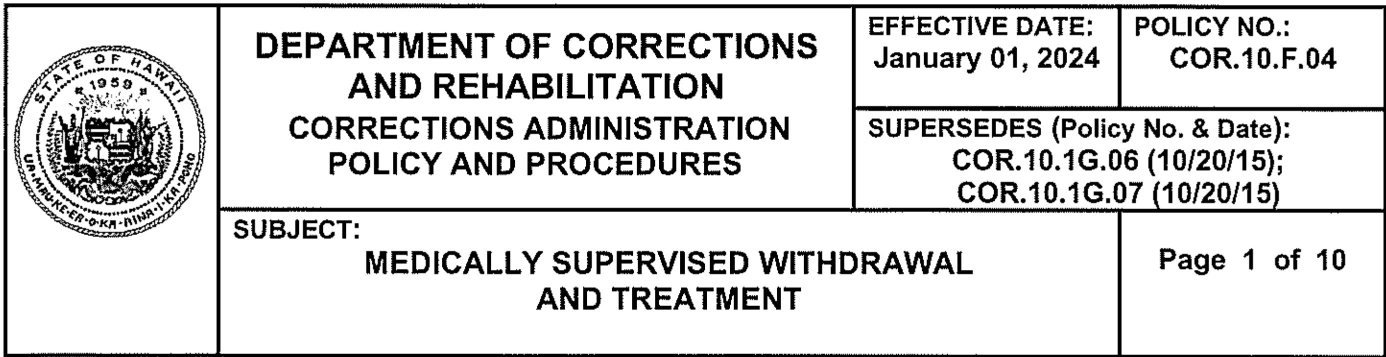


	DEPARTMENT OF CORRECTIONS AND REHABILITATION CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: January 01, 2024	POLICY NO.: COR.10.F.04
		SUPERSEDES (Policy No. & Date): COR.10.1G.06 (10/20/15); COR.10.1G.07 (10/20/15)	
	SUBJECT: MEDICALLY SUPERVISED WITHDRAWAL AND TREATMENT		Page 1 of 10

1.0 PURPOSE

The purpose of this policy is to ensure that incarcerated individuals who are intoxicated or undergoing withdrawal are appropriately managed and treated.

2.0 SCOPE

This policy and procedure shall apply to all correctional facilities, their assigned personnel, and contract staff.

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. Department of Corrections and Rehabilitation (DCR), Policy and Procedures, COR.10.1E.04, Initial Health Assessment.

b. DCR, Policy and Procedures, COR.10.1G.01, Patients with Chronic Disease and Other Special Needs.

c. Guidelines for Managing Substance Withdrawal in Jails: A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals. U.S. Department of Justice, Bureau of Justice Assistance and National Institute of Corrections (2023).

d. Hawaii Revised Statutes §329E, Overdose Prevention and Emergency Response Act.

e. Position Statement: Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths, National Commission on Correctional Health Care, (2021).

f. Position Statement: Opioid Use Disorder Treatment in Correctional Settings, National Commission on Correctional Health Care, (2021).

g. Standards for Health Services in Prisons. National Commission on Correctional Health Care, (2018).

h. Standards for Health Services in Jails. National Commission on Correctional Health Care, (2018).

i. Standards for Mental Health Services in Correctional Facilities. National Commission on Correctional Health Care, (2015).

j. Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. Substance Abuse and Mental Health Services Administration (2019).

.2 Definitions:

a. Medically Supervised Withdrawal (formerly known as detoxification): The voluntary or involuntary gradual reduction or tapering of medications over time under the supervision of a provider to properly manage and substantively mitigate symptoms of withdrawal. The purpose is to reduce or eliminate physiologic dependence on substances.

.3 Forms:

a. Columbia – Suicide Severity Rating Scale: Screening Version – Since Last Contact for Corrections, developed by The Research Foundation for Mental Hygiene, Inc. (attached)

b. Columbia – Suicide Severity Rating Scale: Screen with Triage Points for Corrections, developed by The Research Foundation for Mental Hygiene, Inc. (attached)

c. DCR 0408, CIWA-Ar/COWS Scoring Log for Alcohol /Opiate Withdrawal (attached)

d. DCR 0436, CIWA-B Scoring Log for Benzodiazepine Withdrawal (attached)

4.0 POLICY

.1 The department shall establish protocols based on nationally accepted guidelines for the screening, evaluation, monitoring, and management of incarcerated individuals under the influence of or undergoing withdrawal from alcohol, sedative-hypnotics, stimulants, opioids, and/or other substances.

.2 The department shall establish protocols for the Medication-Assisted Treatment (MAT) program, which addresses the management of incarcerated individuals on Medication-Assisted Treatment (MAT).

.3 Disorders associated with alcohol and other drugs (e.g., HIV, liver disease), shall be recognized and treated in accordance with relevant policies and protocols (see for example, COR.10.1E.04 Initial Health Assessment and COR.10.1G.01 Patients with Chronic Disease and Other Special Needs).

5.0 PROCEDURES

.1 Intoxication, Overdose and Withdrawal Management.

The Medical Director shall establish protocols based on nationally accepted guidelines for the screening, assessment, monitoring, and management of incarcerated individuals under the influence of, or undergoing withdrawal from alcohol, sedative-hypnotics, stimulants, opioids, and/or other substances. The responsible physician shall approve the protocols annually.

a. Screening for Intoxication, Risk of Overdose, and Withdrawal.

1. Screening of all newly incarcerated individuals shall be conducted in accordance with COR.10.1E.02 (Receiving Screening).

2. An incarcerated individual presenting with intoxication should be presumed to be at risk for overdose or subsequent withdrawal until determined otherwise by a qualified health care professional.

3. The screener shall refer an incarcerated individual to a qualified health care professional for immediate clinical assessment if the incarcerated individual:

a) Appears unwell (including those who appear intoxicated).

b) Reports or is known to have used alcohol, sedatives, stimulants, opioids, and/or other substances recently, regularly, and heavily.

c) Reports using alcohol, sedatives, stimulants, opioids and/or other substances in the past week and reports a history of complicated withdrawal.

d) Is known to be pregnant and screens positive for alcohol or opioid use.

4. Upon identification of a newly incarcerated individual who is taking prescription medications associated with physiological dependence (e.g., opioids, sedatives, anxiolytics, stimulants), health care staff shall attempt to verify the prescription (e.g., by checking with prescribers, pharmacies, and community databases such as the Hawaii Health Information Exchange or the Prescription Drug Monitoring Program).

   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 shall consult with a prescriber to determine how to proceed.

b. Monitoring for Signs and Symptoms of Intoxication, Overdose, and Withdrawal.

1. Incarcerated individuals who screen positive for substance withdrawal risk or with known history of withdrawal, even if they appear well, should be monitored by health care staff for the emergence of withdrawal indicators including but not limited to:

   a) Agitation.

   b) Appearing severely depressed or withdrawn.

   c) Dilated or constricted pupils.

   d) Incoherent speech.

   e) Increasing anxiety or panic.

   f) Marked paranoia.

   g) Auditory or visual hallucinations.

   h) Disorientation or altered mental status.

   i) Seizure.

j) Verbalizes having thoughts about hurting themselves or others.

k) Diarrhea.

l) Tremor.

m) Vital signs outside the normal range.

n) Vomiting.

2. If an incarcerated individual reports intoxication or that they are starting to experience withdrawal, the incarcerated individual shall be referred to a qualified health care professional for immediate clinical assessment.

3. Individual differences in metabolism, liver function, and kidney function can cause some individuals to take longer than expected to experience intoxication, overdose, or withdrawal. If withdrawal-like symptoms emerge after the monitoring period has ended, the incarcerated individual should be referred to a qualified health care professional for immediate clinical assessment.

4. Monitoring shall be discontinued early only when ordered by a provider.

c. Clinical Assessment and Diagnosis.

1. An incarcerated individual who has been referred for immediate clinical assessment for intoxication or substance withdrawal shall be assessed by a qualified health care professional.

a) Registered nurses shall conduct and document a clinical assessment, and follow physician-approved protocols defining when coordination with an on-call or on-site provider must take place for the purpose of determining diagnoses and initiating treatment plans.

b) When indicated by protocol, physicians, nurse practitioners, or physician assistants shall diagnose and initiate treatment.

2. The initial clinical assessment should:

a) Identify any emergent medical or psychiatric needs.

b) Evaluate current signs and symptoms of intoxication or withdrawal.

c) Evaluate risk for overdose or severe or complicated withdrawal.

d) Screen for suicide risk using the Columbia – Suicide Severity Rating Scale (C-SSRS).

e) Determine the appropriate level of care.

3. If an incarcerated individual is unable to engage in the full clinical assessment due to intoxication or withdrawal, they should be assessed to determine the need for urgent medical care. The full assessment should be completed once their intoxication or withdrawal symptoms have resolved.

d. Level of Care.

1. 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.

2. When available treatment services and resources at the facility do not meet nationally accepted guidelines, the incarcerated individual should be transferred to an appropriate facility to receive a higher level of care.

3. Incarcerated individuals experiencing severe or progressive intoxication (i.e., overdose), or severe alcohol/sedative withdrawal shall be transferred immediately to a local hospital.

4. Incarcerated individuals presenting with altered mental status regardless of intoxication, overdose, or withdrawal signs and symptoms, shall be transferred immediately to a local hospital.

5. For management of suspected substance overdose:

a) Staff shall follow the principles of first aid and cardiopulmonary resuscitation (CPR) and transfer the incarcerated individual to a local emergency department.

b) If the incarcerated individual is not breathing, or breathing is not sufficient, staff should administer naloxone until response is achieved or care is transferred to EMS.

e. Withdrawal Management by Qualified Health Care Professionals.

1. Medical decisions shall be independent of the custody level or classification of the incarcerated individual.

2. While comprehensive clinical assessment of the incarcerated individual is critical for treatment planning, treatment should not be delayed while awaiting completion of all assessments, laboratory testing, or results.

3. The Clinical Services Administrator or designee shall ensure that nursing staff maintains a daily census of all incarcerated individuals being monitored or treated for substance intoxication, overdose, or withdrawal.

4. The onsite provider shall review daily the status of all incarcerated individuals being monitored for acute withdrawal. If no onsite provider is available, the on-call provider shall be contacted.

5. Intoxication with and withdrawal from alcohol, sedatives, opioids, and stimulants can be dangerous and potentially life-threatening. The intensity of withdrawal cannot always be predicted. Qualified health care professionals shall conduct clinical assessments on a frequency based on specific orders by the provider for the incarcerated individual.

a) Clinical assessments should be conducted by qualified health care professionals not less than twice per day, not more than sixteen (16) hours apart, unless otherwise ordered by the provider.

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

NOT CONFIDENTIAL

i) General physical condition.

ii) Vital signs.

iii) Hydration.

iv) Orientation.

v) Sleep.

vi) Mental status.

vii) Fall risk.

viii) Progression of the withdrawal symptoms.

ix) Timing of the next assessment.

c) As ordered by a provider, qualified health care professionals shall use validated withdrawal assessment instruments, such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA), Revised [DCR 0408, DCR 0436].

6. An incarcerated individual undergoing intoxication or withdrawal management should be assigned a bottom bunk and housed on lower floors, to the extent possible.

f. Monitoring Incarcerated Individuals During Intoxication or Withdrawal Management.

1. An incarcerated individual showing signs of intoxication or withdrawal shall be monitored by qualified health care professionals using protocols approved by the Medical Director, and as clinically indicated until symptoms have resolved.

2. Qualified health care professionals shall regularly monitor for changes in condition of incarcerated individuals undergoing intoxication or withdrawal from any substance.

3. A provider shall determine the frequency and duration of monitoring based on the type of substance taken, when the substance was last taken, and the suspected duration of effect.

   a) Clinical staff should use their judgment to determine when more frequent assessment or monitoring is needed.

   b) The frequency and duration of monitoring or assessment shall not be reduced or discontinued without an order from a provider.

4. Incarcerated individuals being monitored shall be housed in a safe location that allows for effective monitoring. Facilities without a dedicated housing unit for withdrawal management should maintain a current log of all incarcerated individuals being monitored for withdrawal risk and withdrawal management, including the substance(s) for which monitoring is being conducted, and the frequency of monitoring.

5. If the findings from monitoring an incarcerated individual meets the national guidelines to begin prescription medications, medically supervised withdrawal is implemented.

6. Medically supervised withdrawal shall be conducted under provider supervision.

g. Medications.

1. Prescription medications provided for withdrawal management shall be ordered for the incarcerated individual by a prescriber.

2. When prescription medication is included in a withdrawal protocol or pathway, a prescriber shall order implementation of a specific withdrawal protocol or pathway for the incarcerated individual.

3. Naloxone should be readily available to health care and custody staff for overdose reversal, including in all housing units where feasible.

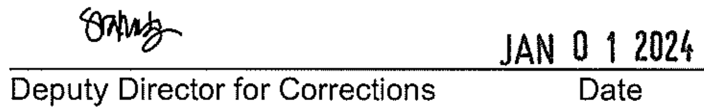
.2 <u>Medication-Assisted Treatment (MAT).</u>

The Medical Director shall develop protocols to address the management of incarcerated individuals on Medication-Assisted Treatment (MAT).

a. An incarcerated individual entering a correctional facility on MAT shall have their medication continued, a plan for therapeutic substitution, or medically supervised withdrawal initiated, as clinically indicated.

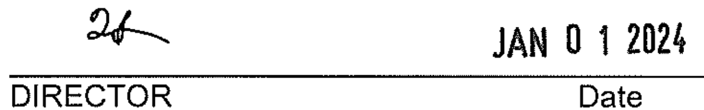
b. When an incarcerated individual is pregnant or tests positive on a urine pregnancy test, and has been diagnosed with opioid dependence, or has been receiving medication for opioid use disorder (including methadone and buprenorphine), a provider shall be contacted by a nurse so that the opioid dependence can be assessed and appropriately treated.

APPROVAL RECOMMENDED:



Deputy Director for Corrections — Date: JAN 0 1 2024

APPROVED:



DIRECTOR — Date: JAN 0 1 2024

Department of Public Safety Health Care Division **CIWA-Ar / COWS Scoring Log for Alcohol /Opiate Withdrawal** Start Date: ________ End Date: __________

Name: _______________________________ SID#:______________ Facility: _____________**CIWA** (2x/day for 7 days):_____ ETOH Withdrawal (Date/Time of Last Drink):_______/_______

COWS (2x/day for 7 days):_____ Opiate (Name/Drug):____________________ Date/Time (of last use): ______/_________ Name of Withdrawal Medication Started :__________________

Date														
Time														
CODE	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Weight														
Temperature														
Blood Pressure														
O2 SAT%														
Pulse/ Respiration	/	/	/	/	/	/	/	/	/	/	/	/	/	/

SCORE: See **CIWA** Scoring Guidelines (other side) Clinical Institute Withdrawal Assessment

CODE	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Nausea & Vomiting														
Tremor														
Paroxysmal Sweats														
Agitation														
Tactile Disturbances														
Auditory Disturbance														
Anxiety														
Headache, fullness in head														
Visual Disturbances														
Orientation / Cloud Sensorium														
Total Score														
Signature / Initials														

SCORE: See **COWS** Scoring Guidelines (other side) Clinical Opiate Withdrawal Scale

CODE	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Resting Pulse Rate														
Sweating														
Restlessness														
Pupil Size														
Bone Joint Ache														
Runny Nose/Tearing														
GI Upset														
Tremor														
Yawning														
Anxiety/irritability														
Gooseflesh Skin														
Total Score														
Signature / Initials														

***Notify Provider if Score greater than/equal to 10 for CIWA, 13 for COWS or**

or if Significant Symptoms or previous Hx seizures or VS abnormal

Initials	Name / Stamp	Initials	Name / Stamp	Initials	Name / Stamp

Department of Public Safety Health Care Division

CIWA-B Scoring Log for Benzodiazepine Withdrawal

Name: ___________________________ SID#:___________ Facility: ______ Date Last Used: _______CIWA-B (bid x 7 days) : Start Date _________ End Date _________

Name of Drug Used: __________Date Last Used: _______ Date Started on Withdrawal Med: _________ Medication Name: ___________________________________

Date														
Time														
CODE	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Weight														
Temperature														
Blood Pressure														
O2 SAT%														
Pulse /Respiration	/	/	/	/	/	/	/	/	/	/	/	/	/	/

SCORE: See CIWA Scoring Guidelines (other side) Clinical Institute Withdrawal Assessment														
CODE	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Irritable														
Fatigued														
Tense														
Difficulty Concentrating														
Loss of appetite														
Numbness/burning on your face, hands or feet														
Heart racing														
Head feels full or achy														
Muscle aches or stiffness														
Anxious, nervous, or jittery														
Upset														
Restful sleep last night														
Weak														
Not enough sleep last night														
Visual Disturbance														
Fearful														
Worry about possible misfortunes lately														
TOTAL SCORE														
Initials														

Clinical Observations														
CODE	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Perspiration														
Tremor														
Restlessness & Agitation														
TOTAL SCORE														
Initials														

Initials	Name

***Notify Provider if Score greater than/equal to 21 for CIWA-B, or if Significant Symptoms or previous Hx seizures or VS abnormal**

Irritable		**Numbness/burning on hands & Feet**		**Upset**		**Fearful**	
0	Not at all	0	No numbness	0	Not at all	0	Not at all
1		1		1		1	
2		2		2		2	
3		3		3		3	
4	Very much so	4	Intense burning/numbness	4	Very much so	4	Very much so
Fatigued		**Heart racing**		**Restful sleep last night**		**Worry about possible misfortunes**	
0	Not at all	0	Not at all	0	Very restful	0	Not at all
1		1		1		1	
2		2		2		2	
3		3		3		3	
4	Unable to function	4	Constant racing	4	Not at all	4	Very much so
Tense		**Head feels full or achy**		**Weak**		**Perspiration**	
0	Not at all	0	Not at all	0	Not at all	0	No sweating
1		1		1		1	
2		2		2		2	
3		3		3		3	
4	Very much so	4		4	Very much so	4	Severe drenching sweats
Difficulty Concentrating		**Muscle Aches/stiffness**		**Not enough sleep last night**		**Tremors**	
0	Not at all	0	Not at all	0	Very much so	0	No tremor
1		1		1		1	
2		2		2		2	
3		3		3		3	
4	Unable to concentrate	4	Severe stiffness & pain	4	Not at all	4	
Loss of Appetite		**Anxious, nervous, or jittery**		**Visual disturbances**		**Restlessness & agitation**	
0	Not at all	0	Not at all	0	Not at all	0	No Tremor
1		1		1		1	
2		2		2		2	
3		3		3		3	
4	No appetite, unable to eat	4	Very much so	4	Very sensitive to light, blurred vision	4	Very much so

Total Score

1-20	Mild Withdrawal	21-40	Moderate Withdrawal	41-60	Severe withdrawal	61-80	Very Severe Withdrawal