Hydroxybutyric Acid (GHB)—description of GHB, including its licit and illicit uses. (DEA)

Substance Use – Prescription Drugs—common medications that are misused and a list of "street names." (NLM's MedlinePlus)

Treatment and Medication

Advisory: Addressing the Specific Needs of Women for Treatment of Substance Use Disorders—advisory for SUD treatment for women. (SAMHSA)

The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management—evidence-based strategies and standards of care for alcohol withdrawal management. (American Society of Addiction Medicine [ASAM])

Buprenorphine Practitioner Locator—listing of practitioners authorized to treat OUD with buprenorphine by state. (SAMHSA)

Buprenorphine Quick Start Guide—fact sheet and checklist for initiating buprenorphine for prescribing medication for the treatment of OUD. (SAMHSA)

FindTreatment.gov—resource for locating treatment providers. (SAMHSA)

"High-dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder"—examination of the safety and tolerability of high-dose buprenorphine induction for patients with OUD presenting to an ED. (JAMA Network)

Innovative Efforts to Distribute Naloxone to Justice-involved Populations—examples from the field, including naloxone distribution via vending machines in county jails. (COSSUP)

Medication for the Treatment of Alcohol Use Disorder: A Brief Guide—guidance on medications to treat AUD. (SAMHSA and National Institute on Alcohol Abuse and Alcoholism [NIAAA])

Medication for the Treatment of Alcohol Use Disorder: Pocket Guide—assistance for clinicians in prescribing medications to treat AUD. (SAMHSA and NIAAA)

Medication-assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning & Implementation Toolkit—toolkit intended to help correctional administrators and health care providers to plan and implement medication-assisted treatment (MAT) programs within jails and prisons. (National Council for Behavioral Health, Vital Strategies)

Medications for Opioid Use Disorder for Healthcare and Addiction Professionals, Policymakers, Patients, and Families, TIP 63—review of U.S. Food and Drug Administration-approved medications for opioid use disorder treatment and other strategies and services needed to support people in recovery. (SAMHSA)

Medications to Treat Opioid Use Disorder Research Report: How Do Medications To Treat Opioid Use Disorder Work?—discussion of how medications to treat OUD work. (National Institute on Drug Abuse [NIDA])

Myths and Facts About Medication-assisted Treatment—debunking of myths about MAT and falsehoods about its provision in jails. (COSSUP)

Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths—position statement on the prevention of opioid overdose deaths. (National Commission on Correctional Health Care [NCCHC])

A National Snapshot Update: Access to Medications for Opioid Use Disorder in U.S. Jails and Prisons—overview of litigation, state legislation, and policies that had been adopted to increase access to MAT. (O'Neill Institute for National and Global Health Law)

Opioid Treatment Program Directory—listing of opioid treatment programs by state. (SAMHSA)

Opioid Use Disorder Treatment in Correctional Settings—position statement on patient health records upon release. (NCCHC)

Performance Measures for Medication-assisted Treatment in Correctional Settings: A Framework for Implementation—framework for jail and prison administrators, program managers, medical staff in correctional settings, and reentry staff to monitor MAT in correctional settings. (Legislative Analysis and Public Policy Association)

A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons—strategies for developing, coordinating, monitoring, and evaluating jail and prison-based programs, as well as lessons learned from two studies. (RTI International with funding from NIDA)

Standards for Opioid Treatment Programs—requirements for corrections-based opioid treatment programs seeking accreditation. (NCCHC)

Substance Abuse Treatment: Addressing the Specific Needs of Women, TIP 51—guidance for providers in offering treatment to women with SUD. (SAMHSA)

Treating Substance Use Disorder in Older Adults, TIP 26—guidance for providers and others to better understand how to identify, manage, and prevent substance misuse among older adults. (SAMHSA)

Treatment for Stimulant Use Disorders, TIP 33—recommendations on treatment approaches, strategies for planning and initiating treatment, as well as how to maximize treatment engagement and retention, and strategies for initiating and maintaining abstinence. (SAMHSA)

Use of Medication-assisted Treatment for Opioid Use Disorder in Criminal Justice Settings—use of MAT for OUD in jails and prisons and during the reentry process, providing an overview of policies and evidence-based practices reducing the risk of overdose and relapse. (SAMHSA)

Reentry

Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide—behavioral health, correctional, and community stakeholders with implementation examples for transitioning people with mental disorders or SUD from correctional settings into the community. (SAMHSA)

National Reentry Resource Center—primary source of reentry information and guidance. (BJA)

Optimizing Insurance Coverage for Individuals Postrelease—position statement on insurance coverage upon release. (NCCHC)

Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide—guidance for community-based behavioral health providers in their clinical and case management practice. (SAMHSA)

Sharing of Patient Health Records Upon Release from Incarceration—position statement on patient health records upon release. (NCCHC)

Screening and Assessment

CIWA-Ar (Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised)—commonly used withdrawal assessment tool for alcohol. (ASAM)

COWS (Clinical Opiate Withdrawal Scale)—commonly used withdrawal assessment tool for opioids. (NIDA)

Screening and Assessment of Co-occurring Disorders in the Justice System—a wide range of evidence-based practices for screening and assessment of people in the justice system who have co-occurring disorders. (SAMHSA)

Screening and Assessment Tools Chart—evidence-based screening tools by substance type, patient age, and administration type. (NIDA)

Screening for Substance Use Disorders in Jails—frequently used screening instruments with descriptions of their purpose, method administration, benefits, considerations, and cost/availability. (COSSUP)

Suicide

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, Treatment Improvement Protocol (TIP) 50—guidelines for working with adults with SUD. (SAMHSA)

Advisory: Addressing Suicidal Thoughts and Behaviors in Substance Use Treatment—guidance on identifying and addressing suicidal thoughts and behaviors among individuals with SUD. (SAMHSA)

American Foundation for Suicide Prevention—voluntary health organization offering those affected by suicide a nationwide community informed by research, education, and advocacy. (American Foundation for Suicide Prevention)

APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts—recommendations for the treatment of depressive disorders (including major depression, subsyndromal depression, and persistent depressive disorder). (American Psychological Association)

Ask Suicide-Screening Questions (ASQ) Toolkit—screening tool for suicide risk. (National Institute of Mental Health)

Suicide Prevention Resource Center—federally supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention. (SAMHSA)

Suicide Prevention Resource Guide: National Response Plan for Suicide Prevention in Corrections—resource on preventing suicide in corrections facilities. (NCCHC, American Foundation for Suicide Prevention)

Telehealth

Telehealth Implementation Support Tool—an online support tool intended to be completed in approximately 20 minutes by a jail administrator, who may need input from other stakeholders. (COSSUP)

"Telemedicine," from the COVID-19 Information web page—guidance on how telemedicine can be used, including the DEA policy on the use of telephone evaluations to initiate buprenorphine. (DEA)

Using Telehealth for Behavioral Health in the Criminal Justice System—a brief on telehealth services and its benefits to the criminal justice system as an innovative strategy for intervention and treatment of OUD. (COSSUP)

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