Substance Use Disorder Treatment for Adults and Adolescents

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Introduction

Scientific evidence has firmly established that substance use disorders represent a chronic, relapsing disease requiring effective treatment with a view toward long-term management. This position statement reflects this science and new national guidelines for treatment of opioid use disorder and is intended to ensure that people with substance use disorders in custody receive evidence-based care in accordance with national medical standards.

This position statement primarily focuses on alcohol, benzodiazepine, and opioid use disorders because of the high rates of death from withdrawal and overdose from these substances. However, the principles of screening, evaluation, provision of evidence-based treatment, and prerelease coordination of care apply to all substance use disorders. While pharmacotherapy options differ among types of substances use disorders, the general principles are similar.

Effective treatment for substance use disorders, including pharmacotherapy (referred to here as medication-assisted treatment [MAT]), particularly when coupled with evidence-based behavioral treatment, improves medical and mental health outcomes and reduces relapses and recidivism[1] (Amato et al., 2005; Bird, Fischbacher, Graham, & Fraser, 2015; Egli, Pina, Skovbo Christensen, Aebi, & Killias, 2011). Care for opioid use disorder has evolved such that MAT and medication-assisted withdrawal (when indicated) with approved medications have become the national medical standard (Amato et al., 2005; Kampman & Jarvis, 2015). Unfortunately, many jails and other facilities do not use MAT, or provide it only in limited circumstances.

Opioid withdrawal in pregnancy can lead to miscarriage, preterm birth, stillbirth, and other adverse outcomes. Therefore, withdrawal, including medically assisted withdrawal, must be avoided through the use of MAT. Among pregnant women, facilities must ensure continuation of MAT or initiate MAT to prevent withdrawal.

Drug use is known to occur in correctional facilities. Consequences of drug use in prison and jail may include drug-related overdose deaths, suicides, increased criminal activity related to drugs and distribution, disciplinary actions, self-harm, and spread of bloodborne infections through needle sharing. Effective treatment for substance use disorders, including long-term MAT, has been shown to reduce these problems in correctional institutions.

Inmates released from prison without MAT have more than 10 times higher risk of dying from overdose in the first 2 weeks following their release than the general population (Binswanger et al., 2007; Merrall et al., 2010). MAT significantly reduces postrelease overdose deaths (Bird et

al., 2015; Gisev et al., 2015). While both methadone and buprenorphine treatment pose some risk for diversion within prisons and jails, some evidence suggests that overall rates of illicit drug use decline following introduction of MAT (Larney et al., 2014).

Although pharmacological treatments have an important role in the treatment of individuals with substance use disorders, the greatest success is seen when psychosocial treatments are combined with pharmacological treatment as part of a comprehensive treatment plan. Behavioral therapies (e.g., contingency management), cognitive behavioral therapy, motivational interviewing, and other types of individual, group, and family psychotherapies have proven effective. Treatment includes many types of additional psychosocial interventions in a variety of treatment settings. Community-based self-help support groups such as Alcoholics Anonymous, Narcotics Anonymous, and other peer-to-peer and self-help approaches represent a potentially important adjunct, but are not a substitute for evidence-based pharmacological and behavioral treatment for substance use disorders.

Individuals entering correctional facilities with opioid dependence are at high risk for opioid withdrawal syndrome (OWS). Suboptimal treatment for OWS creates risk for suffering; potential interruption of life-sustaining medical treatments, such as HIV treatment; exacerbation or masked symptoms from other life-threatening illness; and in some cases death.

With the exception of buprenorphine, the U.S. Drug Enforcement Administration (DEA) holds that it is illegal for a physician to write a prescription for any other opioid, including methadone, for the treatment of opioid dependence except in a licensed treatment program. Thus, it is important for facilities to predetermine how they are going to meet the needs of inmate-patients by continuing or initiating MAT, whether through coordination with an existing licensed treatment program, by seeking stand-alone licensing, or by physician licensing for prescribing buprenorphine.

Clonidine is an antihypertensive medication that is helpful for less severe OWS. However, it is not appropriate during pregnancy or for patients with severe vomiting, diarrhea, and worsening dehydration where hypotension can be fatal.

Persons with alcohol and sedative dependence who enter a correctional facility are at high risk for alcohol withdrawal syndrome (AWS) and related sedative withdrawal syndrome. If not recognized and adequately treated, such withdrawal can progress to delirium tremens and death. AWS is prevalent among those entering holding centers and jails, often beginning during the first 24 hours following the person's last drink. It complicates management of medical and psychiatric problems. Importantly, withdrawal is associated with suicide, an important preventable cause of death in corrections.

The American Society of Addiction Medicine National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use establishes a national benchmark for treatment. Providers in correctional settings should follow these guidelines when treating people with substance use disorders. Effective treatment of those with substance use disorders is key to halting the national epidemic of drug abuse, particularly opioid use disorder, and interrupting the costly cycle of recidivism resulting from this underlying disorder.

POSITION STATEMENT

The National Commission on Correctional Health Care advocates the following principles for care of adults and adolescents with substance use disorders in correctional facilities; these principles reinforce and expand on principles articulated in NCCHC's *Standards for Health Services*. Several points are of primary medical focus in this position statement: screening and identification, continuation or initiation of MAT while incarcerated, monitoring and withdrawal according to national medical standards (if needed), prerelease initiation of treatment and care coordination, and linkage of medication treatment programs with nonpharmacological treatment options.

Screening, Evaluation, and Care Coordination Upon Entry

1. Universal screening of all inmates for risk factors and symptoms of withdrawal must be conducted upon entry into the facility from the community. Valid screening instruments for alcohol, benzodiazepine, and opioid withdrawal should be used; these are available from a variety of sources (e.g., National Institute on Drug Abuse; see also NCCHC standard E-02 Receiving Screening).

2. All inmates who screen positive should receive a medical evaluation that includes the following:

a. Evaluation of current use and status, including current enrollment in a substance use disorder treatment program, e.g., opioid treatment program (OTP), primary care-based buprenorphine treatment, or alcohol treatment program.

b. Pregnancy test, at minimum for all females reporting opioid use, and conversely, opiate use history for all pregnant females. Facilities should follow national medical standards of care in providing appropriate MAT (methadone or buprenorphine), and not withdrawal, to pregnant women with opiate dependence.

c. Assessment for comorbidity and confirmation of medications and dosing, including those used to treat substance use disorders, e.g., naltrexone, acamprosate, methadone, and buprenorphine.

d. Formal assessment for withdrawal severity using validated, standardized instruments such as the Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar), Clinical Institute Withdrawal Assessment for Benzodiazepines (CIWA-B), and the Clinical Opiate Withdrawal Scale (COWS).

Medication-Assisted Treatment

3. Continuation of prescribed medications for substance use disorders: Continuation of opioid agonist treatment treats the physiological and psychological symptoms of dependence and minimizes risk from opioid withdrawal, failure to reinitiate treatment, and relapse due to unexpected inmate release. As with many ongoing medical conditions, stability of treatment and medical condition is important. Continuation of maintenance medications and therapies for

substance use disorders in incarcerations of less than 6 months has proven beneficial to the patient in medical evidence based on randomized controlled studies (Rich et al., 2015). Longer-term stays (when expected confinement is more than 6 months) have less evidence, and the treatment plan, including decisions about continuation, should be evaluated on a case-by-case basis. MAT offers the potential to reduce illicit opioid use inside correctional facilities, which may benefit the individual and the facility.

4. Inmates not receiving MAT prior to entry, or whose MAT is discontinued while incarcerated (which is not preferred), should be offered MAT prerelease when postrelease continuity can be arranged (Kampman & Jarvis, 2015). Use of methadone or buprenorphine avoids medication-assisted withdrawal and improves engagement in treatment upon release (Rich et al., 2015). Some facilities may opt to withdraw inmates with expected confinements that exceed 6 months. In these cases, opioid agonist treatment should be initiated 30 days prior to release to prevent postrelease death from overdose and promote engagement in treatment. Use of naltrexone (an opioid antagonist) requires complete withdrawal before initiation.

5. Appropriate prerelease planning with community OTPs and community buprenorphine prescribers is critical to ensure there is no interruption of treatment. Where there are no community programs, inmates should undergo medication-assisted withdrawal prior to release.

6. Correctional facilities should have several strategies for provision of buprenorphine or methadone to inmates, including during pregnancy. These strategies differ in the level of planning and licensing required.

a. Transport inmates to community OTPs or a hospital (this is sometimes used during pregnancy). OTPs may obtain waivers for use of takeout doses under the custody of the jail or prison in order to minimize the number of transports.

b. Partner with community OTPs for dosing of inmates within the facility. In this case, the dosing is done under the license of the community OTP.

c. Have correctional physicians obtain buprenorphine licenses. This license permits use of buprenorphine for MAT as well as for medication-assisted withdrawal.

d. Obtain an OTP license for the facility. This permits use of methadone and buprenorphine for both treatment and withdrawal. (Note: NCCHC accredits facilities for OTP.)

e. Obtain state and DEA licensing as a health care facility. This entitles the facility to the same exemptions as hospitals for use of methadone or buprenorphine during pregnancy or to ensure treatment of other conditions, e.g., HIV, mental illness.

7. Attention to the needs of pregnant women with substance use disorders, including following national standard of care[2] to provide MAT, and not withdrawal, to pregnant women with opiate dependence, is essential. Treatment should be provided by clinicians with expertise in this area. Initiation of MAT may require inpatient hospitalization. Other opioid medications, such as

acetaminophen with codeine, hydrocodone, or oxycodone, should not be substituted for appropriate medication-assisted treatments because of risk to mother and fetus.[3]

Psychosocial Treatments

8. Correctional facilities should provide nonmedication-based therapies as part of a comprehensive substance use disorder treatment plan.

Medication-Assisted Withdrawal When Indicated

9. Inmates with clinically significant alcohol, opiate, or other drug withdrawal should be treated with evidence-based effective medications, including opioid agonists for severe withdrawal.

10. Inmates should be evaluated and appropriately treated for physical and mental health comorbidity, including concurrent mental health disorders, by qualified health care professionals trained and experienced in managing comorbid disorders.

11. If a patient is on pharmacotherapy for substance use disorders while incarcerated, referral and coordination of community resources is provided for continued treatment for substance use and mental health disorders after release.

12. For individuals who screen positive for substance abuse and are not already involved in a community treatment program, a prerelease evaluation should occur to determine referral and coordination of community resources for treatment for substance use and mental health disorders.

13. Facilities ensure the availability of naloxone (Narcan®) and personnel trained to use it when opioid overdoses occur. Consideration may be given to providing naloxone to high-risk inmates upon release.

14. NCCHC supports high-quality research regarding best practices related to treatment of substance use disorders in corrections. Although a substantial evidence base exists for such treatment, there is a high need for research to determine the best practices for provision of treatment in different types of correctional facilities. Such research is needed to inform optimal treatment type, intensity, timing, and postrelease coordination for different populations (e.g., adolescents, those with chronic persistent mental illness, and those with different types of substance use disorders). Research should also address issues related to risk stratification as well as composition and training of substance use disorder teams.

Adopted by the National Commission on Correctional Health Care Board of Directors October 23, 2016

Notes

1. For more information on MAT, visit the Substance Abuse and Mental Health Services Administration at http://www.samhsa.gov/medication-assisted-treatment.

2. Current medical guidelines are available from the following sources:

National Center on Substance Abuse and Child Welfare. Treatment for Opioid Dependence During Pregnancy. https://www.ncsacw.samhsa.gov/resources/resources-mat.aspx

American College of Obstetricians and Gynecologists. Women's Health Care Physicians Committee Opinion. Opioid Abuse, Dependence, and Addiction in Pregnancy. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy

3. By law, buprenorphine is the only opioid agonist-type drug that physicians can prescribe (outside of an OTP) to treat opioid dependence in any patient, regardless of pregnancy. The law allows for prescribers to write for up to three days as a bridge to MAT.

REfeRenCEs

Amato, L., Davoli, M., Perucci, C. A., Ferri, M., Faggiano, F., & Mattick, R. P. (2005). An overview of systematic reviews of the effectiveness of opiate maintenance therapies: Available evidence to inform clinical practice and research. *Journal of Substance Abuse Treatment, 28,* 321-329.

Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. *New England Journal of Medicine, 356,*157-165.

Bird, S. M., Fischbacher, C. M., Graham, L., & Fraser, A. (2015). Impact of opioid substitution therapy for Scotland's prisoners on drug-related deaths soon after prisoner release. *Addiction;110,* 1617-1624.

Egli, N., Pina, M., Skovbo Christensen, P., Aebi, M., & Killias, M. (2011). Effects of drug substitution programs on offending among drug-addicts. *Campbell Systematic Reviews.* Retrieved from http://www.campbellcollaboration.org/lib/project/79

Gisev, N., Larney, S., Kimber, J., Burns, L., Weatherburn, D., Gibson, A., . . . Degenhardt, L. (2015, June). Determining the impact of opioid substitution therapy upon mortality and recidivism among prisoners: A 22 year data linkage study. *Trends & Issues in Crime and Criminal Justice* (No. 498). Australian Institute of Criminology.

Kampman, K., & Jarvis, M. (2015). American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. *Journal of Addiction Medicine, 9,* 358-367.

Larney, S., Gisev, N., Farrell, M., Dobbins, T., Burns, L., Gibson, A., . . . Degenhardt, L. (2014). Opioid substitution therapy as a strategy to reduce deaths in prison: Retrospective cohort study. *BMJ Open, 4*(4), e004666.

Merrall, E. L., Kariminia, A., Binswanger, I. A., Hobbs, M. S., Farrell, M., Marsden, J., . . . Bird, S. M. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction, 105,* 1545.

Rich, J. D., McKenzie, M., Larney, S., Wong, J. B., Tran, L., Clarke, J., . . . Zaller, N. (2015). Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: A randomised, open-label trial. *Lancet, 386*(9991), 350

P-F-04 MEDICALLY SUPERVISED WITHDRAWAL AND TREATMENT

essential

Standard

Inmates who are intoxicated or undergoing withdrawal are appropriately managed and treated.

Compliance Indicators

1. Protocols exist for managing inmates under the influence of or undergoing withdrawal from alcohol, sedatives, opioids, and/or other substances.
2. Protocols for intoxication and withdrawal are approved by the responsible physician annually and are consistent with nationally accepted treatment guidelines.
3. Individuals showing signs of intoxication or withdrawal are monitored by qualified health care professionals using approved protocols as clinically indicated until symptoms have resolved.
4. Individuals being monitored are housed in a safe location that allows for effective monitoring.
5. If the findings from patient monitoring meet the national guidelines to begin prescription medications, *medically supervised withdrawal* is implemented.
6. Medically supervised withdrawal is done under provider supervision.
7. Inmates experiencing severe or progressive intoxication (overdose) or severe alcohol/sedative withdrawal are transferred immediately to a licensed acute care facility.
8. The facility has a policy that addresses the management of inmates on medication-assisted treatment (MAT).
9. Inmates entering the facility on MAT have their medication continued, or a plan for medically supervised withdrawal is initiated.
10. Disorders associated with alcohol and other drugs (e.g., HIV, liver disease) are recognized and treated.
11. All aspects of the standard are addressed by written policy and defined procedures.

Definition

Medically supervised withdrawal, formerly known as detoxification, is the gradual reduction or tapering of medications over time under the supervision of a provider to properly manage and substantively mitigate symptoms of withdrawal. Its purpose is to reduce or eliminate physiologic dependence on substances. Medically supervised withdrawal may be either voluntary or involuntary.

Discussion

Significant percentages of inmates have a history of alcohol and/or other drug abuse. Newly incarcerated individuals may enter intoxicated or develop symptoms of alcohol or other drug withdrawal. The withdrawal may be mild, moderate, or severe. It requires urgent if not emergent management to prevent complications including death.

The treatment for most non-life-threatening withdrawal is amelioration of symptoms, which can be managed in the convalescent or outpatient setting. Abstinence syndromes in certain groups (including those who are psychotic, geriatric, epileptic, pregnant, adolescent, or otherwise medically ill) may require different protocols.

Medically supervised withdrawal is best managed by a physician or other medical professional with appropriate training and experience. As a precaution, severe withdrawal syndromes must never be managed outside of a hospital. Deaths from acute intoxication or severe withdrawal have occurred in correctional facilities. In deciding the level of symptoms that can be managed safely at the facility, the responsible physician must take into account the level of medical supervision that is available at all times. Clinical management should also include the use of validated withdrawal assessment instruments, such as the Clinical Opiate Withdrawal Scale or the Objective Opiate Withdrawal Scale and the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised.

Facility health staff should ensure that patients with alcohol and other drug problems receive evidence-based care during confinement and are linked to care upon release. Patients with opioid use disorders who are released following long-term confinement are at high-risk for postrelease death from overdose.

This risk can be reduced by continuing MAT (e.g., methadone, buprenorphine, or naltrexone) when appropriate or by initiating MAT prior to release. (Note: Use of methadone for this purpose requires that the facility obtain an opioid treatment program [OTP] license or partner with an OTP community provider; buprenorphine can be prescribed by any physician who holds an appropriate license.) Encouraging and/or facilitating engagement in treatment postrelease can reduce recidivism and mortality. (For more information about OTPs, see NCCHC's *Standards for Opioid Treatment Programs in Correctional Facilities*, which are the foundation of NCCHC's OTP accreditation program.)

If a pregnant inmate is admitted with opioid dependence or treatment (including methadone and buprenorphine), a provider must be contacted so that the opioid dependence can be assessed and appropriately treated with methadone or buprenorphine. Other opioid pain relievers, such as acetaminophen with codeine or hydrocodone, are not appropriate or acceptable substitutions for methadone or buprenorphine. (See F-05 Counseling and Care of the Pregnant Inmate.)

Resources that can be used to develop policies, train staff, and obtain further information include the Substance Abuse and Mental Health Services Administration, the American Association for the Treatment of Opioid Dependence, the American Society of Addiction Medicine, and the American Academy of Addiction Psychiatry.

P-E-10 DISCHARGE PLANNING

essential

Standard

Discharge planning is provided for inmates with serious health needs whose release is imminent.

Compliance Indicators

1. For planned discharges, health staff arrange for a *reasonable supply* of current medications.
2. For patients with serious medical, dental, or mental health needs, arrangements or referrals are made for follow-up services with community prescribers, including exchange of clinically relevant information.
3. The facility has a process to assist inmates with health insurance application prior to release.
4. All aspects of discharge planning are documented in the health record.
5. All aspects of the standard are addressed by written policy and defined procedures.

Definition

Reasonable supply includes a combination of medications and prescriptions to allow the patient time to arrange for follow-up in the community.

Discussion

Discharge planning includes the following:

a. Formal linkages between the facility and community-based organizations
b. Lists of community health professionals
c. Discussions with the patient that emphasize the importance of appropriate follow-up and aftercare
d. Appointments and medications that are arranged for the patient at the time of release
e. Timely exchange of health information, such as problem lists, medications, allergies, procedures, and test results

Establishment of formal or informal agreements with community prescribers can improve timely access to follow-up appointments and timely exchange of health information.

Patients with communicable disease or other serious medical, dental, or mental health conditions are given more than a list of community resources. Referrals are made to specialized clinics or community health professionals, or, if appropriate, direct admission to a community hospital may be arranged.

As part of early discharge planning, prisons need to assist inmates with insurance application prior to release. Prisons should take advantage of federal funding for insurance navigators to facilitate this process. Most prisons begin discharge planning when an inmate enters custody to ensure that all components of the courts, custody, and health are coordinated when release occurs.

Because patients with an opioid addiction history are at higher risk for overdose after discharge, consideration should be given to beginning medication-assisted treatment immediately prior to release. When this is not available, facilities should establish a community partnership for enrollment in an opioid treatment program immediately after release.

Adequate discharge planning is contingent on timely notification by custody staff or court services staff of the inmate's scheduled release. However, if notification is not provided, health staff still have a responsibility to ensure ongoing patient care with community health professionals. Follow-up care also may be required by public health laws (e.g., for various infectious diseases).

Close coordination between designated health staff and any correctional, probation, or parole staff responsible for release planning is recommended. With the patient's permission, health staff may share necessary information and arrange for transfer of health summaries and relevant health records to community prescribers or others assisting in planning or providing for services on release. One way to do this is to give the patient a written continuity of care document that has relevant information such as problem lists, medications, allergies, procedures, and test results.

Programs where community health professionals contact patients in preparation for release are very effective not only in providing the health services needed but also in fostering medication adherence. Establishing therapeutic relationships with community health professionals before release and making formal preparations that focus on transition to the community may also help reduce recidivism.