Adult Custody Policy

9.6.6. Methadone and Suboxone distribution

1. Administration of methadone and Suboxone is monitored so as to limit the opportunity for diversion.

2. Administration of methadone and Suboxone is directly observed by a health care professional.

3. Inmates receiving methadone or Suboxone treatment are frisk searched prior to the distribution of methadone or Suboxone s.15

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4. Inmates are directly monitored for a minimum of 20 minutes by correctional staff following the ingestion of methadone to prevent diversion.

5. Inmates are directly monitored for a minimum of 10 minutes by correctional staff following the ingestion of Suboxone to prevent diversion.

6. Correctional centres maintain procedures that ensure compliance and consistency of practice regarding the distribution of methadone and Suboxone according to provincial policy. Refer to sections 10 and 11, *Health Care Services Manual* for more information regarding methadone and Suboxone distribution.

Health Care Services Manual

10. Methadone *10.1. Methadone maintenance treatment (revised: Dec-12)*

1. The Adult Custody Division makes methadone available to inmates who are admitted to a centre on a recognized methadone maintenance treatment program.

2. Health care staff working in correctional centres of the Corrections Branch are expected to be familiar with, and adhere to, the principles and procedures described in the most recent version of the *Methadone Maintenance Handbook*, which is published by the College of Physicians and Surgeons of B.C.

3. Patients on methadone are housed in centres that offer a daily nursing presence.

4. Inmates who qualify for admission to the B.C. Methadone Maintenance Program and express a desire to participate should be considered according to the criteria outlined in section 1

10.2. Physician communication (revised: Dec-12)

Patients verified to be on a methadone program at the time of admission are eligible for continued methadone treatment while incarcerated. Verification of current methadone treatment is confirmed by contacting the College of Physicians and Surgeons of BC or the patient's community methadone prescriber. When these options are not readily available, a review of the patient's PharmaNet profile is used as verification. Whenever possible, methadone treatment is not interrupted or delayed.

10.3. Methadone orders and documentation (revised: Dec-12)

1. Methadone is ordered by a physician who has a current authorization to prescribe methadone from the College of Physicians and Surgeons of BC. It is the responsibility of physicians providing contracted services to the Corrections Branch to ensure they have the necessary authorization. To facilitate continuity of care, methadone prescriptions written by Vancouver Jail physicians are accepted, as written, until reviewed by the receiving centre physician.

2. Methadone orders are written on the BC Duplicate Prescription forms.

3. Methadone, including contingency methadone stock, is counted at least daily with other controlled drugs. Discrepancies are immediately reported to the P.D.C. Pharmacy.

10.4.Methadone initiation (revised: Dec-12)

The medical director, Corrections Branch, is consulted before treatment with methadone is initiated. Methadone initiation takes place according to the following criteria and procedures:
1. The patient qualifies for the methadone maintenance treatment program (MMP) according to the criteria outlined in the most recent version of the College of Physicians and Surgeons of B.C. *Methadone Maintenance Handbook.*

2. The patient indicates an interest in participating in the methadone program. Once accepted, the patient consents to following the rules of the program and signs a Methadone Maintenance Treatment Patient Agreement before starting methadone.

3. Remanded individuals or inmates with short sentences are eligible for methadone initiation subject to the opinion of the treating centre physician and after discussion with the medical director, Corrections Branch. The anticipated length of stay in custody must be long enough to incrementally dispense a medically safe dose and stabilize the maintenance dose.

4. Before an inmate starts methadone treatment, a methadone physician in the community commits, in writing, to undertake the care of the patient upon release.

5. Anyone with a history of cardiovascular disease, currently on drugs that prolong the QT interval, or other indications for electrocardiogram (ECG) monitoring should have an electrocardiography study completed prior to commencing methadone treatment, and at appropriate intervals thereafter. For patients with no other risk factors for cardiac arrhythmia, it is recommended that an ECG be recorded if the dose of methadone exceeds 150 mg and that this be repeated as clinically indicated.

6. The treating centre physician is trained and experienced in the practice of methadone induction and prepares a written treatment plan using the Corrections Branch Methadone Maintenance Treatment Initiation Plan. The completed form is sent to the medical director, Corrections Branch, for discussion prior to initiating methadone. This plan outlines, among other important treatment components, the:

- Starting dose;
- Frequency and type of patient monitoring to be carried out;
- Anticipated benefits of methadone for the patient; and
- Frequency of physician follow-up during initiation.

7. Once methadone is initiated, a medical practitioner may declare the patient medically unfit for transfer as detailed in section 4.13, *Adult Custody Policy*, until his/her condition is stable and the maintenance dose of methadone is established. In the rare instance when transfer to another centre is contemplated, the receiving centre is consulted in advance and the treatment plan is discussed with the receiving physician. Before patient transfer can take place, the receiving physician must agree to undertake the care of the patient and continue methadone initiation. The medical director, Corrections Branch, is notified of the transfer of a patient undergoing methadone initiation.

8. Prior to starting methadone, the pharmacist is consulted regarding any possible interactions between methadone and other medications currently prescribed for the patient.

9. A urine drug screen is completed prior to starting methadone and includes testing for opiates, cocaine, amphetamine, benzodiazepines and methadone metabolites to verify recent or current drug abuse. The absence of opioids in the urine during assessment does not preclude admission to the MMP if the assessment confirms that methadone maintenance treatment is appropriate.

10. During the methadone initiation phase, a random urine drug screen is completed weekly until the maintenance dose is reached. Following this phase, frequency of urine drug screens are determined by the treating centre physician and written into the treatment plan. All drug screen results are recorded in the Primary Assessment and Care (PAC) inmate health information system.

11. A Frequent Monitoring Record is completed in PAC for all patients undergoing methadone initiation. A nurse reviews and records vital signs and evidence of methadone side effects daily in PAC. This record includes respiratory rate, level of alertness and pupillary size, and ideally occurs at four hours post-ingestion of a methadone dose (peak serum methadone level). Any concerns regarding decreased level of consciousness or respiratory rate are reported to the on-call or treating centre physician immediately. Frequent monitoring is discontinued when the patient has reached an effective maintenance dose, and there have been no dose adjustments within the last seven days.

12. As in the case of methadone maintenance, the methadone dose is withheld from any patient exhibiting signs of somnolence or intoxication. When the dose is withheld, the treating centre physician is notified as soon as practical. The treating centre physician reviews and adjusts the treatment plan accordingly. All changes are recorded in the health care record in PAC.

13. Regular consultations with the medical director, Corrections Branch, are mandatory for all complex cases.

14. The treating centre physician reviews and examines the patient prior to any dose increases. Advance prescriptions for methadone dose increases are not written.

15. The co-ordination of urine testing and treatment, follow-up appointments and progress of new methadone patients are reviewed at least weekly by the health care manager at the centre.

10.5.Methadone distribution (revised: Dec-12)

1. Methadone is not administered without first consulting the patient's photograph to ensure correct identity prior to each methadone dose. In centres utilizing identification bar codes, the bar code is scanned and matched to the bar code on the medication.

2. Administration of methadone occurs in the morning and is undertaken by a health care professional. The methadone dose is followed by one full glass of water (8oz/250ml), inspection of the patient's mouth to ensure swallowing of the entire dose, and then direct observation by correctional staff for a minimum of 20 minutes to reduce the risk of diversion.

3. Each dose of methadone administered is charted on the patient's PAC Medication Record Set and Methadone Drug Control forms. Completed Methadone Drug Control form(s) are faxed to the P.D.C. Pharmacy for stock monitoring.

4. When methadone patients are unable to receive the prescribed methadone dose in the morning due to a court appearance or transfer, arrangements within each centre are made for them to receive the methadone in the evening of the same day when possible. When methadone patients reach health care prior to 6 p.m. and it is verified that the methadone dose was not given that morning, they receive the full prescribed dose. When methadone patients reach health care between 6 p.m. and 10 p.m. and it is verified that the methadone dose was not given that morning, half of the prescribed dose is given to them. A methadone dose is not given after 10 p.m. A return to usual dosing the next morning occurs when possible. When methadone patients do not receive any methadone doses for three days, they are seen by a physician to have their methadone dose reviewed.

10.6.Addiction counselling (revised: Dec-12)

All patients on methadone are referred for addiction therapy and counselling.

10.7.Withdrawal (revised: Sep-15)

1. Patients who wish to decline methadone treatment or have been discharged from the methadone maintenance treatment program (MMP) are placed on a methadone withdrawal protocol. The College of Physicians and Surgeons of B.C. indicates that "the maximum weekly reduction of methadone should be no more than five percent of the total dose in order to minimize withdrawal symptoms and the risk of relapse. Tapered dosages should be undertaken as a trial of weaning off methadone. Patients who relapse to opioids or decompensate in other aspects of their lives during or after the trial of weaning should be offered re-entry to MMP and re-stabilized. Patients should not be penalized for unsuccessful weaning from MMP."
2. When involuntary withdrawal of methadone is considered, the Corrections Branch medical director is consulted regarding a tapering schedule.

3. In all cases where methadone must be tapered, whether voluntarily or involuntarily, the tapers must be safe, humane and provide regular withdrawal assessment using the COWS assessment tool and appropriate, effective adjunctive symptom relief therapy.

10.8. Disposal (revised: Dec-12)

Expired or unused methadone is sent to the P.D.C. Pharmacy for disposal.

10.9.Discharge from Corrections (revised: Dec-12)

1. To ensure methadone therapy continues after the patient is discharged from a correctional centre, an individualised discharge plan is formulated.

2. When informed of a patient's planned discharge date, the health care professional contacts the patient's community methadone physician and arranges an appointment, preferably for the actual date of discharge. If this is not feasible, the correctional centre physician writes a methadone prescription and faxes it to the patient's designated community pharmacy. The prescription covers the time period up to and including the day the patient is able to see his/her community methadone physician (i.e. no longer than seven days).

3. Patients are not given methadone to take with them upon discharge.

4. Discharge methadone prescriptions are faxed directly to the patient's designated pharmacy. The original is mailed, not given to the patient.

5. A methadone transfer form is completed and faxed to both the College of Physicians and Surgeons of B.C. and the community methadone physician.

11. Suboxone

11.1. Introduction

Suboxone does not replace methadone for the treatment of opioid dependency, but there are situations when this treatment modality is considered. Suboxone sublingual tablets are only prescribed by physicians who have experience in substitution treatment of opioid drug dependence. Suboxone is only prescribed under the following circumstances:

• The physician must have a methadone maintenance exemption. Intrinsic in obtaining and maintaining a methadone maintenance exemption is education and experience in substitution treatment of opioid drug dependence.

• Physicians must have completed the online education module by Schering-Plough Canada available at *www.suboxonecme.ca*. Completion of this module is based on an honour system, and is not verified except in unusual circumstances.

11.2. Suboxone maintenance treatment

1. The Adult Custody Division makes Suboxone available to inmates who are admitted to a centre on a recognized Suboxone maintenance treatment program.

2. Health care staff working in correctional centres are familiar with, and adhere to the principles and procedures described in, the most recent version of the *Methadone Maintenance Handbook* that is published by the College of Physicians and Surgeons of B.C.

3. Patients on Suboxone are housed in centres that offer a daily nursing presence.

4. Patients on Suboxone sign a Suboxone Maintenance Treatment Patient Agreement.

11.3. Suboxone initiation

1. There are some clinical circumstances when the physician may wish to initiate Suboxone treatment, or convert a patient from methadone to Suboxone, as in the case of a patient with a prolonged QT interval or a patient at high risk of a prolonged QT interval.

2. Suboxone initiation follows the same process as outlined in section 10.4 (with the exception of subsection 10.4(5)) and is completed in consultation with the medical director, Corrections Branch.

11.4. Physician communication

A patient on Suboxone at the time of admission continues on this medication, provided the treating physician in the community (i.e. the patient's primary Suboxone prescriber) or a review of the patient's current PharmaNet profile confirms the patient's treatment status. Whenever possible, Suboxone treatment is not interrupted or delayed.

11.5. Suboxone orders and documentation

1. Suboxone is ordered by a physician who is contracted through the current health services provider and authorized by the College of Physicians and Surgeons of B.C. to prescribe Suboxone.

2. Suboxone orders are written on BC Duplicate Prescription forms.

3. Suboxone, including contingency stock, is counted at least daily with other controlled drugs. Discrepancies are immediately reported to the P.D.C. Pharmacy.

11.6. Suboxone monitoring

1. A urine drug screen for methadone or methadone metabolite (EDDP), buprenorphine, cocaine, opiates, amphetamines and benzodiazepines is completed prior to continuation of Suboxone maintenance treatment.

2. A Frequent Monitoring Record is completed in the Primary Assessment and Care (PAC) inmate health information system for all patients continuing on Suboxone maintenance treatment. A nurse reviews and records vital signs and evidence of Suboxone side effects daily in PAC. This record includes respiratory rate, level of alertness and pupillary size, and ideally occurs at three hours post-Suboxone dose (peak serum Suboxone level). Any concerns regarding decreased level of consciousness or respiratory rate are reported to the on-call or treating centre physician immediately. Frequent monitoring is discontinued when the patient has reached an effective maintenance dose, and there has been no dose adjustment within the last seven days.

3. Random urine drug screens are performed, at minimum, every four weeks during the period of incarceration. Any screens positive for illicit substances other than buprenorphine require review and discussion with the treating centre physician before distribution of more Suboxone dosing.

4. The Suboxone dose is withheld from any patient exhibiting signs of somnolence or intoxication. When the dose is withheld, the treating centre physician is notified as soon as practical. The treating centre physician reviews and adjusts the treatment plan accordingly. All changes are recorded in the health care record in PAC.

11.7. Suboxone distribution

1. Suboxone is not administered without first consulting the patient's photograph to ensure correct identity prior to each dose. In centres utilizing identification bar codes, the bar code is scanned and matched to the bar code on the medication.

2. Administration of Suboxone occurs in the morning and is undertaken by a health care professional. The dose of Suboxone is preceded by one full glass of water (8oz/250ml). In direct view of the health care professional, the patient places the Suboxone under the tongue and allows it to dissolve. Direct observation by correctional staff occurs for a minimum of 10 minutes to reduce the risk of diversion. Inspection of the patient's mouth occurs following this period, to ensure the medication has completely dissolved.

3. Each administered dose of Suboxone is charted on the patient's Primary Assessment and Care (PAC) Medication Record Set and Suboxone Drug Control forms. Completed Suboxone Drug Control forms are faxed to the P.D.C. Pharmacy for stock monitoring.

11.8.Addiction counselling

All patients on Suboxone are referred for addiction therapy and counselling.

11.9.Withdrawal (revised: Sep-15)

1. All patients who voluntarily or involuntarily discontinue a Suboxone maintenance program are offered the opportunity of a graduated withdrawal from the program.

2. If abrupt discontinuation of Suboxone maintenance treatment is considered, the medical director, Corrections Branch is consulted.

3. In all cases where Suboxone must be tapered, whether voluntarily or involuntarily, the tapers must be safe, humane and provide regular withdrawal assessment using the COWS assessment tool and appropriate, effective adjunctive symptom relief therapy.

11.10. Disposal

Expired or unused Suboxone is sent to the P.D.C. Pharmacy for disposal.

11.11. Discharge from correctional centre

1. To ensure Suboxone maintenance treatment continues after the patient is discharged from a correctional centre, a discharge plan is formulated on an individual basis.
2. When informed of a patient's planned discharge date, the health care professional contacts the patient's community Suboxone physician and arranges an appointment, preferably for the actual date of discharge. If this is not feasible, the correctional centre physician writes a Suboxone prescription and faxes it to the patient's designated community pharmacy. The prescription covers the time period up to and including the day patients are able to see their community Suboxone physician (i.e. no longer than seven days).

3. Patients are not given Suboxone to take with them upon discharge.

4. Discharge Suboxone prescriptions are faxed directly to the patient's designated pharmacy. The original is mailed, not given to the patient.

11.12. Suboxone for rapid opiate detoxification (revised: Oct-15)

Suboxone can be used as a short-acting opioid medical detoxification. It is used to minimize withdrawal symptoms from short-acting opioids, reduce the risk of medical complications, reduce transfers to hospital, and improve patient outcomes on admission to a provincial correctional centre.
1. A comprehensive patient assessment is performed by nursing staff during the admission process when the initial health assessment (IHA) is completed.

2. If there is a potential for alcohol and/or opiate withdrawal, a Clinical Institute Withdrawal Assessment of Alcohol – revised Scale (CIWA-Ar) form and a Clinical Opiate Withdrawal Scale (COWS) form is completed. Chart the CIWA-Ar and COWS scale results in the IHA in Primary Assessment and Care (PAC) inmate health information system.

If the CIWA – Ar (Alcohol) scale is:
• 10 or greater, call the physician for an Alcohol Withdrawal Protocol; or
• greater than 15, contact the physician URGENTLY.

If the COWS (opiate) score is:
• 13 or greater, call the physician for a Suboxone Withdrawal Protocol;
• 3 or greater for the GI section, call the physician for a Suboxone Withdrawal Protocol; or
• greater than 24, contact the physician URGENTLY.

3. The Suboxone Withdrawal Protocol is not prescribed concurrently with the Alcohol Withdrawal Protocol.

4. A urine drug screen (UDS) is completed. Chart the UDS result in PAC.

5. The patient must be free from short-acting opioids for at least 12 hours.

6. Discuss the patient's condition with the physician and obtain orders to start on the Suboxone Withdrawal Protocol.

7. Obtain the patient's informed consent.

8. Educate the patient about Suboxone and give them the Suboxone patient information sheets.

Explain that:
• The tablet must completely dissolve under the tongue
• They will be observed for a minimum period of 10 minutes to ensure the risk of diversion is reduced
• Withdrawal symptoms will improve in 20-30 minutes.

9. After obtaining a physician's order, initiate the 4 day withdrawal protocol:
• Day 1: 8 mg Suboxone sublingually
• Day 2: 8 mg Suboxone sublingually
• Day 3: 6 mg Suboxone sublingually
• Day 4: 2 mg Suboxone sublingually

10. Suboxone distribution occurs in the morning. Follow the process as described in section 11.7.

11. If the first dose is given stat, continue with the second dose the next morning.

12. A Frequent Monitoring Record is completed in PAC for all patients undergoing rapid opiate detoxification using Suboxone. A nurse reviews and records vital signs and evidence of withdrawal symptoms daily in PAC for each of the three days duration of the protocol.

13. A withdrawal episode is created in PAC.

14. Ensure the patient remains hydrated for the duration of the protocol.

15. Refer patient to the treating centre physician on the third day as needed.

16. Repeat the COWS on day 4 and day 8, and document in PAC.

17. Contact the on-call or treating centre physician for any urgent problems.