Correctional Service of Canada: Specific Guidelines for Methadone Maintenance Treatment

Prepared by
Correctional Service of Canada
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(This version supersedes previous versions)

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Tables and Checklists

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Correctional Service of Canada would also like to recognize the professional contribution of various community practitioners and their professional organizations. Incorporation of their input allows for a more consistent approach to methadone delivery across the country.

Section A: GENERAL BACKGROUND ON OFFENDERS AND SUBSTANCE ABUSE

Section A: General Background on Offenders and Substance Abuse

Drug Abuse. Approximately 67% of offenders in federal prisons have substance abuse problems. For approximately 20% of these offenders, the problem is serious and requires substantive treatment. These offenders are more likely to engage in poly-drug use and a variety of high-risk behaviours such as injection drug use. For example, 35% of federal offenders reported using heroin in the six months prior to their arrest; heroin and cocaine are the drugs that are injected most frequently. Research consistently indicates that, as with other forms of substance abuse, IV drugs users are over-represented in correctional populations. In addition, research has established that virtually all incarcerated heroin addicts, if not treated, will return to using heroin on release.

High Risk Activities. People admitted to correctional facilities are more likely to have engaged in high-risk behaviours such as injection drug use, or exchange of sex for money, food, shelter, or drugs. Also, while in prison, a proportion of inmates continue to engage in high risk behaviours such as needle sharing for injection drug use (IDU), non sterile tattooing, and unprotected sex. These individuals are at a higher risk for HIV and HCV infection than the general population of Canada. The cycle of heroin use, crime, arrest, imprisonment and now, blood borne infection, is evident in the lives of opiate addicts.

HIV Increase. Between 1989 and 2001, the number of HIV positive inmates has gone from 24 to 223. Overall in 2001, 4.7% of female inmates and 1.7% of all male inmates were reported to be HIV positive. This represents a rate close to ten times higher than in the Canadian population (1.8% vs. 0.1%)

Hepatitis C Increase. In the case of Hepatitis C, 2,993 inmates were known to be HCV positive as of year-end 2001. This represents an increase of 451 known cases from 2000. The prevalence of HCV infection among Canadian inmates is much higher than in the general population (23.2% vs. 0.8%).

Solution-oriented Initiatives. CSC, as part of the Canadian Strategy on HIV/AIDS and in partnership with Health Canada, has implemented several initiatives aimed at preventing the transmission of infectious diseases and at reducing the harms associated with risky behaviours. For example, CSC currently provides the following:

- confidential voluntary testing for infectious diseases with pre and post test counselling to offenders, on admission and throughout incarceration
- educational materials and programs for offenders and staff
- condoms, dental dams, water based lubricants and bleach in all institutions
- appropriate care, treatment, and support for inmates with infectious diseases
- immunizations for Hepatitis A and Hepatitis B
- Methadone Maintenance Treatment
- Substance Abuse Programs

Issues and Concerns/Strategies

The high proportion of offenders with substance abuse problems and the prevalence of infectious diseases in federal prisons raise several concerns.

- greater demand for appropriate care, treatment and support for offenders infected with HCV and HIV
- increased risk to staff, other inmates and visitors of disease transmission in the event of exposure to blood or body fluids
- increased risk to public health and safety upon reintegration of the offender into the community
- increased risk of re-incarceration due to the relationship between substance abuse and criminal behaviour

In order to address these concerns, CSC has adopted a balanced approach to the issue of offender substance abuse by focusing on reducing the supply of, and demand for, drugs among offenders, as well as supporting the development of harm reduction strategies to reduce the negative consequences associated with drug use.

> **Supply reduction strategies** aim to prevent the entry of drugs into federal institutions. They include searching visitors and offenders, and using drug-detection dogs and ion scanners.
>
> **Demand reduction strategies** include allowing the offender to live on a specialized Intensive Support Unit that provides a positive and supportive environment aimed at assisting the offender in achieving a drug-free lifestyle.

Harm Reduction Approach

CSC Substance Abuse Programs are firmly based on the **harm reduction approach**. As a result, total abstinence is not a required outcome for offenders' participation in methadone treatment. Accordingly, reduced or controlled use of alcohol and other drugs is considered a positive step in the process of gradual disengagement from problematic substance use. Preliminary evidence indicates that offenders whose post-treatment goal was to moderate their use were readmitted for new offences at a significantly lower rate than offenders who were attempting to abstain from all intoxicants.

Although abstinence from risky behaviours is undoubtedly the most desirable goal, this may not be achievable or desirable for the person in the **risky situation**. Therefore, rather than focusing on abstinence as the only worthwhile treatment goal, the harm reduction approach focuses on minimizing the consequences of the risky behaviour. Consequently, the person is educated on how to minimize the negative consequences of their risky behaviours and, depending on the circumstances, provided with the means to achieve this.

The harm reduction approach is based on the following principles.

- Recognize the problem.
- Retain a value-neutral view of the activity or of the person (without judgement).
- Focus on the problem.
- Understand that abstinence is the best goal but not immediately achievable for everyone.
- Recognize the client's role and rhythm.

As an example, the sex trade poses significant harm to the health of prostitutes, their clients, and the public at large, by contributing to the spread of sexually transmitted diseases, particularly HIV. Although the sex trade cannot be fully eradicated in Canadian society, education and awareness programs on the use of condoms, and the provision of free condoms to street workers, can help eliminate the harms associated with this risky practice.

As can be seen from this illustration, the success of the harm reduction approach is based on the maintenance of a value-neutral view of the behaviour and of the person (e.g., the sex trade worker). Harm reduction is a social framework that seeks to decrease the negative consequences associated with risky behaviours, including injection drug use, tattooing and unprotected sex.

In correctional facilities around the world, the harm reduction approach is being recognized as an effective approach to addressing risky behaviours, including injection drug use. For example, the following harm reduction approaches have been adopted in various correctional jurisdictions and in the community.

- safer sex education
- use of condoms and dental dams
- safer injection drug use information
- methadone maintenance treatment
- bleach kit programs
- safe tattooing practices
- needle exchange programs

Substance Abuse Programs

In terms of programming, CSC's Substance Abuse Programs consist of a range of institutional- and community-based programs that are matched to the severity of the offender's substance abuse problem. The national programs are cognitive-behavioural in orientation and include a strong emphasis on structured relapse-prevention techniques. Skill development, using a variety of techniques such as role-playing, problem-solving, and graduated practice, is the focus of attention. In addition, the programs incorporate "motivational enhancement" techniques (Prochaska and DiClemente 1995; Miller 2002) as a fundamental way of working with offenders in an effort to maximize their readiness for, and commitment to, behaviour change. Taken together, these approaches are drawn from the most recent developments in research and clinical practice from the non-correctional substance abuse treatment arena.

Methadone Maintenance Treatment (MMT)

Clinical Indications for the Use of Methadone in Canada

Methadone Maintenance. Daily oral ingestion of methadone over a long period of time is currently the only authorized opioid for long-term (more than 180 days) out-patient pharmacological treatment of opioid-dependent persons.

Detoxification. Detoxification using methadone is the administration of gradually decreasing doses over a period not exceeding 180 days. This process permits weaning and avoids the onset of withdrawal symptoms such as mydriasis (dilated pupils), piloerection (goose-flesh), vomiting, restlessness, and rhinorrhea (runny nose).

Analgesia. Methadone may be used in pain relief in some cases.

Health Canada, Drugs Directorate Guidelines

Note: The focus of methadone use within CSC is "maintenance" as described in *CSC: Specific Guidelines for Methadone Maintenance Treatment.*

Methadone Maintenance Treatment (MMT) is the most effective treatment for individuals with serious heroin and other opioid addictions, where the route of choice is intravenous. The goal of MMT is to reduce the negative consequences of opioid addiction and injection behaviours. Maintained on MMT, many opioid addicts have accomplished the following:

- stopped using needles
- seen dramatic improvement in their overall health
- returned to their work and families
- decreased their criminal behaviour and incidence of incarceration
- extended their life expectancy

(Note that for some people methadone is a life long treatment.)

The administration of methadone to heroin addicts on a maintenance basis has been a recognized medical intervention since the early 1960s. It is consistent with the harm reduction approach adopted in other jurisdictions, including the United States, Australia and several European countries. For example, MMT is available in correctional facilities in Germany, Denmark, Australia, Spain and Switzerland and at the correctional complex on Riker's Island in New York City. In addition, British Columbia Provincial Corrections have provided MMT to opioid-addicted offenders since 1996.

Experiences in these jurisdictions have demonstrated the following results.

- reduction in injecting and needle sharing in prison when MMT is available
- decrease in drug-related prison violence
- decrease in crime following release
- easier management of those inmates

Providing MMT to opioid-addicted offenders will contribute towards meeting CSC's Corporate Objectives related to offender reintegration and health of offenders, staff and the general public.

Section B: METHADONE MAINTENANCE TREATMENT IN CSC

Section B: Methadone Maintenance Treatment in CSC

Methadone Maintenance Treatment (MMT) within CSC is a comprehensive and integrated program for intravenous opioid-addicted inmates/offenders. It integrates the medical management of the inmate/offender with existing institutional and community-based substance abuse treatment programs and services.

CSC: Goals and Objectives of MMT

The **goal** of MMT is harm reduction, not abstinence, in order to minimize the adverse physical, psychological, social, and criminal effects associated with opioid use, including the spread of HIV and other infectious diseases in CSC institutions and in the community.

Note that in CSC, MMT is never initiated for the purposes of analgesia (pain control) or detoxification.

The **objectives** of MMT are the following.

- Decrease the number of intravenous injections.
- Reduce relapse to opioid drug use.
- Improve the state of health and quality of life of inmates/offenders.
- Assist and motivate inmates/offenders to gradually disengage from all illicit drug use.

Some of the **anticipated outcomes** of MMT are the following.

- Reduction in the transmission of HIV and other blood-borne pathogens in the inmate population due to decreased sharing of injection equipment.
- Promotion and protection of the health and safety of inmates/offenders, corrections staff, and communities upon release.
- Reduction of drug use and trafficking, institutional violence, and criminal activity associated with illicit drug use and trafficking, during prison terms and after release.
- Assistance to inmates/offenders to effectively manage their lives and to successfully reintegrate into the community.

CSC: Admission Criteria and Quality Assurance for MMT

Methadone providers have a responsibility to ensure quality care for methadone recipients congruent with the guidelines of their respective Provincial Colleges of Physicians and Surgeons or Health Canada (for provinces without separate methadone guidelines). Keeping this in mind, CSC has incorporated key information from those guidelines in this document.

To ensure their MMT is delivered in a safe and responsible manner, each provider must ensure their number of methadone recipients does not exceed their ability to provide the mandated parameters of care, support, and monitoring for each recipient. This will be a dynamic process as the capacity situations within institutions and regions change due to the ever-changing profile of each participant on MMT. Staff familiarity with MMT and increasing numbers stabilized on the treatment, will allow for consideration of new initiations.

The number of inmates that an institution and/or region can accommodate on MMT can vary based on the following:

- transfer or release of methadone recipients
- number of "stable" and "non-stable" methadone recipients
- voluntary or involuntary tapers
- institutional capacity to safely implement MMT
- funding for additional institutional resources

In most communities, including CSC, demand for methadone programs currently surpasses providers' ability to supply the service. However, methadone treatment **must** be initiated for inmates who meet both the General Admission Criteria below *and* the Priority Admission Criteria.

General Admission Criteria

General Admission criteria include *all* of the following.

- Diagnosis of dependence to opiates, where the route of choice is intravenous, as established in the DSM-IV (See Appendix D) *or* a well-documented history of opiate addiction indicating a high risk of relapse, as confirmed by a certified institutional physician; and
- A small likelihood of benefit from non-methadone treatment as evidenced by a past history of treatment failures; and
- Agreement to terms and conditions of Methadone Maintenance Treatment as evidenced by acceptance and willingness to sign the *MMT Agreement (CSC/SCC 1260-05)*.

Priority Admission Criteria

Priority Admission Criteria include *any* of the following

Note: Those assessed as meeting both general and priority admission criteria should always be started on methadone without delay.

- Female inmates who are pregnant and currently opioid dependent or were previously opioid dependent, and are at a high risk for relapse. (Highest Priority)
- Inmates who are HIV positive *and* currently opioid dependent.
- Inmates who have been determined to require treatment for Hepatitis C. (Prior to initiation of Hepatitis C treatment, a period of abstinence from all drugs, including alcohol, is required. However, methadone may be taken.)
- Inmates who are currently opioid dependent with a recent history (within the past 3 months) of a life-threatening opiate overdose, endocarditis, septicemia, septic arthritis, and/or suicidal behaviour directly related to their opiate dependence.
- Inmates who are opioid dependent and who will be released within the next 6 months with established release plans for a community methadone provider.

Admission Criteria Issues

Admitted to CSC — On Methadone

Inmates generally enter CSC institutions from Provincial Correctional Centres but may enter directly from the community or remand centres in certain circumstances (e.g., international transfer, parole violation, or temporary detainee).

- *Admission Criteria:* General

Note: Inmates who enter CSC already on methadone must undergo the same assessment process as inmates who apply for methadone initiation within CSC. For those entering CSC already on methadone, the MMT is continued throughout the assessment process (if confirmation of participation in MMT is obtained).

Admitted to CSC Reception Centres — Not on Methadone

CSC Reception Centres receive the majority of inmates transferred from Provincial Correctional Centres. These inmates typically do not stay in the CSC Reception Centres for more than 2–3 months before penitentiary placement and transfer to their parent CSC institution.

The instances where an inmate is initiated while at CSC Reception Centres should be rare. In most cases initiation should begin at the parent institution.

Of those who meet priority criteria, pregnant inmates with a current opiate addiction and HIV positive inmates with a current opiate addiction should be considered the highest priority. These inmates should undergo assessment for and initiation of methadone maintenance treatment (with their consent) prior to transfer to their parent institution.

- *Admission Criteria:* Priority and General

Admitted to Temporary Detention Units — Not on Methadone

Circumstances may develop where an offender who has not been on MMT is suspended from parole and placed in the Temporary Detention Unit because of escalating risk that involves opiate abuse.

Offenders who meet the criteria for MMT and who are suspended and incarcerated as temporary detainees may, time permitting, be initiated on methadone prior to release. If the duration of incaceral time does not permit enough time to fully assess the offender for methadone involvement, methadone can be included in release plans.

- *Admission Criteria:* Priority and General
  (specifically **"**Inmates who are opioid dependent and who will be released within the next 6 months with established release plans for a community methadone provider.")

Table 1: CSC "Stable" and "Non-Stable" Monitoring Guidelines

"Non-Stable" Monitoring Guidelines	"Stable" Monitoring Guidelines
Criteria	***Criteria***
A methadone recipient is considered "non-stable" if **ANY** of the following apply. (An individual who is stable can become non-stable if any of these criteria become applicable.) • He/she is in the first 3 months of MMT. • He/she entered CSC on methadone and has been in CSC for less than 3 months (even if he/she was considered "stable" outside of CSC). *For inmates who have been on MMT in CSC for more than 3 months (whether he/she began methadone in CSC or outside of CSC).* • He/she has had a urine drug screen in the last 3 months that was positive for non-prescribed medications and/or has refused to provide a specimen in the last 3 months. • His/her dosage has increased equal to or greater than 10 mg in the last month **due to patient reports of withdrawal symptoms.** • He/she has reported at least one unobserved vomited dose in the past month. • He/she is not complying with any part of his/her *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03).* • He/she has contravened the rules of the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* in the last 3 months. • There is a strong suspicion by any member of the MIT or direct care provider (nurse issuing methadone and/or monitoring urine sample collection) that the inmate has diverted doses of methadone and/or tampered with urine specimens. • He/she is on a voluntary or involuntary taper from MMT.	A methadone recipient is considered "stable" if **ALL** of the following apply. • He/she has been on methadone for at least 3 months within CSC. • He/she has had negative urine drug screens for 3 months and has not refused to provide a urine specimen in the last 3 months. • His/her methadone dosage has not increased by greater than 10 mg in the past month. • He/she has complied with all aspects of his/her *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* for a period of 3 months. • He/she has complied with all aspects of the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* for a period of 3 months. **Notes:** A "stable" methadone recipient can become "non-stable" if any of the criteria outlined in "'Non-Stable' Monitoring Guidelines occur. Any MIT member who becomes aware of such occurrences must notify the OPI to have an urgent MIT meeting called. The physician does not have to wait for the MIT meeting to increase frequency of urine drug screens or physician visits.

"Non-Stable" Monitoring Guidelines	"Stable" Monitoring Guidelines
Minimum requirements	***Minimum requirements***
The following minimum requirements apply for a methadone recipient who has… - entered CSC on methadone within the last 3 months *or* - initiated methadone within CSC in the last 3 months • Random urine drug screen twice a week (for opiates, cocaine, benzodiazepines, and methadone metabolites) • Physician visits every week • MIT meeting every month • High Frequency sessions, or other substance abuse treatment, as recommended by the correctional programs officer (e.g., once a week). The following minimum requirements apply for a methadone recipient who has… - been in CSC more than 3 months *and* - has been on MMT more than 3 months. • Random urine drug screen every 1–2 weeks for opiates, cocaine, benzodiazepines, and methadone metabolites • Physician visits every 1–2 weeks • MIT meetings every 1–2 months • High Frequency to Moderate Frequency sessions, or other substance abuse treatment, as recommended by the correctional programs officer (e.g., every 1–2 weeks). **Notes:** The above are minimum requirements and depend on the reason for which the inmate is designated as "non-stable" by the MIT. For example, if the reason is a positive urine drug screen, the MIT may wish to do random urine drug screening once or twice a week. If the reason is that the inmate is not showing up for counselling sessions, but is compliant with Health Services requirements, the MIT may wish to do random urine drug screening and physician visits every two weeks.	The following minimum requirements apply for the stable methadone recipient. They are applicable as long as the client remains on MMT. • Random urine drug screen every 2 weeks for opiates, cocaine, benzodiazepines, and methadone metabolite • Physician visits every 3–4 weeks • MIT meetings every 3 months • Low Frequency sessions with the correctional programs officer, or other substance abuse programs recommended by the correctional programs officer (e.g., once a month).

CSC: Methadone Intervention Team (MIT)

ⓘ See also Section C: Specific Responsibilities of CSC's MIT Members.

A Methadone Intervention Team (MIT) is established for each inmate/offender who is admitted to Methadone Maintenance Treatment (MMT). This team is not a new structure but rather integrates into and builds on existing CSC structures and processes, including an inmate's/offender's case management team and Correctional Plan.

The MIT is a multidisciplinary team mandated to coordinate the delivery of MMT in CSC operational units and to ensure seamless continuity of MMT between institutional and community settings.

All team members are expected to share the following aspects.

- Team member has something to offer the team.
- Team member stands to gain from the experience.
- Team member will negotiate differences of opinion toward a common treatment goal.
- Team member will respect the team process and other members.
- Team member will understand the theory of the Harm Reduction Model.

The responsibilities of the *institutional* team include the following.

- Assess the inmate for admission to MMT. Members of the team will ensure that the application process does not exceed 45 working days.
- Complete the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* with the inmate.
- Complete the MMT assessment process.
- Conduct an Initial Case Conference, MIT meetings, and on-going monitoring and interventions as required.
- Develop the inmate's *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* and coordinate its implementation.
- Establish and periodically review the institution's methadone access log, where required.
- Establish links between institutional and community MMT programs, prior to release or on suspension of conditional release.
- Assess the inmate for termination of MMT
- Participate in such correctional processes as risk assessment and release planning.
- Notify the OPI if an assessment indicates that the inmate is not a candidate for MMT. Any member of the MIT may do this. This applies even to inmates admitted to CSC on methadone. The OPI will schedule an MIT meeting to discuss this.

Institutional MIT Members

- The **Inmate** voluntarily participates in MMT and acts as a partner with members of the Methadone Intervention Team in the delivery of MMT.
- The **Institutional Parole Officer** initiates release planning, monitors institutional behaviour, and incorporates MMT into the inmate's Correctional Plan.
- The **Institutional Correctional Programs Officer** assists in the development of the substance abuse intervention component of the *MMT Plan* and coordinates the delivery of substance abuse programs and services to the inmate.
- The **Nurse** administers the clinical component of MMT in accordance with their prevention role in the management of infectious diseases and in the area of health promotion.
- The **Physician**, in consultation with other MIT members, makes all final medical decisions related to MMT, including admission, termination, and urine drug screens.
- The **Officer of Principle Interest** provides overall leadership to the MIT by coordinating all administrative and quality assurance aspects of MMT within the institution.
- The **Pharmacist** (as consultant only) is responsible for the dispensing of methadone and acts as an important resource for institutional and community nurses and physicians, in accordance with their role in heath promotion and disease prevention.
- Other staff as required (psychologist, psychiatrist, elder, and chaplain) will provide support identified as necessary by the MIT.

Community MIT Members

- The **Offender** voluntarily participates in MMT and acts as a partner with members of the Methadone Intervention Team in the delivery of MMT
- The **Community Parole Officer** provides overall leadership for the community MIT. He/she arranges for the establishment of the community Methadone Intervention Team. The **Senior Parole Officer/Case Management Supervisor** is responsible for overall quality assurance of the documentation and data entry. Offices/Units that supervise a large number of offenders who are on MMT may find it advantageous to identify a Parole Officer as coordinator. It is recognized that a reduced supervision caseload will be required, and that some additional administrative duties will result.
- The **Community Correctional Programs Officer** coordinates the delivery of substance abuse programs and services to the offender.
- The **Psychologist** (as required, CSC district or on contract)

Section C: SPECIFIC RESPONSIBILITIES OF CSC'S MIT MEMBERS

Inmate/Offender

MIT Role: To voluntarily participate in MMT and to act as a partner with members of the Methadone Intervention Team in the delivery of MMT.

Initial Assessment / Continuation of Methadone

- Tell CSC staff you would like to be on MMT.

Admitted to CSC — On methadone

- Immediately notify health services of participation in a community program and give your verbal consent to the nurse to continue on methadone.
- Sign *Release of Information* to obtain treatment history from previous community MMT provider.

- Discuss with your parole officer that you would like to apply for Methadone Maintenance Treatment.
- Submit a *Written Request* to the parole officer indicating your reasons for application to Methadone Maintenance Treatment, as well as individual goals, level of commitment, and motivation.
- Participate in the assessment process, as directed by members of the MIT.
  - ➔ Review the *MMT Agreement (CSC/SCC 1260-05)* in detail and bring questions forward to members of the MIT.
  - ➔ Sign the Section B: Agreement to Participate in Assessment Process/ Acknowledgement of Terms and Conditions for MMT of the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05).*
    - This indicates that you understand every aspect of the *MMT Agreement (CSC/SCC 1260-05)* and agree to participate in the assessment process.

Initial Case Conference *and* MMT Initiation

- Sign the Section E (page 4) of the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* thereby committing to respect the conditions outlined in it.

- Assist the MIT to develop an individualized *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* and the *Methadone Maintenance Substance Abuse Treatment Plan (CSC-SCC 1260-01)* and commit to working toward achieving identified goals.
- Inform the institutional/community parole officer of any developments, which may have relevance to MMT, especially those impacting on release planning.

MMT Administration *and* Monitoring

- Attend and participate in MIT meetings.

- Attend and participate in substance abuse treatment programs as recommended by the institutional/community correctional programs officer and in conjunction with the parole officer's recommendations.

- Follow your *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* and *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05).*

Suspension of Methadone/Readmission to MMT

- To voluntarily terminate participation in MMT, submit a *Written Request* to the physician.

- To be considered for re-admission to MMT, submit a *Written Request* to the parole officer.

Release Planning

- Participate in release planning activities as directed.

Institutional Parole Officer (PO)

MIT Role: To initiate release planning, monitor institutional behaviour, and incorporate MMT into the inmate's Correctional Plan.

Table 2: *Institutional* Parole Officer — Checklist for Initial Assessment

Items to complete *prior* to the Initial Case Conference	3
Written Request for MMT from inmate o Send to correctional program officer if inmate is applying for MMT. o Send to Health Services if inmate has been admitted to CSC already on MMT.	
If the inmate has been admitted to CSC already on methadone, place a flag on OMS.	
Give a copy of the *Methadone Maintenance Treatment Client Handbook* (or approved substitute) to inmate.	
"Agreement to Participate in Assessment Process / Acknowledgement of Terms and Conditions for Methadone Maintenance Treatment" section *of Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05, page 1)* o Signed by inmate (explain first). o Sign and send to correctional programs officer.	
Complete the *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)* with the inmate. o Send to correctional programs officer.	
Forward a copy of the following forms to the correctional programs officer: o Intake Assessment o Correctional Plan o Last Correctional Plan Progress Report	
Notify OPI that initiation process has commenced.	
Prepare to verbally highlight release plans etc. at the Initial Case Conference.	
Items to complete *during or following* the Initial Case Conference	
Verbally highlight release plans etc. at the Initial Case Conference.	
Sign *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05-page 4)*.	
Ensure integration of MMT into the inmate's Correctional Plan. o Place a flag on OMS. o Complete an OMS Memo to File summarizing Initial Case Conference. o Notify the inmate's CO II of the inmate's acceptance to MMT	

Initial Assessment / Continuation of Methadone

- Support the inmate in writing the *Written Request* for MMT.
- Ask the inmate to submit a letter to the MIT explaining their motivation, commitment, and personal goals related to MMT. If the inmate is unable to write, make arrangements for the inmate to dictate a letter for submission.
- Any staff member can identify that an inmate may be a candidate for MMT but the assessment process begins with the inmate and his/her institutional parole officer.
- The inmate must complete this letter and submit it to the parole officer prior to the Initial Case Conference.

  ➔ Forward this letter to the appropriate person as it is an essential component of the MMT assessment process.

  - <u>If the inmate has been admitted on methadone</u>, forward the letter to Health Services for incorporation into the MMT Plan.
  - <u>If the inmate is starting methadone within CSC</u>, forward the letter to the correctional programs officer as part of the assessment package.

- If the inmate has been admitted to CSC already on methadone, place a flag on OMS.

- Give a copy of the *Methadone Maintenance Treatment Client Handbook* or approved substitute to the inmate.

- Review all sections of the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* with the inmate.
- Review Section D: Terms and Conditions for Methadone Maintenance Treatment and explain the assessment process.
- Refer the inmate to the appropriate MIT member if the inmate has questions about the *MMT Agreement (CSC/SCC 1260-05)* or any aspect of MMT that the parole officer is unable to answer. The inmate must have all questions answered prior to signing this initial section. The inmate returns to the parole officer once his/her questions/concerns have been dealt with.

  ➔ Obtain the inmate's signature on the Section B: Agreement to Participate in Assessment Process/Acknowledgment of Terms and Conditions for MMT, which indicates he/she understands every aspect of the *Agreement* and agrees to participate in the assessment process.

  ➔ Sign the same section and forward the form to the correctional programs officer.

- Complete the *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)* with the inmate. (See two scenarios below.)
- This will help ascertain the following.
  - soonest possible date of release
  - location of release
  - availability of methadone in the location of release

  ➔ Forward the completed *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)* to the correctional programs officer, along with the signed *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)*, thus notifying him/her of the referral for completion of substance abuse assessment.

- It is the Parole Officer's responsibility to ensure a copy of the Intake Assessment, Correctional Plan, and last Correctional Plan Progress Report are provided to the correctional programs officer for incorporation into the inmate's methadone assessment documentation kept on the inmate's Medical Record.

- Notify OPI that the initiation process has commenced.

- Prepare to verbally highlight release plans, any contributing factors related to the inmate's substance abuse history, and current opiate addiction at the Initial Case Conference.

If methadone not available in the planned location of release

This situation arises when the inmate plans to be released to an area either without a methadone clinic *or* with a clinic, but where he or she cannot be accommodated.

Scenario: Inmate will be incarcerated* less than *six months from date of application

- If the inmate is unwilling/unable to relocate, the initiation of methadone may not be an option.

  ➔ Notify the OPI to list this inmate on the agenda for the next MIT.
    - At this meeting, present the results of the *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)*, highlighting the specific challenges to release planning and what you attempted in order to overcome the challenges.
    - The MIT will decide if the assessment process should proceed or not.

Scenario: Inmate will be incarcerated* more than *six months from date of application

- Pre-release planning, 6 months prior to release, will include evaluation of the inmate's necessity to relocate or taper off methadone.
    - Community availability of methadone is growing in many areas; therefore, relocation or taper may not be necessary.

Initial Case Conference *and* MMT Initiation

- Give a verbal summary to the MIT. Highlight release plans, any contributing factors related to the inmate's substance abuse history, and current opiate addiction at the Initial Case Conference.

- Sign the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05, page 4).*

- Ensure integration of MMT into the inmate's Correctional Plan, including the following.
  - ➔ Place a methadone flag on OMS.
  - ➔ Complete an OMS Memo to File summarizing the Initial Case Conference, indicating the inmate's acceptance into MMT, and any ensuing appropriate entries.

    OMS Memo to File: When posting an OMS Memo to File for MMT issues, please type "METH " immediately followed by the year and month as the first word in the subject line. For example "METH0310" would indicate the Memo to File was written in October 2003. This ensures all memos related to methadone are readily identifiable.

    (Note: OMS entries must not mention specific infectious diseases (e.g., Hepatitis C, HIV) because this would breach medical confidentiality).
  - ➔ **If the inmate is not accepted into MMT**, complete an OMS Memo to File outlining the reasons that the inmate was not accepted. The reasons provided should directly relate to the General and/or Priority Criteria.

- Notify the inmate's CO II and work supervisor (if applicable) of the inmate's acceptance to MMT.
- Discuss with the CO II and work supervisor (if applicable) any methadone related behaviour (e.g., persistent nodding, or somnolence) that should be reported to Health Services during initiation. Explain the need to document the inmate's behaviour on OMS, using Memo to File.

Scenario: In CSC Reception Centres and/or Temporary Detainee Units, if inmate is admitted on methadone and will be incarcerated* less than *6 months

- If an inmate will be incarcerated here for significantly less than 6 months, an MIT meeting *may* not be necessary.
- An MIT meeting is more likely to be indicated if the inmate is not complying with the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* and/or there are release planning or transfer issues that require the attention of the MIT.

MMT Administration *and* Monitoring

Monitoring guidelines pertinent to Parole Officer ⓘ For further details, see "CSC 'Stable' and 'Non-Stable' Monitoring Guidelines" in Section B. of this manual.	
"Non-Stable" Monitoring Guidelines	**"Stable" Monitoring Guidelines**
• High to Moderate Frequency sessions, every 1–2 weeks. (OMS Casework Record by Correctional Program Officer after each session.) • MIT meeting every 1–2 months. (OMS Memo to File by OPI, or delegated person, after each meeting.)	• Low Frequency sessions, once a month. (OMS Casework Record by Correctional Program Officer after each session.) • MIT meeting every 3 months. (OMS Memo to File by OPI, or delegated person, after each meeting.)

- Attend MIT meetings and review release plans at each meeting.
- Ensure "Summary of release planning" in Section C: Release Planning of the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* is kept up to date.
- Ensure communication and information sharing among MIT members, as needed.

- Monitor the overall institutional behaviour of the inmate related to the MMT.
- Meet inmate on a regular basis, and as needed.
- Encourage abstinence from illicit drug use, recognizing the need for the inmate to minimize the harms of injection drug use.

- Include MMT in Correctional Plan Progress Reports (CPPR) as required.
- This revision to the Correctional Plan can be done in a CPPR or in the Correctional Plan itself, at the parole officer's discretion.
- Following methadone initiation, forward a copy of all subsequent CPPRs to Health Services.
- Participation in MMT is voluntary and is not to be included in the CP timeline.

- Notify all MIT members of any movement of the inmate, to ensure continuity of methadone dosing.
- This includes UTAs, ETAs, work releases, private family visits, and pending transfer for external court in provincial facilities
- Write an OMS Memo to File.

OMS Memo to File: When posting an OMS Memo to File for MMT issues, please type "METH " immediately followed by the year and month as the first word in the subject line. For example "METH0310" would indicate that the Memo to File was written in October 2003. This ensures all memos related to methadone are readily identifiable.

ⓘ See Section D: Methadone Dosing Issues of these guidelines. In particular, see the following items relating to parole officer's role: all sections on Releases, UTAs and ETAs.

Release Planning

Note: For purposes of MMT, the *Institutional* Parole Officer must initiate release planning.

- Consider MMT in all release planning activities.

- Ensure that there is no disruption to the inmate's MMT as a result of release planning or transfer.
  - ➔ Begin release planning at least 6 months prior to release.
  - ➔ *At least 6 months prior to release*, ensure the inmate has identification (birth certificate, social insurance number) and medical coverage in the province of release.
  - ➔ If inmate will likely be incarcerated for *less than* 6 months, make direct contact with possible community methadone provider and pharmacy.
  - ➔ Request the community parole officer to make the arrangements through completion of either a *Community Strategy* or *Community Assessment*.
    - Ensure transition into a community MMT program on release by assisting the inmate in locating a community MMT provider.

- Notify the nurse of all details of release plans (e.g., clinic/physician name and contact information). The nurse will provide the clinic/physician with any medical information they request.

- Provide the community parole officer with copies of all documents relevant to MMT prior to the inmate's release.

- Complete the Assessment for Decision (part of OMS file) prior to the release.
- Reflect in this report all communication between the institutional parole officer and the community parole officer, in preparation for the inmate's release into the community.
- Forward this report to the National Parole Board for their decision to grant (or not) release with or without conditions.

Institutional Correctional Programs Officer

MIT Role: To assist in the development of the substance abuse intervention component of the *MMT Plan* and to coordinate the delivery of substance abuse programs and services to the inmate.

The MMT substance abuse intervention is to be conducted by people with appropriate knowledge and skills to effectively deal with MMT high need/risk inmates.

ⓘ See Appendix H: Qualifications of MMT Substance Abuse Program Providers.

Table 3: *Institutional* Correctional Programs Officer—Checklist for Initial Assessment

Items to complete *prior* to the Initial Case Conference	3
Documents received on _____ from _____.	
Complete *Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04)* with the inmate; Complete "Post-interview Summary Ratings" (page 9) following this interview.	
Complete *Substance Abuse Report* and post as an OMS Memo to File.	
Forward the following completed documents to the appropriate service. o **to Health Services,** if your assessment indicates the inmate IS a candidate for MMT o **to the OPI**, if your assessment indicates that the inmate IS NOT a candidate for MMT o *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* o *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)* o OMS documents o Inmate's letter (when available) o *Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04)* o Substance Abuse Report	
Prepare to give a verbal summary of the substance abuse assessment at the Initial Case Conference.	
The Initial Case Conference will take place on _____	
Items to complete *during or following* the Initial Case Conference	
Attend the Initial Case Conference and provide a verbal summary of the substance abuse assessment.	
If the inmate is admitted to MMT, complete sections A. and B. of the *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01)* o A) Help inmate to complete o B) Complete "Summary of participant's needs".	
Sign the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05—page 4)*	
The inmate started substance abuse treatment or Counselling on _____	
The *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01)* started on _____	

Note: Institutions may continue to complete the Addiction Severity Index (ASI) if they choose to do so, but this is no longer a requirement of CSC's Specific Guidelines for Methadone Maintenance Treatment.

Initial Assessment / Continuation of Methadone

- On receiving the appropriate documents, schedule the substance abuse assessment interview with the inmate.
- The inmate's parole officer sends the following completed documents to the correctional programs officer to request that the inmate be scheduled for a substance abuse assessment.
    - *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)*
    - *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)*
    - *OMS forms: Intake Assessment, Correctional Plan, last Correctional Plan Progress Report*
    - *Inmate's letter (when available)*
- Although an inmate is encouraged to meet with the correctional programs officer to ask questions and discuss all elements of MMT, the assessment process must be initiated through the inmate's parole officer. It is critical for the inmate to make an informed decision regarding his/her involvement with CSC's MMT when initiating the process.
- The substance abuse assessment includes completion of the following documents:
    - *Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04)*
    - Substance Abuse Report

- Prior to the interview with the inmate, review the following documents.
- Review the inmate's OMS information, provided by the Parole Officer as well as any Computerized Lifestyle Assessment Instrument (CLAI)/Computerized Assessment of Substance Abuse (CASA) results, and any previous programming experience.
- <u>If the CLAI/CASA results are not available</u>, administer the "Drug Abuse Screening Test", "Alcohol Dependence Scale" and "Problems Related to Drinking" measures during the assessment interview.
- <u>If the CLAI/CASA results are available</u>, review the inmate's written reasons for wanting access to MMT.

Note: If Inmate has been incarcerated for several years, previous CLAI/CASA results may not reflect current substance abuse patterns.

- Complete *Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04)* with the inmate.
- The semi-structured interview is designed to gather key information on the nature and severity of the inmate's substance abuse problem. This information is required for the *Substance Abuse Report*, as well as by other members of the MIT.

- Complete section "Post-interview Summary Ratings" (page 9) at the end of the overall substance abuse assessment.

- Following completion of the above questionnaire, complete a *Substance Abuse Report*.

  ⓘ See Table 4: Notes on Substance Abuse Report below, for details on what to include in this report.

  ➔ Save the report as an OMS Memo to File titled "*Substance Abuse Report"*. The completed report is to be authorized and locked.

  OMS Memo to File: When posting an OMS Memo to File for MMT issues, please type "METH " immediately followed by the year and month as the first word in the subject line. For example "METH0310" would mean that the Memo tot File was written in October 2003. This ensures all memos related to methadone are readily identifiable.

  ➔ Notifiy the OPI that the *Substance Abuse Report* has been completed and is available on OMS.

  Scenario: If your assessment indicates that the inmate* is *a candidate for MMT

  ➔ Forward the completed substance abuse assessment documents along with the other completed documents to Health Services, thereby notifying them of the referral.
  - *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)*
  - *Methadone Release Planning Questionnaire (CSC/SCC 1260-00) and OMS documents*
  - *Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04) and inmate's letter (when available)*
  - Substance Abuse Report

  ➔ Prepare to give a verbal summary of the substance abuse assessment at the Initial Case Conference.

  Scenario: If your assessment indicates that the inmate* is not *a candidate for MMT (for example, the inmate's drug of choice is cocaine)

  ➔ Send any completed portions of the MMT assessment documents (*see list in previous scenario)* to the OPI instead of Health Services.
  - The OPI will list the inmate for review at the next MIT meeting. During this meeting, the MIT will determine if the MMT assessment process should proceed. This process will ensure that if applicants are determined to be ineligible for MMT, the decision will be made by a multidisciplinary group rather than a single individual.
  - If, at that meeting, the MIT is still unsure of the inmate's eligibility… the OPI will ask Health Services to complete the *Medical Assessment for Methadone*

Initiation (CSC/SCC 1260-02) and schedule an Initial Case Conference to discuss the case further and make a final decision.

Table 4: Notes on the Substance Abuse Report

	Notes on the Substance Abuse Report
Purpose	The purpose of this report is to provide the MIT with information that will be used to determine the inmate's suitability for MMT.
Source of Content	The report summarizes key information gleaned from the Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04)
Content & Length	Make the report brief—about one page in length. The original copy of documents completed during the interview will remain in the inmate's Medical Record. Therefore, rather than replicate all the details, provide a summary of the key information, keeping to the main points that support your recommendations. Prepare no more than three or four sentences that summarize pertinent information for each of the following components. • Overview of assessment interview (the name of the person who conducted the interview, when the interview took place, and general comments on the inmate's appearance and demeanour during the interview) • Opiate use **(include intravenous and oral use)** • Previous attempts to quit • Incarcerated opiate use • Previous MMT experience • Other drug use history • Previous substance abuse programs • Opiates and life areas • Substance use and crime • CSC's MMT and personal plans • Final conclusions (based on final rating scales) and final MMT recommendation
Note	The *Substance Abuse Report* will be available to readers in OMS. Therefore, the report must not mention specific infectious diseases (e.g., Hepatitis C, HIV) because this would breach medical confidentiality.

Initial Case Conference *and* MMT Initiation

- Attend the Initial Case Conference and provide a verbal summary of the substance abuse assessment.

- If the inmate is admitted to MMT, complete sections A. and B. of the *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01).*

- Enrol the inmate in an appropriate substance abuse program or for counselling sessions.
- The substance abuse intervention component of MMT shall be consistent with the elements of existing substance abuse programs (e.g., OSAPP).

It must be noted that the inmate may require a period of stabilization (possibly several months) prior to commencing substance abuse programs. During this time, the correctional programs officer should maintain contact with the inmate.

- Sign the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05—page 4)*.

MMT Administration *and* Monitoring

Monitoring guidelines pertinent to the Correctional Program Officer ⓘ For further details, see "CSC 'Stable' and 'Non-Stable' Monitoring Guidelines" in Section B. of these guidelines.	
"Non-Stable" Monitoring Guidelines	**"Stable" Monitoring Guidelines**
• High to Moderate Frequency sessions, every 1–2 weeks. (OMS Casework Record after each session.) • MIT meeting every 1–2 months. (OMS Memo to File by OPI, or delegated person, after each meeting.)	• Low Frequency sessions, once a month. (OMS Casework Record after each session.) • MIT meeting every 3 months. (OMS Memo to File by OPI, or delegated person, after each meeting.)

NOTE: Following each session with a methadone recipient, an OMS Casework Record must be completed. After selecting 'Offender' as the 'Source of Information', select 'methadone program contact' within the 'Type of Interaction' table. This will assist in data collection.

- Participate in MIT meetings and update the MIT of the inmate's attendance, frequency and progress made with the substance abuse intervention sessions.
  - ➔ Monitor and report the performance and progress of the inmate in substance abuse programs.

- Develop the *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01).*
  - ➔ Coordinate and provide substance abuse intervention (group and/or individual counselling) to the inmate participating in MMT.

- Every six months, revise the *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01)* with the inmate and complete Section C. Post-assessment Summary (Page 4).
  - ➔ Forward the completed original to Health Services to be filed on the Medical Record.

- Update the MMT Plan at each MIT meeting

Release Planning

- Assist the institutional parole officer and nurse in the inmate's release planning.

- Assist the inmate in developing an effective relapse prevention component of the inmate's release plan.

- Notify correctional programs officer in the receiving institution/community to ensure continuity of substance abuse treatment.

Nurse

MIT Role: In accordance with their prevention role in the management of infectious diseases and in the area of health promotion, the nurse will administer the clinical component of MMT.

- The nurse must complete, forward, and file the necessary Provincial College of Physicians and Surgeons forms throughout MMT. (See Appendix I.)

- Document on the Progress Notes of the Medical Record any inmate complaints, concerns, symptoms, notes on methadone administration, physical status, urine drug screens, MIT meetings and overall progress in MMT, as well as incidents or any actions taken by the nurse.

- Indisputable records must be kept on the inmate's Medical Record of results of urine drug screening. The results, identified on the kit, must be photocopied (place kit in a clear plastic baggie to photocopy), signed and dated by the nurse.

Table 5: Nurse — Checklist for Initial Assessment

Items to complete and/or forward to OPI, *prior* to the Initial Case Conference	3
If admitted on methadone: o Obtain verbal consent from inmate to continue on methadone o Have inmate sign *Release of Information* to obtain medical records from the community o Following confirmation, obtain order for dosage o Schedule next available physician visit o Review the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* with inmate. o Forward *Agreement* to institutional parole officer	
Explain the *Disclosure of Medical Information Agreement (CSC/SCC 1260-06)* to the inmate and have him/her sign	
Review the *Treatment Options for Opiate Addiction (CSC/SCC 1260-07)* with the inmate and have him/her sign that this has been reviewed.	
Documents reviewed and information included in medical assessment: o *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)* o *OMS documents* o *Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04)* o Copy of the Substance Abuse Report o *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* o *Inmate's letter (when available)*	
Complete *Medical Assessment for Methadone Initiation (CSC/SCC 1260-02)* o Pages 1–4 completed o Ensure all required immunizations are given and results of urine screens for general toxicology and blood tests are obtained. o The DSM IV criteria have been met; signed by physician (page6) o Physical Exam done by physician (page 5) o Physician's Assessment/Plan (page 6) o Referral to Psychology, *if required.* o Form signed by nurse on page 6 to indicate the process is complete.	
Complete a brief summary of the clinical assessment in the Medical Record.	
The Initial Case Conference will take place on _____	
All original documents filed in the Medical Record on _____	
Items to complete *during or following* the Initial Case Conference	
Provide a verbal summary of the inmate's medical assessment at the Initial Case Conference.	
MMT Agreement (CSC/SCC 1260-05) signed by the inmate and all MIT members.	
Complete the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* o Place on chart.	
Write a summary of the results of the Initial Case Conference in the Medical Record.	

Initial Assessment / Continuation of Methadone

- Conduct an admission chart review to identify any inmates currently on MMT.

Admitted to CSC — On methadone

Health Services in the receiving institution must ensure the continuity of methadone treatment. If an institution does not have week-end nursing coverage, that institution *must* have a plan in place to ensure continuity of methadone for an inmate who is admitted after hours on Friday and/or on the week-end. The Chief of Health Services is responsible for this plan which varies from institution to institution.

- Obtain verbal consent from the inmate to continue on MMT.

- Confirm participation in MMT, and last methadone dose given.
  - ➔ Review the accompanying Medical Record (where applicable) for methadone dose and time of last dose. If this information is absent, the nurse must contact the appropriate source to obtain this information.
  - ➔ Obtain a signed *Release of Information* from inmate.
    - The release must allow the current methadone provider (community methadone clinic, physician's office, or provincial Correctional Centre) to release to the CSC physician any information they believe pertinent to the inmate's ongoing MMT.
    - Such information should include the inmate's dose (including time of last dose), treatment history, and copies of any physical examinations or laboratory investigations performed within the past year by the previous MMT provider.
    - If the clinic or physician's office is closed, ask the inmate to sign a *Release of Information* allowing the pharmacy he/she attended to provide information regarding methadone dose, date and time of last dose received, and if any carries were issued at that time.
    - Some provincial facilities require a *Release of Information* signed by the inmate prior to providing information to CSC.

- Obtain an order for the dosage, until an assessment is completed by the physician.
- Contact the institutional physician or physician on call (process to be determined by each institution).
- If the dosage *has* been confirmed. The physician should provide a prescription for that dose until the institutional physician can see the inmate on the next clinic day.
- If the dosage *has not* been confirmed. If an inmate claims to be on methadone but the nurse

Admitted to CSC — On methadone

is unable to confirm as no documentation is received with the inmate to indicate he/she is a methadone recipient, and the nurse is unable to contact the previous methadone provider or pharmacy, the institutional physician or physician-on-call must determine the course of action. Methadone should not be provided in this case.

- Make arrangements with either the Regional Pharmacy (where available) or local pharmacy to obtain methadone.

- Manage any doses sent with inmate.
  - Doses of methadone may arrive with the escorts. The nurse must document in the narcotic control record what happened to this medication, in accordance with the *Controlled Drugs and Substances Act* (e.g., the methadone is entered into stock, disposed of, or returned to the pharmacy).

- Ensure any pertinent assessment documents are available for the current assessment process.
  - The offender *may* have on file documents from a previous assessment for MMT, including the parole officer assessment, the medical assessment and the substance abuse assessment.
  - All previous assessments and documents related to MMT must be reviewed by the respective MIT member and updated to be congruent with the assessments and procedures outlined in these guidelines.
  - All signatures for consents and agreements **must** be newly obtained.

- Schedule the inmate for the next available physician clinic (within 7 days).

- Review the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* with the inmate in detail.
  - **This is a critical element of MMT,** and the nurse must take enough time to review all sections of the *MMT Agreement (CSC/SCC 1260-05)* with the inmate and ensure the inmate understands and agrees.
    - ➔ Obtain the inmate's signature for Section B: "Agreement to Participate in Assessment Process / Acknowledgement of Terms and Conditions for MMT" on page 1 of the agreement.
    - ➔ Forward the agreement to the inmate's parole officer.

Admitted to CSC — On methadone, will be incarcerated *less than* 6 months

- If an inmate will be incarcerated for significantly less than 6 months, an MIT meeting *may* not be necessary.
- An MIT meeting is more likely to be indicated if the inmate is not complying with the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* and/or there are release planning or transfer issues that require the attention of the MIT.
- This also applies in CSC Reception Centres and/or Temporary Detainee Units.

All inmates

Unless otherwise stated above, the following process applies to all inmates on methadone, whether admitted on methadone or initiated within CSC.

- Review the following completed documents on receipt as part of the assessment.
  - *Methadone Release Planning Questionnaire (CSC/SCC 1260-00)*
  - *OMS documents*
  - *Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04)*
  - Copy of the Substance Abuse Report
  - *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)*

- Schedule the inmate for an interview to complete appropriate sections of the *Medical Assessment for Methadone Initiation (CSC/SCC 1260-02).*
  - ➔ Explain the medical assessment process to the offender.
  - ➔ Complete pages 1-4.
  - ➔ Ensure all required immunizations are given , urine screens for general toxicology and blood tests are performed and results available prior to the inmate's appointment with the physician.
    - Review the Medical Record to determine which immunizations and screening tests are required.
    - All blood tests (unless otherwise specified) must be within 2 months of application or continuation.

- Explain the *Disclosure of Medical Information Agreement (CSC/SCC 1260-06)* to the inmate and have him/her sign that it has been explained to them.

- Review the *Treatment Options for Opiate Addiction (CSC/SCC 1260-07)* with the inmate and have him/her sign that this has been reviewed.

- Review the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* with the inmate in detail.

- The inmate may have already reviewed the Agreement and signed the section "Agreement to Participate in Assessment Process / Acknowledgement of Terms and Conditions for MMT" with the parole officer when agreeing to be assessed.
- **This is a critical element of MMT,** and the nurse must take enough time to review all sections of the *MMT Agreement (CSC/SCC 1260-05)* with the inmate and ensure the inmate understands and agrees.

- Ensure the physician has completed and signed the appropriate sections of the *Medical Assessment for Methadone Initiation (CSC/SCC 1260-02).*
  - ➔ The DSM IV criteria have been met (page 6)
  - ➔ Physical Exam (page 5)
  - ➔ Physician's Assessment/Plan (page 6)
    - Check that the section on co-morbidity has been completed and any necessary referrals have been sent.
  - ➔ *In cases where there is psychiatric co-morbidity*, ensure a referral to Psychology is completed by the physician and sent to Psychology department.
    - This is to obtain a mental health assessment and to provide the inmate with an additional resource, which may be required as the inmate stabilizes on methadone.
    - The psychological assessment does not have to be completed prior to methadone initiation.
    - The psychologist will determine with the inmate if ongoing psychological intervention will be required. (If required, the psychologist should become part of the MIT.)

- Once the entire medical assessment is complete, complete a brief summary of the medical assessment.
  - ➔ Sign the *Medical Assessment for Methadone Initiation (CSC/SCC 1260-02)* to indicate the process is complete.

- Forward the following completed documents to the OPI.
- completed *Medical Assessment for Methadone Initiation (CSC/SCC 1260-02)*
- brief summary of the medical assessment
- completed documents received from the parole officer and correctional programs officer
- any other supporting documentation, (i.e., psychological reports)

Initial Case Conference *and* MMT Initiation

- Attend the Initial Case Conference and provide a verbal summary of the inmate's clinical assessment.
- If an inmate was admitted to CSC on methadone, and will be incarcerated for significantly less than 6 months, an MIT meeting *may* not be necessary.
    - An MIT meeting is more likely to be indicated if the inmate is not complying with the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* and/or there are release planning or transfer issues that require the attention of the MIT.
    - This also applies in CSC Reception Centres and/or Temporary Detainee Units.

- Complete the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03).*
- If an inmate was admitted to CSC on methadone, and will be incarcerated for significantly less than 6 months, a *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03) may* not be necessary.
    - An *MMT Plan (CSC/SCC 1260-03)* is more likely to be indicated if the inmate is not complying with the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* and/or there are release planning or transfer issues that require the attention of the MIT
- Use information from the completed MMT assessment documents and consult the guidelines on 'Stable' versus 'Non-Stable' classifications.

ⓘ See "CSC 'Stable' and 'Non-Stable' Monitoring Guidelines" in Section B. of these guidelines.

- Ensure the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* has been signed by the inmate and all members of the MIT, prior to placing the original on the inmate's Medical Record. The physician, parole officer, correctional programs officer, and officer of principle interest must sign on page 4.

- Write a note in the Medical Record summarizing the results of the Initial Case Conference.

Table 6: Notes on the *MMT Plan (CSC/SCC 1260-03)*

The *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* is individualized for each methadone recipient. The nurse is responsible for keeping it up to date.

– Use a pen to complete the inmate identification as this information will not change.

– Use a pencil to complete sections that will be updated.

– Date and initial all entries/changes to this working Treatment Plan. Photocopies of previous changes to the MMT Plan must be filed on the Medical Record. An alternate method is to complete the MMT Plan electronically. Print and file the document on the Medical Record after each change.

Section B: Inmate Goals(page 1)

- Include information from the assessment documents and inmate's letter.
- Update as needed, usually every 6 months.

Section C: Release Planning(page 1)

- Initially, complete using the *Methadone Release Planning Questionnaire (CSC/SCC 1260-00).*
- It is important to review this information with the inmate at each MIT meeting, as a change in release plans may significantly affect CSC's ability to ensure continuity of methadone treatment on release.

Section D: Psychiatric Co-morbidity(page 1)

- If the inmate has psychiatric co-morbidity, an update on his/her status should be provided by the nurse (using available reports), psychologist, or psychiatrist, every second MIT meeting.
- *Section E: Progress Update (page 2)*

"First potential date inmate may be considered as stable"

- Every time a "Stable" inmate meets any of the criteria for "Non-stable" status, the date they may next be considered as "stable" is 3 months from the incident.
- For example, if a "Stable" inmate has a positive urinalysis on January 1, his/her status changes to "Non-Stable" and the next potential date that the inmate's status could change back to 'Stable', if no further incidents occurred, would be April 1.

"Notes"

- Document specific concerns here, ensuring they are addressed on an ongoing basis at the MIT meetings. Use this section also for reminders of occurrences requiring praise and support for the inmate from the MIT.

MMT Administration *and* Monitoring

Monitoring guidelines pertinent to Health Services (nurse) ⓘ For further details, see "CSC 'Stable' and 'Non-Stable' Monitoring Guidelines" in Section B. of these guidelines.	
"Non-Stable" Monitoring Guidelines	**"Stable" Monitoring Guidelines**
• Urine drug testing twice a week OR every 1–2 weeks. • Physician visits every 1–2 weeks. • MIT meeting every 1–2 months. (OMS Memo to File by OPI, or delegated person, after each meeting.	• Urine drug testing every 2 weeks • Physician visits every 3–4 weeks • MIT meeting every 3 months. (OMS Memo to File by OPI, or delegated person, after each meeting.

- Administer methadone to the inmate on a daily basis under direct observed therapy.
  ⓘ See Table 7: Nurse's Guidelines for Methadone Administration below.

- Ensure the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* is updated and maintained regularly.
  - ➔ The *MMT Plan (CSC/SCC 1260-03)* should be updated at each physician visit.
    - Remember, the physician does not have to wait for a routine or urgent MIT meeting to change dosage, frequency of random urinalysis, or frequency of physician visits. Nonetheless, these changes must remain in the time frames provided in the "Stable" and "Non-Stable" sections of these guidelines.
  - ➔ Bring a copy of the *MMT Plan (CSC/SCC 1260-03)* to all MIT meetings.
  - ➔ Review and update the *MMT Plan (CSC/SCC 1260-03)* at MIT meetings.
  - ➔ Keep historical paper copies of the *MMT Plan (CSC/SCC 1260-03)* on file in the Medical Record.
    - Maintaining this paper history of changes is essential for both CSC as well as audit purposes for the Provincial Colleges of Physicians and Surgeons.
  - ➔ Place a copy of the Memo to File, completed by the OPI after each MIT meeting, in the Medical Record.
  - ➔ Place a copy of updated Methadone Maintenance Substance Abuse Treatment Plans (CSC/SCC 1260-01), completed (every 6 months) by the correctional programs officer in the Medical Record.
  - ➔ Place a copy of each CPPR, provided by the parole officer, in the Medical Record.

- File all methadone related documents (including urine drug screening results relative to methadone) chronologically in a separate file folder placed on the spike on top of Section 6 of the Medical Record. This will ensure that methadone documents are filed together, are accessible to other MIT members without providing access to the entire Medical Record, and are readily available for audit purposes.

NOTE: When a methadone recipients's Medical Record is accessed through Access to Information and Privacy (ATIP), the process to number methadone related documents within the separate file folder on top of Section 6 must be as follows:

Step 1: Remove methadone related documents from the separate file folder

Step 2: Place these documents chronologically with other documents on Section 6 of the Medical Record

Step 3: Number all documents while in chronological order

Step 4: Photocopy documents while in chronological order and provide to ATIP in chronological order

Step 5: Return original methadone related documents to the separate file folder in the order they were in in Step 1 above. Place the separate file folder on top of Section 6 of the Medical Record.

- Coordinate the collection of urine drug screens in accordance with the procedures provided in Section E: Urine Drug Screening in these guidelines.

- Provide ongoing health teaching.

- Contact the OPI to request a meeting of the MIT on an as-needed basis.

- Ensure the inmate's immunizations are kept up-to-date and periodic physical examinations are performed by the institutional physician every eighteen months.

- Where applicable, notify any specialist or consultant of the inmate's participation in MMT. Use the *Letter Concerning Analgesia for An Inmate on Methadone Treatment (CSC/SCC 1260-08).*

- Assist the parole officer in co-ordinating the provision of methadone in the event of UTAs, ETAs, work releases, private family visits and pending transfers for external court in provincial facilities.

Table 7: Nurse's Guidelines for Methadone Administration

Nurse's Guidelines for Methadone Administration	
Location of administration	Administer methadone in the Health Services Centre. Special circumstances may require administration in another secure location.
Restrictions on inmate	Inmates must not bring any type of container to the methadone administration area (e.g., cups or plastic bags). Only one inmate at a time should be allowed in the immediate methadone administration area. If the inmate appears to be intoxicated, **do not give methadone**. Notify physician for further instructions. The inmate may be observed and reassessed at a later time.
Verification of inmate	Ensure the following *prior to each methadone dos*e for *each inmate*. • Inmate must show photo identification. If your institution does not require inmates to carry photo identification, then a photo must be printed from OMS and kept in the institutional pharmacy. • Compare the photo ID to the inmate and confirm his/her name. • Nurse must enforce **"NO ID, NO METHADONE".**
Verification of ingestion	Administer methadone separately from other medication parades. The nurse must observe the inmate ingest the entire dose of methadone. The nurse must observe the inmate drink a glass of water or drink from a water fountain, after ingestion of methadone. If handed a glass of water, the inmate must not keep the glass after drinking the water. The inmate must then speak to the nurse. Inmates may use the bathroom *prior* to receiving their dose of methadone (especially if a urine drug screen is required that day) but should not be allowed to use the bathroom *following* methadone ingestion.
Monitoring of inmate	Each inmate must be monitored for a minimum of 20 minutes after methadone ingestion. Anyone can perform this monitoring. At least half of the methadone dose is absorbed from the gastrointestinal tract within 20 minutes and is detectable in the bloodstream after 30 minutes. Therefore, any diverted doses will have a lesser concentration.

Nurse's Guidelines for Methadone Administration	
Non-compliance	If an inmate fails to comply with this method of methadone administration, the nurse must do the following. • Document this failure to comply on the Progress Notes of the Medical Record. • Notify the institutional physician of the offender's failure to comply. • Advise the members of the MIT and request the OPI to call an MIT meeting if necessary. • Counsel the inmate regarding reasons why compliance is important.
Medication errors	Report all methadone medication errors to the Chief of Health Services and institutional physician **immediately**, whether the inmate has received too much or too little methadone. Complete a *Nursing Incident Report (CSC/SCC 0098)* and send the original to the Chief of Heath Services.
Methadone overdose	Each institution must have a clinical standing order in place to guide the immediate and follow-up actions of nursing staff in the case of methadone overdose. In all cases of methadone overdose, the inmate must be monitored for 24 hours following treatment, and subsequent methadone doses adjusted (as required) by the institutional physician. Monitoring will be based on the protocol as ordered by the institutional physician.
Reporting clinical concerns	Alert the physician regarding any clinical concerns. Report to the physician and MIT if the inmate misses any doses of methadone. Report signs of withdrawal or toxicity immediately to the institutional physician.
Documentation	Document methadone doses administered on the Medication Administration Record and Narcotics Record.
Legislation requirements	Adhere to the Controlled Drugs and Substances Act with respect to access, dispensing, recording, storage, handling and distribution of methadone from pharmacy to institution to inmate.
Dosing Issues	ⓘ See Section D: Methadone Dosing Issue" of these guidelines. In particular, see these items relating to nurse's role: Missed Dosed; Vomited Doses; and all sections on Transfers, UTAs and ETAs.

Note: The above method of methadone administration assists in the provision of safe MMT for methadone recipients and other inmates.

Table 8: Nurse's Guidelines for Specimen Collection for MMT Routine Urine Drug Screening

Nurse's Guidelines for Specimen Collection for MMT Routine Urine Drug Screening	
Recommended time of day to collect urine specimens	Before the day's methadone dose. Reasons include: - Improves compliance in providing the required specimen for screening. - Provides status of methadone metabolism at the end of the dosing period so more useful for titration. The literature also states early-day samples are preferred over late-day samples.
Schedule for collection	Must be done on **random dates**, (i.e., do not notify the inmate in advance that a urine specimen will be obtained on a certain date). Inmate ingests methadone at the same time every day. Therefore, upon initiation of methadone, advise the inmate that he/she could be asked to provide a urine specimen on any day. He/she is expected to attend for daily methadone dosage able to provide a urine specimen.
If inmate unable to provide a specimen	If the inmate refuses to provide a specimen (or delays), **do not withhold the methadone dose**. However, note this action on the Progress Notes of the Medical Record, and on the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03),* for discussion at the next MIT meeting.
Optimal procedure for collection	Optimal procedure is **by direct observation by a nurse of the same sex as the inmate,** (i.e., the nurse stays in the cubicle with the inmate). If this is not possible, because of safety issues, or absence of a same sex nurse, the following alternative procedure is mandatory.

Nurse's Guidelines for Specimen Collection for MMT Routine Urine Drug Screening (cont'd)	
Alternative Procedure	Note: This procedure is consistent with recommendations in *Methadone Maintenance: A Physician's Guide to Treatment* (Brand 1998). An inmate washroom must be available in which there are electronically operated solenoid valves on the water lines. The control panel must be located outside of the inmate bathroom and have colour indicator lights for ON/OFF operating mode. The nurse switches the control panel to 'ON' and drains the pipes in the bathroom of water. Blue food colour is placed in the toilet bowl. All soap or cleaning agents should be removed from the bathroom. The inmate should remove any jackets or bulky sweatshirts (e.g., worn over a tee-shirt) prior to entering the inmate bathroom. The nurse hands the specimen collection container to the inmate and advises that he/she has no more than 4 minutes to void and hand the container back to the nurse.
Verification of specimen	Upon receipt of the urine specimen, the nurse places a temperature strip on the container, close to the bottom, and a temperature should register almost immediately. Temperatures (by fast-response electronic thermometer or temperature strip) must be taken within 4 minutes of voiding to be interpreted properly. If there are no problems, the nurse can then turn the water can back on in the inmate bathroom for the inmate to wash his/her hands.
If temperature does not register	If a temperature does not register on the strip, and less than 4 minutes have passed since voiding, try a second temperature strip. If this second temperature strip does not register, then it is considered a tampered specimen. If tampering is suspected, a second sample should be collected the same day so results can be compared. This must be clearly documented by the nurse on the Progress Notes of the Medical Record and on the "Notes" section of the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03,)* to be discussed at the next MIT.
Documentation	Indisputable records must be kept on the inmate's Medical Record of results of urine drug screening. The results, identified on the kit, must be photocopied (place kit in a clear plastic baggie to photocopy), signed and dated by the nurse.

Release Planning / Transfer

- Coordinate, along with parole officer, discharge planning in conjunction with the MIT.

Transfer between institutions

- ➔ Complete the *Administrative Summary (CSC/SCC 0377)* and contact the health care centre in the receiving institution several days prior to transfer to ensure continuity of MMT.
- ➔ Follow the instructions "Transfer to another CSC Institution" on page 70 of these guidelines.

Release from CSC to another prison jurisdiction

- ➔ Ensure that the inmate's medical information related to MMT is shared in a timely manner

Release to the community

- ➔ Ensure that the medical requirements for admission to the community MMT program are addressed to ensure continuity of MMT.
- ➔ Assist the institutional parole officer as required to contact a community methadone provider and pharmacy.

- Notify the physician regarding release or transfer plans.

- Record a detailed discharge-planning note in the Medical Record.

Physician

MIT Role: The Physician makes all final clinical decisions related to MMT, including final decisions on MMT admission, termination and urine drug screens, in consultation with other team members.

The Physician has final approval over all aspects of MMT. Ultimately, as the licensed methadone prescriber, the physician can make unilateral decisions as he/she deems necessary. These instances should be the exception rather than the rule.

- All institutional physicians on contract with Correctional Service of Canada must obtain authorization to prescribe methadone from the appropriate federal and/or provincial authority. Proof of this authorization must be provided to the Chief of Health Services.

- All documentation from the Provincial Colleges of Physicians and Surgeons must be completed throughout MMT.

Initial Assessment / Continuation of Methadone

- Review all completed assessment documents from MIT members.

- Complete the following sections of the *Medical Assessment for Methadone Initiation (CSC/SCC 1260-02).*
- Certify that DSM IV criteria for substance dependence (opiate) have been met (page 6)
- Physical exam (page 5)
- Physician's Assessment / Plan (page 6)
  - ➔ Order appropriate toxicology urine drug screens as outlined in Section E: Urine Drug Screening in these guidelines.

- Provide health promotion information to inmate, in particular discouraging the use of illicit drugs while participating on MMT.

Admitted to CSC — On methadone

- Contact community physician to obtain information on inmate's participation in community MMT.

- Provide prescription to continue the inmate on methadone if MMT participation is confirmed.

Initial Case Conference *and* MMT Initiation

- Participate in the Initial Case Conference.
- Ensure applicant meets the admission criteria, prior to initiation of methadone.
- Establish and prescribe the initial dosage as outlined in Section D: Methadone Dosing Issues of these guidelines.
- Sign the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)*.

MMT Administration *and* Monitoring

- Monitor inmate's dosage and adjust as required in accordance with Section D: Methadone Dosing Issues of these guidelines, and in accordance with guidelines from the Provincial College of Physicians and Surgeons, where applicable.
  - ⓘ See Section D: Methadone Dosing Issues in these guidelines for details.
  - ⓘ See Appendix I: Guidelines from Provincial Colleges of Physicians and Surgeons.
- Participate in a portion of all MIT meetings.
- Act as resource to staff and inmates.
- Initiate methadone and report to the Provincial College of Physicians and Surgeons as required.
- Assess inmate on a regular basis and as outlined in the " 'Stable' and 'Non-Stable' Monitoring Guidelines" found in Section B. of these guidelines.
  - ➔ Order appropriate toxicology urine drug screens as outlined in Section F: Urine Drug Screening in these guidelines.
  - ➔ Request psychological and/or psychiatric assessment, or any other relevant referrals, where indicated.
  - ➔ Perform physical examinations on methadone recipients every 18 months.

- ➔ Following each inmate clinic visit, document progress on the Progress Notes of the Medical Record, including the following.
    - progress report on the dependence problem and other problems identified
    - onset of new problems, if applicable
    - use of drugs and/or other substances since the last visit
    - results of ancillary examinations, if applicable, and the consequent medical management
    - justification for any changes in dosage or in the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)*, particularly in cases of high doses (> 120 mg / day)
    - next appointment date
    - prescription including start and stop dates

      (Collège des médecins du Québec/Ordre des pharmaciens du Québec, 2000**)**

- Monitor the withdrawal process in cases of voluntary or involuntary withdrawal from MMT.

- Complete the *Letter Concerning Analgesia for An Inmate on Methadone Treatment (CSC/SCC 1260-08)* (if not done by nurse) for all consultant appointments.

- Participate in establishing contingency plans for week-end service.

- Ensure medical directives are given for methadone overdose.

Release Planning

- In consultation with the MIT, in particular the nurse, assist to ensure continuity of MMT upon discharge.

- Ensure the inmate's MMT history is transferred to the new treating physician.

- Initiate voluntary/involuntary taper or alternative supportive treatment if MMT is not available on discharge.

Officer of Principal Interest (OPI)

MIT Role: To provide overall leadership to the MIT by coordinating all administrative and quality assurance aspects of MMT within the institution.

The Warden is responsible for selecting the individual who will assume the role of the Officer of Principal Interest (OPI) within the institution.

ⓘ See Appendix G: Criteria for Selection of OPI.

Table 9: Officer of Principle Interest—Checklist for Initial Assessment

***Ensure completion of the following items prior* to the Initial Case Conference**	3
Inmate's letter received from PO	
Methadone Release Planning Questionnaire (CSC/SCC 1260-00) received from PO o completed by PO with inmate. o BF date recorded	
Copy received from PO: o Intake Assessment o Correctional Plan o last Correctional Plan Progress Report	
Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05) received. Section B signed by o inmate o PO	
Methadone Maintenance Substance Abuse Assessment Questionnaire (CSC/SCC 1260-04): received from Correctional Program Officer.	
Substance Abuse Report received from Correctional Program Officer	
Treatment Options for Opiate Addiction (CSC/SCC 1260-07) explained to the inmate by nurse and signed by inmate and nurse. Received from nurse.	
Disclosure of Medical Information Agreement (CSC/SCC 1260-06) explained to the inmate by nurse and signed by inmate and nurse. Received from nurse.	
Medical Assessment for Methadone Initiation (CSC/SCC 1260-02) sent by the nurse. o Pages 1–4 completed by nurse (nurse signed on page 6) o Page 5–6 completed, physician signed on page 6 o Referral to Psychiatry sent, if required o DSM IV criteria signed by physician (page 6)	
Items to complete *during or following* the Initial Case Conference	
Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05) signed by all members of MIT —page 4	
If case accepted, PO has o placed a Flag on OMS o placed an OMS Memo to File regarding summary of initial case conference	
All lists have been updated. (OPI)	
Last updated the regional methadone coordinator on _____	

Initial Assessment / Continuation of Methadone

- Assure that the timelines established for the completion of the offender's assessment for MMT suitability are met (i.e., maximum 45 working days). Use the date on the Methadone Release Planning Questionnaire to count from.

- Coordinate preparation (date, time, and place) of the Initial Case Conference upon receipt of the completed MMT assessment documents (See checklist above, Table 9).
  - ➔ Record the BF date from the *Methadone Release Planning Questionnaire (CSC/SCC 1260).*
  - ➔ Review the documents to ensure they are complete. Return any incomplete documents back to the assessor for completion.

Admitted to CSC — On methadone

- **If an inmate will be incarcerated for significantly less than 6 months**, an MIT meeting *may* not be necessary.
- An MIT meeting is more likely to be indicated if the inmate is not complying with the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* and/or there are release planning or transfer issues that require the attention of the MIT.
- Also, a *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)* may not have to be initiated.

Transfer to another CSC institution while awaiting methadone initiation

The OPI at the sending institution must contact the OPI at the receiving institution to ensure that the inmate's name and date he/she was put on the access log are incorporated into the receiving institution's access log. If that institution does not have an access log, the inmate may be able to initiate methadone as soon as the MIT members can review the completed assessment.

Initial Case Conference *and* MMT Initiation

- Ensure all members of the MIT sign the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05—page 4).*
  - ➔ Distribute a copy of the signed agreement to the inmate.
  - ➔ Send the original to Health Services to be filed in the Medical Record.

- Ensure appropriate admission criteria are used.
  - ⓘ See "CSC: Admission Criteria and Quality Assurance for MMT" in Section B. of this manual.

- Maintain quality assurance of MMT.
- Monitor quality assurance by ensuring adherence to all parameters outlined in these guidelines.
- Each CSC institution must ascertain the number of methadone recipients that can be managed in a safe manner and in accordance with all parameters of these guidelines, with the resources available in the institution.
  - ➔ Inform the Regional Methadone Coordinator if the number of inmates who have completed the assessment process exceeds the current capacity of the institution to deliver MMT.

- Manage methadone treatment access by compiling and maintaining statistics in an access log regarding the following items.
- Record the number of inmates on MMT in the institution, including those removed from MMT and reasons for removal, and those who were not approved for methadone during the assessment process.
- Record the date the inmate's assessment process was completed and the date the inmate's name was added to the access log.
  - ➔ Coordinate periodic reviews of this log with the core institutional MIT members and affected parole officers.
    - Any specific concerns should be raised during this meeting, (e.g., if an MIT member believes one inmate should take priority over another on the access log).
    - If no concerns are raised, the inmate who has been present on the access log the longest should have priority for methadone initiation.
    - If a decision can't be reached, the institutional physician will make the decision.

- Add the inmate to the list for their next required MIT meeting.

MMT Administration *and* Monitoring

Monitoring guidelines pertinent to the OPI ⓘ For further details, see "CSC 'Stable' and 'Non-Stable' Monitoring Guidelines" in Section B. of this manual.	
"Non-Stable" Monitoring Guidelines	**"Stable" Monitoring Guidelines**
• MIT meeting every 1–2 months. (OMS Memo to File by OPI, or delegated person, after each meeting.)	• MIT meeting every 3 months. (OMS Memo to File by OPI, or delegated person, after each meeting.)

- Convene, coordinate, and attend meetings of the MIT as outlined in the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)*. Coordinate additional meetings as required.
  - ➔ Review and provide input into the inmate's *MMT Plan (CSC/SCC 1260-03)*.
  - ➔ Coordinate meetings—attended by core MIT members and parole officers responsible—to review the log related to methadone access at periodic intervals.
    - Meeting frequency would depend on length of the list, openings, and resource changes.
  - ➔ Add the inmate to the list for their next required meeting.

- Following each MIT meeting, ensure an OMS Memo to File is completed (delegate as necessary).

  OMS Memo to File: When posting an OMS Memo to File for MMT issues, please type "METH " immediately followed by the year and month as the first word in the subject line. For example "METH0310" would indicate the Memo to File was written in October 2003. This ensures all memos related to methadone are readily identifiable.

  Note: OMS entries must not mention specific infectious diseases (e.g., Hepatitis C, HIV) because this would breach medical confidentiality.

- Monitor institutional resources related to the provision of MMT.
- Each department should verbalize any restrictions on resources, whether financial, physical or human. This should be done on a continual basis, in consultation with their institutional physician and coordinated by the OPI. For example, if the Health Services unit stated they could safely manage 12 methadone recipients and maintain compliance with the parameters outlined within these guidelines, but the institution only had one Correctional Programs Officer, the number 12 may have to be decreased to a more manageable number.
  - ➔ Inform the Regional Methadone Coordinator of any resource challenges the institution may be experiencing.

- ➔ Inform the Regional Methadone Coordinator if inmates are received at your institution from a CSC reception centre and all assessment documents are not complete. Ensure completion at your site.
- ➔ Inform the Regional Methadone Coordinator of any change of OPI incumbent.

- Act as the institutional contact for the Regional Methadone Coordinator for dissemination of information and updates to *Correctional Service of Canada: Specific Guidelines for Methadone Maintenance Treatment.*

- Liaise with the Regional Methadone Coordinator as required.
  - ➔ Forward information from access logs as required.

Release Planning

- Update appropriate logs as necessary.

CSC Pharmacist

MIT Role: In accordance with their role in heath promotion and disease prevention, the pharmacist is responsible for the dispensing of methadone and acts as an important resource for institutional and community nurses and physicians.

Each region, and institutions within a region, may use a different pharmacy arrangement. Methadone may be provided by a community pharmacy, a hospital pharmacy, etc.

Note: Regional and Institutional Pharmacists must meet the requirements set out in the Controlled Drugs and Substances Act with respect to access, dispensing, recording, storage, handling and distribution of methadone from the pharmacy to the offender.

Initial Assessment / Continuation of Methadone

Admitted to CSC — On Methadone

- Confirm previous dosage, if applicable.
- If required, liaise with the inmate's community pharmacy to determine whether/when the inmate had his/her last dose, and confirm dosage (if the inmate has been admitted to a CSC institution directly from the community).
- In provinces where the pharmacist has access to a local/provincial pharmacy computer system, the pharmacist may conduct a review of the inmate's drug history to identify whether the inmate is on methadone, and if so, when his/her last dose was, the prescribing physician's address and telephone number, and the inmate's most recent dosage.

- Arrange prescription and delivery of methadone.
- Coordinate with the institutional nurse regarding obtaining an order from the institutional physician to continue the inmate on methadone.
- Make arrangements for the methadone to be delivered to the institution in a timely manner so the inmate may have little disruption in his/her MMT.

Initial Case Conference *and* MMT Initiation

Not applicable.

MMT Administration *and* Monitoring

- Provide methadone drug information as requested by Health Services and other CSC staff.

- Participate in developing procedures/policies as they pertain to the handling, storage, and transportation of methadone.

- Through regular pharmacy audits, ensure that methadone is appropriately transported, stored, recorded, administered, and handled in compliance with the *Controlled Drugs and Substances Act*.

- Liaise with the Regional Methadone Coordinator and participate in ongoing educational/ training sessions for CSC staff.

- Monitor medication profiles of methadone recipient and alert physicians when concurrent drugs are prescribed that affect methadone plasma levels.

Release Planning

- After an inmate is released, ensure all residual methadone remaining at the institution is disposed of in accordance with the *Controlled Drugs and Substances Act*.

- Report as required to the Provincial College of Physicians and Surgeons, in cases of transfer of an inmate to another CSC Pharmacy or community pharmacy.

Community Parole Officer (PO)

MIT Role: To provide overall leadership for the community MIT and to arrange for the establishment of the community Methadone Intervention Team.

The **Senior Parole Officer/Case Management Supervisor** is responsible for overall quality assurance of the documentation and data entry. Offices/Units that supervise a large number of offenders who are on the MMT may find it advantageous to identify a Parole Officer as coordinator. It is recognized that a reduced supervision caseload will be required, and that some additional administrative duties will result.

Release Planning

Note: For purposes of MMT, the *Institutional* Parole Officer must initiate release planning.

- Upon receiving the release plan from the institutional parole officer, collaborate as requested to establish a community methadone provider and pharmacy that agrees to continue methadone treatment upon the offender's release.
  - ➔ Liaise with the institutional parole officer to gain a full appreciation of the offender's methadone and substance abuse history, and to identify any ongoing issues from the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03).*

- Consult a community correctional programs officer to request comments on offender programming needs in the community in relation to methadone use.

- Make all arrangements regarding a community methadone provider and pharmacy.
- This can be done through completion of either a *Community Strategy* or *Community Assessment*, at the request of the institutional parole officer, for offenders who will be released from a federal institution in greater than 6 months from the date of request.
  - ➔ Facilitate the sharing of the offender's methadone history with the community MMT provider. Requests for medical information should be relayed to the inmate's institutional Health Services unit.

- Identify members of the community Methadone Intervention Team (MIT). In the community, the MIT is composed of the offender, community parole officer, programs officer and possibly the senior parole officer.

- Update information on the release planning for MMT in the offender's Correctional Plan via the Correctional Plan Progress Report, including other appropriate entries on OMS.

- Check for flag on OMS.

Initial Interview upon Release/ Continuation of Methadone in Community

- Meet with the offender to review any issues related to the offender's participation in the community MMT program.
  - ➔ Request the offender to sign a *Release of Information* so the community methadone provider can share relevant information pertaining to MMT. Send the signed Release of Information to the community methadone provider.
  - ➔ If the inmate refuses to sign a Release of Information, ensure this is documented on an OMS Memo to File.
  - ➔ Contact the offender's community MMT provider to provide them with your contact information.

- Ensure integration of MMT into the offender's Correctional Plan via the Correctional Plan Progress Report, including appropriate entries on OMS.
  - ➔ Include MMT in Correctional Plan Progress Reports (CPPR), as required.

- Confirm members of the community MIT.

- Schedule a meeting with the community MIT and the offender for as soon as possible after release.
- In limited circumstances, due to geographical circumstances where face-to-face contact is difficult, an appropriate alternative arrangement should be discussed with the parole officer and their supervisor. This initial MIT meeting may have to be conducted by phone.
- The Senior Parole Officer may participate if deemed necessary.

MMT Administration *and* Monitoring in Community

- Coordinate the overall case management in the community.
  - ➔ Coordinate case conferences and meetings as required.
    - In limited circumstances, due to geographical circumstances where face-to-face contact is difficult, an appropriate alternative arrangement should be discussed with the parole officer and their supervisor. The case conference may have to be conducted by phone.
  - ➔ Maintain ongoing contact with the community MMT provider and with the community correctional programs officer.

- Document results of case conferences and meetings on an OMS Memo to File

  OMS Memo to File: When posting an OMS Memo to File for MMT issues, please type "METH " immediately followed by the year and month as the first word in the subject line. For example "METH0310" would indicated the Memo to File was written in October 2003.

  This ensures all memos related to methadone are readily identifiable.

  - ➔ Ensure documentation reflects the source of the information i.e. whether provided by offender or by community clinic.

- Ensure access for the offender to the appropriate substance abuse interventions, as identified in the release plan, or as current status warrants.

- Ensure access for the offender to the appropriate counselling and support services as identified in the release plan, or as current status warrants.
- Encourage abstinence from all illicit drugs, recognizing the need for offender to minimize the harms of injection drug use.

Suspension

Note: While providing updates on offender's programming needs and status is the primary responsibility of the community correctional programs officer, in areas where there is no community correctional program officer the following responsibilities may have to be assumed by the community parole officer.

Suspension — Admitted to a Remand Centre/ Federal Institution

- Liaise with the institutional parole officer to provide an update on offender's current situation and programming needs. Ensure methadone programming information and a current evaluation is complete and communicated to the institution without delay.

- Participate in a case conference with the relevant institution staff to ensure methadone treatment continues and site receives all relevant information.

- Provide the institution with the contact information of the community methadone clinic/provider, and/or pharmacy who can provide Health Services with information on dosing.

Warrant Expiry

- Provide assistance and encouragement so that an offender's relocation at warrant expiry is managed in such a way as to maintain continuity in MMT.

Community Correctional Programs Officer

MIT Role: To assist in the development of the substance abuse intervention component of the *MMT Plan* and to coordinate the delivery of substance abuse programs and services to the offender.

Release Planning

Note: For purposes of MMT, the *Institutional* Parole Officer must initiate release planning.

Prior to Release to the Community (including parole)

- At the release planning stage, a correctional programs officer should be consulted by the community parole officer completing the report to comment on offender programming needs in the community in relation to substance abuse problem

Offender returns to the community post-suspension

- If methadone was not available at the remand centre and the offender is released back to the community, a re-initiation of methadone may be required. The offender will likely experience a non-stable period.

- Re-evaluate the programming needs if suspension was due to a breach (using other substances).

- Liaise with the community parole officer and methadone provider.

Initial Assessment / Continuation of Methadone in Community

- Liaise with the institutional correctional programs officer.
- Gain a full appreciation of the offender's methadone and substance abuse history.

- Meet with the community parole officer and offender.
- In limited circumstances, due to geographical circumstances where face-to-face contact is difficult, an appropriate alternative arrangement should be discussed with the community correctional program officer and their supervisor.
- Review expectations for the community, (i.e., any issues related to the offender's participation in community substance abuse programs).

MMT Administration *and* Monitoring

- Monitor the offender's participation in community substance abuse programs as identified in the release plan.
  - ➔ Document interactions and interventions with an OMS Memo to File.

    OMS Memo to File: When posting an OMS Memo to File for MMT issues, please type "METH " immediately followed by the year and month as the first word in the subject line. For example "METH0310" would indicate the Memo to File was written in October 2003.This ensures all memos related to methadone are readily identifiable.

  - ➔ Encourage abstinence, recognizing the need for the offender to minimize the harms of injection drug use.
  - ➔ Where required, document the offender's use of methadone in program performance reports.
  - ➔ Maintain ongoing contact with the offender's community parole officer.
  - ➔ Adapt substance abuse interventions and counselling to meet the offender's needs.

- Participate in case conferences and meetings.
  - In limited circumstances, due to geographical circumstances where face-to-face contact is difficult, an appropriate alternative arrangement should be discussed with the community correctional program officer and their supervisor

Suspension

Note: While providing updates on offender's programming needs and status is the primary responsibility of the community correctional programs officer, in areas where there is no community correctional program officer, the following responsibilities may have to be assumed by the **community parole officer**.

Suspension — Admitted to a Remand Centre/ Federal Institution

- Liaise with the institutional correctional programs officer to provide an update on the current situation and programming needs. Ensure programming information and a current evaluation is complete (to go on case management file to follow the offender).

- Attend a case conference with the community parole officer and relevant Remand Centre staff to ensure methadone treatment continues and the site receives all relevant information.

Warrant Expiry

- Assist the community parole officer to ensure that any relocation of the offender is managed in such a way as to maintain continuity in his/her MMT.

Section D: METHADONE DOSING ISSUES

Section D: Methadone Dosing Issues

The illicit supply of opiates within CSC is not consistent in quantity or quality. Physicians must **be cautious and ensure they do not over estimate tolerance, based on the inmate's self-reported use.**

Initial Dosing & Stabilization

"Start low – go slow"

(motto from College of Physicians and Surgeons of Ontario, 2001)

Initial Dose

During methadone initiation, in cases where any symptoms of withdrawal are to be avoided (e.g., **pregnancy or impaired cardiac status** in which autonomic instability may be dangerous), multiple daily doses (split doses) should be used during initiation to allow for rapid stabilization while maintaining safety. Following initiation, the dosing schedule should be altered to either once daily or multiple daily dosing according to the clinical setting. Advice from the regional methadone medical consultant is recommended.

- The initial dose of methadone will not exceed 30 mg for inmates who commence methadone maintenance therapy (MMT) within CSC. The typical starting dose is 15-30 mg by mouth per day (see note below).
- The initial dose of up to 15-30 mg must not be increased for at least 5 days.
- During the initiation period, a physician must reassess the use of currently prescribed opiates.

Note: For those beginning MMT, starting doses of 40 mg have lead to deaths after three days of treatment (Caplehorn 1998). The lethal dose is even less if taken together with other opioids, alcohol, benzodiazepines or barbiturates. Three days represents the average time for an individual being dosed daily to reach 87.5% of steady state for a drug with an elimination half-life of 24 hours (College of Physicians and Surgeons of Ontario, 2001). If the individual does not achieve adequate reduction in withdrawal symptoms, and does not show evidence of sedation at this dose, the dose may be safely increased.

Dose Increases

- Methadone doses should not be increased more frequently than every 5 days during the initiation period.
- Each dose increase will not exceed a 5–10 mg range.
- Dose is not to be increased in response to complaints of pain unless those complaints of pain relate to withdrawal symptoms.

Reasons for dose *increases* include:

- Signs and symptoms of withdrawal
- Amount and/or frequency of opioid use not decreasing
- Persistent cravings for opioids
- Failure to achieve a dose that blocks the euphoria of short acting opioids

Dose decreases

Reasons for dose *decreases* include:

- Persistent nodding
- Somnolence
- Tapering (voluntary or involuntary) from MMT.

Maintenance dose

A daily dose above 120 mg is considered high. If the physician has difficulty stabilizing the patient's dose above this level, it is recommended that a physician should consider seeking advice from the regional methadone medical consultant or the provincial College of Physicians and Surgeons. The institutional physician must document on the Progress Notes the justification for a dose exceeding 120 mg.

Resumption of Methadone Maintenance Treatment

In some cases, an inmate may present for continuation of MMT that has been started outside the corrections system (the inmate did not enter CSC from a Provincial Correctional Centre). In these cases, it can be difficult to assess with certainty the degree of methadone or opioid tolerance that is present. Most community methadone maintenance treatment programs have provision for unobserved dosing (take-home doses/carries). Diversion of some or all of the prescribed methadone is not uncommon. This can lead to a dangerous overdose when the full dose of methadone is given. In such cases, it would be safer to **split the dose** of methadone into several smaller doses **for the first day** so that patient response to methadone may be assessed. If there are no signs of sedation observed, the full once-daily dose may be resumed.

Split doses

Split dosing should be considered ONLY in circumstances where it is absolutely necessary (investigate cause) and in consultation with the Regional Methadone Consultant.

Reasons to consider split doses include:
(These are only two examples for which further investigation is warranted.)

- Methadone recipients may complain that they feel their methadone dose is not maintaining them free from withdrawal symptoms for 24 hours, even after several dose increases
- Methadone recipient's urine is negative for methadone metabolites and tampering seems unlikely due to the vigilance of the nurses during specimen collection.
- See note on pregnancy/impaired cardiac status, etc. in "Initial Dose" above.

Infrequently, rapid metabolism may affect the half-life of methadone, potentially resulting in a need to provide methadone more frequently than once daily. Also, some medications that the inmate may be prescribed decrease the half-life of methadone, resulting in dramatic drops in serum methadone levels, thus creating symptoms of withdrawal. In cases of rapid metabolism, simple dose increases of once-daily dosing will not correct the situation. **The institutional physician will assess every case individually.**

If the **results of the tests presented below** indicate a peak to trough ratio greater than 2:1, the half-life of the drug is less than 24 hours, and split dosing may be necessary to prevent drastic drops in serum methadone levels.

Laboratory investigations to determine peak to trough ratio

To investigate serum half-life, the peak to trough ratio can be determined. The peak represents the highest serum methadone level achieved (usually between 2-4 hours post-ingestion) and the trough represents the lowest serum level (immediately before methadone ingestion). This ratio should be less then 2:1, indicating the dosing interval is at least as frequent as the drug half-life

Specimens needed:

- Blood is drawn prior to methadone ingestion, 2 hours post-ingestion, and 6 hours post-ingestion for a total of three blood specimens.
- A urine specimen is obtained at the same time as the blood specimen.

Include with specimens:

- The specimens must clearly indicate the time of collection.
- The requisition should note "serial serum for methadone parent and metabolite (EDDP) with accompanying urine for quantification of same".
- Creatinine and pH of the first urine specimen must also be requested.
- A photocopy of the inmate's medication administration record must accompany the following specimens to the laboratory.

Dosing Contingencies

Missed Doses

Note: Dose adjustments *must* be ordered by the institutional physician, in each case.

- The **nurse** must notify the institutional physician of any missed doses and the reason for missing documented in the Medical Record.
- To determine the next dose, the physician can use the formula provided in Chapter 4 of *Methadone Maintenance: A Physician's Guide to Treatment* (Brands 1998).
- The dose must be decreased to below 30 mg after 5 consecutive missed doses in order to assess loss of tolerance. The dose can be more quickly increased back to the original dose in most cases, after adequate tolerance is demonstrated.

Vomited Doses

Note: Dose adjustments *must* be ordered by the institutional physician, in each case.

People will occasionally report that they vomited after receiving a drug. This may be true, or the claim may be made in attempts to access more of a drug. As it may be lethal to replace a dose of methadone that has been reported as vomited when in fact the dose was not vomited, the following protocol recommended by the College of Physicians and Surgeons of Ontario in 2001 may be adopted.

If the emesis is **witnessed** by a health professional or staff member, the dose may be replaced as follows.

- Emesis less than 15 minutes after methadone ingestion, replace the full dose (first day only; see paragraph below for 2 consecutive days).
- Emesis between 15 to 30 minutes after methadone ingestion, replace 50% of the dose.
- Emesis greater than 30 minutes after methadone ingestion, no replacement.

It is important to remember that a person retains approximately 40% of what they have ingested even after forceful emesis. The physician must be contacted for direction if the inmate is observed to vomit his/her methadone on 2 consecutive days. Sipping the replaced dose, or the addition of an anti-emetic may be helpful in reducing the risk of emesis. Therefore, if the inmate has been observed to vomit his/her methadone dose less than 15 minutes after ingestion, over 2 consecutive days, replacing the entire dose of methadone on the second day may potentially result in overdose.

If the inmate meets the above criteria to have the full dose or part of the dose replaced after one occurrence of observed emesis, but there is no available dose of methadone on site with which to do this, the physician must be contacted to advise a course of action.

Repeated reports of vomited doses should be noted and discussed with the inmate during an MIT meeting.

Planned Dose Interruptions

Note: Dose adjustments *must* be ordered by the institutional physician, in each case.

In situations where it becomes necessary to temporarily discontinue oral methadone treatment (such as during post operative NPO orders), withdrawal from opioids must be anticipated and prevented. This can be done by the parenteral administration of a suitable alternative opioid, titrated to prevent withdrawal symptoms.

Voluntary Tapers

Note: Dose adjustments *must* be ordered by the institutional physician, in each case.

The rate of voluntary taper is determined by the physician and the methadone recipient. Voluntary tapers must be gradual in order to prevent relapse. As a rule, the rate of taper should be no more than a 10% dose reduction every 5-10 days. Inmates should be informed of the risk of relapse and that the dose can be increased again if they so choose. During a voluntary taper, the physician will designate a previously 'Stable' methadone recipient as 'Non-Stable'. This will be reflected on their *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)*. In general, larger dose reductions are possible at the beginning of the taper but often need to be reduced during the last 20-30% of the titration process. Due to the long elimination half-life, it may be 7-14 days after a dose reduction that withdrawal symptoms will become evident.

Involuntary Tapers

Note: Dose adjustments *must* be ordered by the institutional physician, in each case.

Involuntary tapers *must be considered* if repeated counselling for the following has not resulted in compliance.

- failure or refusal to provide urine for drug screens
- failure to attend physician appointments
- diversion of methadone (dealing or not taking it)—as evidences by repeated urine reports indicating no methadone metabolites
- falsifying urine samples in any way

The above list is not to be considered all-inclusive.

Involuntary tapers *will result immediately* if any of the following occur.

- **threatening** (or other forms of intimidation) the safety or well-being of a staff member (includes any staff member related in any way to MMT, e.g., security staff in the Health Services Centre), another methadone recipient.
- engaging in **disruptive behaviour** (includes but is not limited to inciting, swearing, yelling, smashing property) in any area directly related to MMT

- engaging in **violent behaviour** towards a staff member, another methadone recipient, or another person, in any area or in any way directly related to MMT

  (College of Physicians and Surgeons of Ontario, 2001)

The rate of involuntary tapers must be humane. However, care should be taken that tapering would not result in the continuation of MMT for an unnecessarily prolonged period of time. All available supportive services (e.g., psychology, relapse prevention counselling) must be offered to the inmate along with clinical management of withdrawal symptoms.

Carries/Temporary Arrangements

"Carries" or "take-home" doses of methadone **will not be available** to inmates residing in CSC institutions at any time.

Table 10: Overview of Accessing Methadone during Temporary Absences (see details below)

Inmate's location	Doses during Temporary Absences
CCCs and CRFs	Inmate goes to a community pharmacy/clinic on a daily basis.
UTAs with *any* of the following: - Proximity to CSC institutions - No community methadone service provider - UTA/work release, restricted community access	CCC may use a CSC institutional health care department
UTA ETA *overnight*	Inmate picks up daily dose at a pharmacy near the UTA/ETA.
ETA *for one day*	Inmate must receive his/her dose before leaving the institution.
Work release/ Residing in community (excluding routine 'fence clearance' status)	Inmate obtains the prescription from a clinic, and goes to clinic/pharmacy daily to take the methadone.
Private Family Visiting Units	Inmate is escorted daily to Health Services.
Conditional Release, in care of community methadone provider	Inmate receives methadone as determined by the community methadone provider
Community Hospital	Unit doses may be supplied to the Community Hospital Pharmacy under certain conditions. (See "Transfer to a Community Hospital" below.)

Transfer to a Provincial Correctional Centre

Inmates occasionally have to return to Provincial Correctional Centres to attend court or to stay overnight during a transfer process.

The **nurse** should advise the Health Services department in the Provincial Correctional Centre of the transfer as soon as the transfer becomes known. The **nurse** must fax the last Progress Note regarding MMT completed by the physician, and a copy of the *Methadone Maintenance*

Treatment Plan (CSC/SCC 1260–03) to Health Services in the Provincial Correctional Centre. Any further requests of the receiving centre should be accommodated to the extent possible.

On the day of transfer, communication must be clear between institutions regarding whether or not the inmate has received his/her dose of methadone for that day and the inmate's normal dosing time. If an inmate had been receiving their methadone daily at 0730, and the receiving institution's methadone parade is daily at 1630, the inmate may require a graduated dosing time change to prevent anxiety and perceived withdrawal. This should be discussed with the receiving centre prior to the transfer.

Doses should not need to be sent with the transfer if the above process is followed. If for some reason a dose is sent, the same process should be followed as outlined below.

Transfer to Another CSC Institution

Carries, or 'take-home' doses of methadone, will not be available to inmates residing in CSC institutions at any time.

However, in special circumstances methadone doses can be transferred between CSC institutions when necessary (e.g., **unscheduled security or medical transfers**). These doses should accompany the Medical Record in such a way that continuity of handling can be demonstrated. The receiving institution must respond in writing to the sending institution indicating the number of methadone doses that were received. This documentation should be placed with the corresponding Narcotic Record.

The **nurse** should notify the receiving institution of the date of transfer of the inmate as soon as it becomes known. The receiving institution will then notify their pharmacy. In cases where the pharmacy remains the same, the sending and the receiving **nurse** can notify the pharmacy.

The **nurse** must fax the last Progress Note completed by the physician (for proof of dosage), and a copy of the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03),* to Health Services in the receiving institution. The **nurse** should contact the receiving pharmacy to advise them of the transfer and inquire what information they require.

On the day of transfer, the **nurse** must communicate clearly with the receiving institution regarding whether or not the inmate has received his/her dose of methadone for that day and the inmate's normal dosing time. If an inmate had been receiving their methadone daily at 0730, and the receiving institution's methadone parade is daily at 1630, the inmate may require a graduated dosing time change to prevent anxiety and perceived withdrawal.

If an inmate is scheduled for an **inter-regional transfer,** (i.e., the transfer will take most of one day), **graduated dosing time changes** should be initiated at the sending institution in the days prior to the transfer. The inmate should take his/her methadone dose prior to leaving the institution on the day of inter-regional transfer.

Release to a CCC/CRC

For offenders in Community Correctional Centres (CCCs) and Community Based Residential Facilities, there will be no carry privileges.

For offenders residing in Community Correctional Centres (CCCs), CSC is still responsible for ensuring that essential health services are provided. However, most CCCs do not have **in-house** methadone clinics. These offenders, and in most cases those residing in Community Residential Centres (CRCs), will receive methadone through community methadone pharmacy/clinics on a daily basis. In this case, the **community parole officer** is to maintain contact with the community pharmacy/clinic and update the offender's progress on an OMS Memo to File as required.

OMS Memo to File: When posting an OMS Memo to File for MMT issues, please type "METH " immediately followed by the year and month as the first word in the subject line. For example "METH0310" would indicate the Memo to File was written in October 2003.This ensures all memos related to methadone are readily identifiable.

Community Correctional Centres with **in-house** methadone clinics are expected to enforce the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05),* and maintain the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03).*

In unusual circumstances, a CCC may use a CSC institutional health care department. These circumstances include proximity to CSC institutions, lack of community methadone service providers for an offender released on UTA, or work release with restricted community access. In such rare occurrences, the **institutional parole officer** shall complete the advance arrangements. The **community parole officer** will arrange for the establishment of a community Methadone Intervention Team.

Conditional Release in Care of Community Methadone Provider

If an offender is living in the community on conditional release, but not residing in a Community Correctional Centre (CCC) or a Community Residential Facility (CRF), and is in the care of a community methadone provider, he/she may receive carries from the community clinic under the supervision of the community methadone clinic.

Unescorted Temporary Absences (UTA)

Risk assessments for Escorted/Unescorted Temporary Absences and work releases shall take into consideration the availability of **guest dosing** in the community in relation to the risk of discontinuing treatment during the ETA/UTA or work release.

In unusual circumstances, a CCC may use a CSC institutional health care department. These circumstances include proximity to CSC institutions, lack of community methadone service providers for an offender released on UTA, or work release with restricted community access. In such rare occurrences, advance arrangements shall be completed by the **institutional parole officer**.

If an inmate is going on a UTA, a pharmacy in the area of the UTA must be contacted and arrangements made by the **nurse** and **institutional parole officer** for the inmate to pick up his/her daily methadone dose. The inmate must be advised in advance to bring photo identification with him/her or the pharmacist may not provide the methadone. The pharmacist must witness the ingestion of methadone and record this according to their own provincial narcotic administration regulations. The pharmacy should be asked exactly what they require in advance in order to provide the methadone, and these requirements communicated to the inmate.

If the **nurse** and **parole officer** are unable to locate a pharmacy in the immediate area of the UTA, the inmate must be advised and given the choice to proceed with the UTA without methadone, if the assessed risk does not warrant cancellation of the UTA.

Transfer to a Community Hospital

If an inmate on methadone is transferred to a community hospital for in-patient or out-patient services, the **nurse** should ensure that the *Letter Concerning Analgesia for An Inmate on Methadone Treatment (CSC/SCC 1260-08)* accompanies other transfer documents. This practice will ensure continuity of care and provide the community hospital with a contact name if questions arise.

Some community hospital pharmacies do not supply methadone to in-patients. Each institution should be aware, in advance, if doses of methadone must accompany the inmate to the community hospital and arrangements made if further doses are required. If further doses must be sent, the **institutional physician** should contact the inmate's physician in the community hospital to determine the inmate's status and medication profile, thereby assessing if dosage adjustments are required. The community hospital should be requested to give institutional Health Services at least 24 hours notice prior to discharge. This will allow notification to the CSC Regional Hospital (if applicable) or continuity of care at the parent CSC institution.

Escorted Temporary Absences (ETA)

If an inmate is going on an ETA **for one day**, to outside court or an outside medical appointment for example, the methadone dose should be administered to the inmate before he/she leaves to ensure the time period between doses does not exceed 24 hours. The **institutional physician** should be consulted if the methadone dose must be given greater than 4 hours before or after the usual dosing time.

If an inmate is going on an ETA **overnight**, the same arrangements as above must be made with a pharmacy in the ETA area. Security and/or non-security escorts should not be asked to carry or administer methadone.

If the inmate is going to a medical appointment during which they might receive analgesic, the **nurse** should ensure that the *Letter Concerning Analgesia for An Inmate on Methadone Treatment (CSC/SCC 1260-08)* accompanies other transfer documents.

Work Releases

Work release (excluding the routine 'fence clearance' status) involving inmates on methadone can be complicated by a lack of specific instructions on the work release decision and/or the release certificate. Although living in the community, the inmate remains under the authority of the institution. Therefore, it is essential that the need of the inmate to attend a clinic in order to obtain the prescription and to attend daily a clinic/pharmacy to take the methadone, be included in the comments of the decision maker (Warden/Deputy Warden), as well as on the release certificate. Normally, this provision is met by including a separate ETA package (prepared by the **parole officer**), for the sole purpose of attending clinic and pharmacy appointments, in the release application, case preparation, and decision.

Failure to include this option in the work release information makes it virtually impossible for inmates on work release to obtain methadone as the CCC/CRF responsible for supervision will not have legal authority to escort him/her off site for reasons unrelated to the specific release plan. The decision maker (Warden/Deputy Warden), should not be presented with case preparation for work release that does not include a separate provision for methadone access.

Private Family Visiting Units (PFVU)

Carries will not be issued to an inmate who will be residing in the private family visiting unit overnight. The inmate must be escorted daily to Institutional Health Services at the appropriate time to take his/her methadone dose.

Visitors who are methadone recipients, and who will be residing in the private family visiting unit overnight, must leave their methadone dosages in a locked cabinet outside of the PFVU. Visits and Correspondence (V+C) staff will provide the visitor with daily access to the locked cabinet at their stated dosage time. It is recommended that the visitor place the methadone dosages inside the cabinet, that the key for the cabinet be issued to the visitor after the methadone is placed in the cabinet, and that the key returned when the visit is completed. All dosages should have intact protective seals. V+C staff should alert Health Services immediately if there are any concerns

Section E: URINE DRUG SCREENING

Section E: Urine Drug Screening

The results of a urine drug screen provide valuable information and can be used as an aid for the following.

- Document baseline drug use and periods of abstinence.
- Verify self-report of drug use.
- Verify the methadone recipient is ingesting the methadone.
- Aid in establishing functional stability.
- Minimize possible drug interactions.
- Adjust methadone dosage.
- Re-evaluate treatment goals.
- Modify the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)*

(College of Physicians and Surgeons of Ontario, 2001)

Urine Screens for General Toxicology

As part of the process of Medical Assessment for Methadone Initiation, two randomly timed urine specimens must be sent for general toxicology. It is important to explain to the inmate that these results do not have to be positive for opiates in order to qualify for MMT. In the correctional setting, inmates not currently using opioids can be initiated on methadone if they have a documented history showing a pattern of long-term dependence and a high risk of relapse. General toxicology screens provide the physician and MIT with more information than the routine screens for cocaine, opiates, methadone metabolite, and benzodiazepines. The physician can order urine specimens for general toxicology screening at his/her discretion, at any time.

Routine Urine Drug Screens

ⓘ See also Table 8: "Nurse's Guidelines for Specimen Collection for MMT Routine Urine Drug Screening" in Section C of these guidelines under "Nurse".

Schedule

ⓘ See also "CSC "Stable" and "Non-Stable" Monitoring Guidelines " in Section B. of these guidelines.

The frequency of random urine drug screens for cocaine, opiates, methadone metabolite, and benzodiazepines depends on the methadone recipient's classification as 'Stable' or 'Non-stable'.

In the first 3 months on MMT (whether the inmate entered CSC on methadone or began methadone within CSC in the past 3 months), random urine screens must be performed *twice a week*.

After the first 3 months on MMT, the non-stable methadone recipient must undergo random urine screens *every one to two weeks*. This decision is made by the MIT and is determined in relation to the reason the inmate is considered non-stable.

> For example, if the inmate is classified as non-stable due to positive urinalysis, the MIT may wish to continue doing urinalysis *every week.*
>
> On the other hand, if the inmate is classified as non-stable due to something unrelated to urinalysis, and past screens have been negative, the MIT may choose to have random urine screens *every two weeks*.

Once the inmate is classified as 'stable', a random urine drug screen for cocaine, opiates, methadone metabolite, and benzodiazepines *every two weeks* is appropriate.

Drug Screening Kit Versus Laboratory Screening

If a national standing offer for on-site urine drug screening kits is not in place, it is at the discretion of the institution and/or region if a laboratory will be used or if an on-site urine drug screening kit will be used for routine testing.

If a national standing offer is in place for on-site urine drug screening kits, these kits must be used exclusively for on-site screening. Laboratories must still be used for general toxicology screens.

If an on-site urine drug screening kit is used for routine urinalysis for cocaine, opiates, methadone metabolite, and benzodiazepines, the kit must be reliable, and indisputable records must be kept on the inmate's Medical Record of the results. The results, identified on the kit, must be photocopied (place kit in a clear plastic baggie to photocopy), signed and dated by the nurse.

It must be noted that drug screening kits are not recognized in court as being reliable enough to seriously impact a liberty interest. Manufacturers and distributors claim a high accuracy rate; however, these claims are based on optimal conditions that do not exist in a CSC environment. These kits do have sufficient reliability and accuracy for monitoring methadone recipients.

Results of Random General Toxicology and Routine Urinalysis

Consent and use of results

> **Note:** All urine drug screens obtained for MMT within CSC, whether analyzed by a urine drug screening kit or an external medical laboratory, are not part of or connected to CSC's security urinalysis programs and the testing processes of its official laboratory.

The results of all urine drug screens obtained for the purpose of MMT —whether general toxicology or routine urinalysis—are part of the inmate's Medical Record. By signing the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)*, the inmate/offender has given consent for the results of urine drug screens, obtained for the purpose of MMT, to be

shared with **members of the MIT**.

The results are used by all members of the MIT for dosing issues, counselling, and supporting the inmate in his/her commitment to become abstinent and in altering the *Methadone Maintenance Treatment Plan (CSC/SCC 1260-03)*.

As with all medical information shared with the MIT and relevant to MMT, the information *may not* be shared outside of the MIT without a signed *Release of Information* by the inmate/offender, and *may not* be used for any purpose outside of MMT.

> The only instances in which urine drug screen results obtained for MMT may be shared without the inmate's/offender's consent are:
>
> - to protect the inmate's/offender's health or safety or the health or safety of another person;
> - where the release is otherwise required and authorized by law or authorized under the Privacy Act.
>
> The inmate/offender must be advised of this release of information. If the inmate/offender believes this release of information was inappropriate, he/she has the right to address the release through the appropriate process of recourse.

The results of urine drug screens, obtained for MMT, are <u>not</u> to be used as the basis for disciplinary actions. **Community parole officers** must ensure that the results of urine drug screens, performed by the community methadone provider and shared with the CSC community MIT, **are only used** to adjust their frequency of interaction with the offender and/or identify further programming or counselling needs.

<u>Positive results</u>

The Correctional Service of Canada's MMT is not an abstinence program. A positive urine drug screen will not immediately result in a dosage taper from the treatment.

Each institutional MIT must decide, on an *individual* basis for each methadone recipient, how long positive urine screens will be allowed to continue—in spite of ongoing counselling—before the inmate's commitment and motivation for MMT must be reassessed. The inmate's functionality and overall progress will be taken into consideration when decisions are made on possible termination of MMT for prolonged use of unauthorized drugs.

<u>Contesting results</u>

If any MIT member (usually the inmate) strongly disagrees with a urine result, and the test was done in a laboratory, the laboratory may be contacted to perform confirmation testing.

Section F: SUBSTANCE ABUSE INTERVENTION

Section F: Substance Abuse Intervention

ⓘ See also Appendix H: Qualifications of MMT Substance Abuse Program Providers

ⓘ See also description of role for *Institutional* Correctional Programs Officer and for *Community* Correctional Programs Officer in Section C: Specific Responsibilities of CSC's MIT Members.

Background

Quality substance abuse intervention is a critical element for a successful methadone maintenance treatment program. The **purpose** of Substance Abuse Intervention in relation to Methadone Maintenance Treatment (MMT) is to assist the inmate in addressing problem areas in his/her various life areas, which was not possible when he/she was actively using heroin or other opioids. With the inmate's physical requirements being met through the proper titration of methadone, these intervention sessions are designed to address the psychological and environment needs of the inmate so he/she may learn to cope with life without the use of heroin and other opioids.

Once the inmate has been accepted into MMT, he/she meets with the correctional programs officer to establish a specific *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01)*. This plan will identify specific areas the inmate will address through his/her substance abuse intervention sessions and must be maintained throughout.

It must be noted that the inmate may require a period of stabilization (possibly several months) prior to commencing substance abuse programs. During this time, the correctional programs officer should maintain contact with the inmate.

As well, the inmate is expected to participate in regular substance abuse intervention. This intervention may take the form of one of the following.

- group maintenance sessions
- individual appointments
- a combination of the two

The following guidelines articulate the content and process of the CSC's MMT Substance Abuse Intervention and offer guidance in creating and following the *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01).*

Table 11: Notes on MMT Substance Abuse Intervention

	Notes on MMT Substance Abuse Intervention
Goals of Intervention	To assist the inmate in maintaining compliance with the *Methadone Maintenance Treatment Agreement (CSC/SCC 1260-05)* and **to encourage and support offenders to lead a drug free life** To increase the likelihood of success by providing the inmate with the required skills and knowledge to address his/her areas of need.
Focus of Intervention	The focus of the intervention will be on addressing the immediate and long-term needs of the inmate in order to become stable in each of his/her life areas. Although the intention of the intervention is not necessarily to work toward moving the inmate to a point where he/she is voluntary weaned from MMT, the correctional programs officer should be ready to deal with this issue should it arise.
Group Size for Sessions	Consistent with other core program standards, **maximum group size is 10**. **If the number of inmates on MMT reaches beyond 10**, it is recommended that the site conduct more than one group session per week to accommodate the maximum number of participants. **Sites without sufficient numbers** to conduct groups (e.g., less than 4 MMT inmates), are encouraged to participate in OSAPP or Choices maintenance sessions, if they meet the criteria of those groups. However, they would require supplemental sessions, as required, to focus on specific methadone concerns. An alternative to group sessions for sites with few inmates on MMT would be to conduct individual sessions.
One on one Intervention Sessions	These may be conducted with inmates **if they are warranted**, as follows. • Sessions are required in addition to weekly sessions. • Immediate issues arise that can't wait for the next group session. • The site does not have a sufficient number of MMT inmates to conduct group sessions. **However:** • One-to-one sessions do not replace weekly group sessions. • One-to-one sessions should follow the same process and content guidelines provided earlier in this document. • It is recommended to employ group sessions whenever possible, and minimize the use of one to one sessions.

Notes on MMT Substance Abuse Intervention (cont'd)	
Frequency of Sessions	ⓘ See "Frequency of Substance Abuse Intervention Sessions" below. ⓘ See also "CSC 'Stable' and 'Non-Stable' Monitoring Guidelines" in Section B. of these guidelines.
Content of Sessions	The MMT sessions can take a wider scope than those of other maintenance sessions (OSAPP/Choices).
Facilitator's approach	The facilitator is required to tailor the content and approach of the sessions according to the participant's level of expertise and previous programming experiences. The key is to satisfy the specific needs of the inmates in their initial and on-going stabilization on MMT, to focus on improving each of their life areas and assist them in their reintegration.
Recommended topics of skills for sessions	The following are recommended topics/skills to be considered by the correctional programs officer when preparing the structured segment of each intervention session. • Education regarding methadone and the common side-effects • 'Myths' of methadone • The 'stigma' of being on methadone • Current challenges of being on MMT • Specific risk situations (current and future) • Problem solving strategies (use current, real life scenarios) • Cognitive coping skills (identify destructive thinking patterns and employ coping by thinking techniques), as well as … • Behavioural coping skills to enhance the inmate's ability to effectively cope with unpleasant emotions, physical discomfort, pleasant emotions, personal urges and temptations, conflict with others, pressure from others to use and good times with others • The inmate's crime cycle and its relation to substance use • Slips versus relapse • Relapse prevention strategies • Relapse management strategies • Aftercare • Life area planning (e.g., substance use, work/school, relationships, health and fitness, leisure) • Pain management strategies • Relaxation and stress management

Format of Individual or Group Maintenance Sessions

The intervention sessions follow a similar format to that of the OSAPP and Choices maintenance sessions. Each intervention session is to be conducted in an interesting and interactive manner.

1. **Warm-up** (check in, re-establish rapport).
2. **Current Issues:** Explore how the inmates have been coping since the previous session, as well as to identify issues that have emerged. The correctional programs officer must be ready to deal with any and all issues that are identified. In most cases, a decisional balance, problem solving and motivational interviewing techniques will be necessary to assist the inmate address his/her immediate concerns and those issues which may affect his/her success or compliance with the *MMT Agreement (CSC/SCC 1260-05).*
3. **Prepared Lesson Plan/Exercise:** Based on the inmates' identified need areas and the progress to date, a specific lesson or exercise is prepared by the correctional programs officer in advance (see "Content of Sessions" in Table 11: Notes on MMT Substance Abuse Intervention above).
4. **Explore anticipated issues** that may be encountered by the inmates between now and the next session, and if required, assist in developing action plans.
5. **Establish specific objectives** and/or tasks for the inmate/s to work on through to the next session.
6. **Wrap-up.**

Frequency of Substance Abuse Intervention Sessions

Not all inmates on methadone are the same—some will require frequent intervention and close supervision, while others will not. These differences may be based on a number of variables such as the length of time on MMT, level of stability, urine drug screen results, his/her engagement in the correctional plan and progress made toward addressing his/her problem areas.

Consistent with the principle of matching need with appropriate intervention, the following guidelines are designed to maximize the service provided to each inmate, as well assist the correctional programs officer in deciding which inmates are in the highest need of intervention. This approach takes a three-tiered 'cascading approach' with MMT inmates requiring High, Moderate or Low frequency. This design should maximize the program's effectiveness and efficiency for both inmates *and* correctional programs officers.

Changes of Frequency

It is imperative that all staff closely monitor each inmate. Based on his/her attitude, behaviour and circumstances, the inmate's required frequency will fluctuate. For example, an inmate in the moderate category may be required to attend intervention sessions more frequently if his/her behaviour warrants it. However, as the inmate's monitored behaviour stabilizes, then his/her required frequency would again be reduced. The inmate's required frequency should be revisited at each MIT meeting.

High Frequency:
Minimum Attendance of Once per Week

Inmates categorized as requiring High Frequency

- Are starting on MMT and have not yet reached their stabilized dosage.
- Have been on MMT for less than 3 months.
- Are displaying risky and/or deteriorating behaviour (positive urinalysis tests, not abiding by MMT agreement, disruptive).
- Are only interested in 'warehousing on methadone' and not interested in addressing their Correctional Plan;
- Have limited information about methadone, its purpose and its side-effects.
- Display a clear need to address skills deficits.

Moderate Frequency:
Minimum Attendance of Once every Two Weeks

Inmates categorized as requiring Moderate Frequency

- Have been on MMT for more than 3 months.
- Have achieved a stabilized dosage.
- Are displaying few symptoms of risky or deteriorating behaviour.
- Are still slightly resistant to intervention sessions.

Low Frequency:
Minimum Attendance of Once per Month

Inmates categorized as requiring Low Frequency

- Have been on MMT for a minimum of 6 months.
- Have minimal or no symptoms of risky or deteriorating behaviour.
- Are attending to their Correctional Plan.
- Are demonstrating progress in their life areas.
- Are classified as "Stable" by the MIT and is monitored under the *Stable Monitoring Guidelines* in these guidelines.

Table 12: Notes on the *Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01)*

Notes for the Correctional Programs Officer on The ***Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01)*** (referred to in this table as the *"Treatment Plan")*	
Purpose	The *Treatment Plan* provides the inmate with a treatment focus and assists the correctional programs officer in determining the content to prepare and deliver for each intervention session. The *Treatment Plan* is dynamic and changes with the needs of the inmate.
Formulating the *Treatment Plan*	Following the Initial Case Conference, the inmate and correctional programs officer review the inmate's needs, as identified from the substance abuse assessment process as well as the options listed on the *Treatment Plan.* Each option listed in the form represents a key life area, a specific risk situation, or a combination of the two, and are based on the risk categories identified by the *Inventory of Drug Taking Situations*. Each option requires the development of "coping by thinking" or "coping by doing" skills. These skills are compatible with those found in the "Content of Sessions" segment of Table 11: Notes on MMT Substance Abuse Intervention.
Section A (pages 1–2)	Inmate identifies specific areas he/she is interested in working on. Then based on these choices, he/she selects the top 3 areas he/she wishes to work on first, rates his/her current coping ability and details the steps he/she will take to improve the area. The inmate and correctional programs officer sign the completed form at the *beginning* of the assessment period.
Section B (page 3)	The "Summary of Participant's Needs" identifies the inmate's top three need areas from his/her *Treatment Plan* and details the skills required to further improve the inmate's coping ability. This will help identify the focus for the intervention sessions that will be conducted over this assessment period. The correctional programs officer completes this section at the *beginning* of the assessment period.
Section C (page 4)	The "Post-assessment Summary" summarizes the inmate's progress made in the specific areas that were identified at the beginning of this assessment period. The correctional programs officer completes this section at the *end* of the assessment period (e.g., 6 months later).

Notes for the Correctional Programs Officer on The ***Methadone Maintenance Substance Abuse Treatment Plan (CSC/SCC 1260-01) (cont'd)*** (referred to in this table as the *"Treatment Plan")*	
Reassessing the inmate *and* Revising the *Treatment Plan*	Periodically, but **at least every 6 months**, the correctional programs officer revisits the inmate's *Treatment Plan.* • The inmate and correctional programs officer repeat the initial process for formulating the plan and identifying the inmate's three most pertinent areas to work on. • The correctional programs officer also completes the "Post-assessment Summary", rating the inmate's progress since the previous assessment (e.g., attendance, participation, attitude). • Share this information with the other MIT members to contribute to the overall management of the inmate's MMT. Summarize inmate's progress at each MIT meeting.
Maintaining a Record	After each revision of the *Treatment Plan*, the correctional programs officer must provide a copy of the *Treatment Plan* to the nurse for filing on the inmate's Medical Record. This file, containing historical revisions, is necessary for audit purposes, and will assist in monitoring the inmate's progress.

APPENDICES

Appendix A: Glossary

6-MAM: 6-monoacetylmorphine. Its detection is a clear indicator of heroin use. This metabolite is not produced or available from any other source and can only be detected by confirmatory techniques such as HPLC or GC/MS.

amphetamines: a sympathomimetic amine that has a stimulating effect on both the central and peripheral nervous systems. It relaxes both systolic and diastolic blood pressure and bronchial muscle, contracts the sphincter of the urinary bladder, and depresses the appetite. Abuse of this drug and its salts may lead to dependence, characterized by symptoms ranging from strong psychic dependence to marked tolerance. Abrupt withdrawal can cause severe fatigue, mental depression, and abnormalities in the electroencephalogram.

CAMH: In 1998, the Centre for Addiction and Mental Health was formed by the successful merger of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute and the Queen Street Mental Health Centre.

ASI: The Addiction Severity Index assesses the severity of an individual's use problems across a variety of areas of functioning.

benzodiazepines: Any of a group of minor tranquilizers having a common molecular structure and similar pharmacological activity, including anti-anxiety, sedative, hypnotic, amnesic, anticonvulsant and muscle relaxing effects.

benzoylecgonine: The major metabolite of cocaine, produced by hydrolysis of the drug by plasma esterases and detectable in the blood by laboratory testing.

BF: bring forward system

Case Conference Report: Report on the review of a patient's case by the Methadone Intervention Team (MIT)

CCC: Community Correctional Centre. A CSC residential facility that houses federal offenders who have been conditionally released to the community. The facility provides general counselling and/or an enhanced programming component, and assistance in reintegrating the offender in to the community.

Choices: The Community Correctional Brief Treatment, Relapse Prevention and Maintenance Program is a low intensity substance abuse program that focuses on relapse prevention.

CLAI: The Computerized Lifestyle Assessment Instrument is a structured substance abuse assessment that is administered during offender intake at regional reception and assessment centres.

CO II: A correctional officer responsible for interaction with inmates and supervision of inmates in all activities within the unit (including shops), and recreational and social development.

CP timeline: The Correctional Plan timeline sets out the day events and activities that will occur during the offender's sentence. Key eligibility dates (ETA, UTA, day and full parole, etc.) will be automatically included by OMS to establish a framework and to provide information to the offender.

CPPR: Correctional Plan Progress Report.

CRF/CRC: Community (Based) Residential Facility/Centre. Similar to CCC except the facility is owned and operated by a private agency which contracts with the CSC. Staff are not employees of CSC.

diarrhea: Abnormal frequency and liquidity of fecal discharges.

dysphoric mood: Excessive pain, anguish, agitation; disquiet; restlessness; malaise.

EDDP: 2-ethylidene-1.5-dimehtyl-3.3-diphenylpyrrolidine. The principal urine methadone metabolite, confirming compliance to MMT.

EMIT opioid test: Enzyme-multiplied immunoassay technique.

epistaxis: Hemorrhage from the nose—also called nosebleed.

ETA: Escorted Temporary Absence refers to an escorted inmate absence from a penitentiary for a defined period of time, for medical, administrative, community service, family contact, personal development for rehabilitative purposes, or compassionate reasons.

Flag on OMS: Existence of critical information is entered as a "flag". The continuing validity is verified periodically and items no longer applicable should be inactivated.

FPS: Finger printing system.

GC/MS: Gas Chromatography/Mass Spectroscopy is a chromatographic technique. It is the most accurate and expensive identification method available and requires technical expertise.

Health Care Record (in CSC): Record which contains documents concerning health services provided to an inmate/patient while in custody.

HCV infection: An infection of the liver caused by the Hepatitis C virus and spread through direct blood-to-blood contact with an infected person.

HISAP: The High Intensity Substance Abuse Program is a cognitive-behavioural intervention for offenders with substantial to severe substance abuse problems.

HIV infection: An infection with the human immunodeficiency virus and the cause of AIDS (Acquired Immunodeficiency Syndrome). The HIV virus is a retrovirus and can be spread through sexual or blood-to-blood contact with an infected person. Two types have been identified: type 1 (HIV-1) and type 2 (HIV-2).

HPLC: High Performance Liquid Chromatography.

HPLC-REMEDI: Combined chromatography with UV spectrophotometry.

IDU: Injection drug use or intravenous drug use.

insomnia: The inability to sleep; abnormal wakefulness.

lacrimation: The secretion and discharge of tears.

MIT: The Methadone Intervention Team is a multidisciplinary team mandated to coordinate the delivery of MMT within an institutional and community settings.

MMT: Methadone Maintenance Treatment is the most effective treatment for individuals with serious heroin and other opioid addictions.

NIDA-5: the 5 drug classes that the National Institute on Drug Abuse has identified for the purposes of testing which are cocaine, opioids, amphetamines, THC (cannabis), PCP (phencyclidine).

NIDA-8: Includes benzodiazepines and two specific opioids in addition to the above 5 drugs.

OMS Memo to File: A document generated in relation to offender progress/activities, usually as a result of an internal review or decision-making board review, or case conference.

OMS: The Offender Management System is an electronic filing and data collection system that CSC uses to store and maintain offender information.

OPI: The Officer of Principle Interest provides leadership to the MIT by coordinating all administrative and quality assurance aspects of the program within the institution.

opioids: Any synthetic narcotic that has opiate-like activities but is not derived from opium.

OSAPP: Offender Substance Abuse Pre-Release Program is a moderate intensity cognitive-behavioural intervention for offenders with moderate substance abuse problems.

pupillary dilation: Dilation of the pupil, the dark circular opening in the centre of the iris of the eye, which varies in size to regulate the amount of light reaching the retina.

PCP: phencyclidine hydrochloride. PCP is an illegal, common street drug. It has other names, including angel dust. It can be smoked, snorted, injected or taken by mouth.

PFVU: Private Family Visiting Units. The Private Family Visiting Program provides eligible offenders and visitors with extended private visits within the institution to enable them to foster personal relationships in home-like surroundings.

piloerection: Erection of the hair (goose bumps).

Progress notes: Document in the Health Care Record where health care professionals document their observations and interactions with the patient.

quinolone antibiotics: any group of synthetic antibacterial agents (e.g., Cipro®)

rhinorrhea: The free discharge of a thin nasal mucus.

THC: delta-9-tetrahydrocannabinol: This is the main mind-altering (psychoactive) ingredient in marijuana, a drug made from the genus of flowering herbs called Cannabis sativa.

UTA: Unescorted Temporary Absence. An unescorted temporary absence from a penitentiary for a defined period of time, for the following reasons: medical, administrative, community service, family contact, personal development for rehabilitative purposes, or compassionate reasons.

UV spectrophotometry: An apparatus for estimating the quantity of colouring matter in solution by measuring the quantity of light absorbed in passing through the solution.

V+C: Visits and Correspondence area.

Warrant Expiry: The date at which a sentence ends. This date represents when the court-imposed sentence terminates.

Appendix B: References

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Appendix C: Policy and Legislation Related to MMT in CSC

Corrections and Conditional Release Act (CCRA)

Section 76	Programs for offenders
Section 86	Provision of health care services
Section 87	Service to consider health factors
Section 88	Consent to treatments

Corrections and Conditional Release Regulations (CCRR)

Section 64 (1) (b)	Any treatment program that is designed to assist in the rehabilitation of an inmate who has a problem of substance abuse is a prescribed substance abuse program.

Commissioner's Directives

CD 095	**Information Sharing**
Paragraph 1-2	Development and implementation of drug strategies such as treatment thus successfully reintegrating inmates into society as law-abiding citizens.
CD 585	Correctional Plan
Paragraph 6	Inmates with documented substance abuse problem should identify specific needs and realistic expectations in addressing their problems.
CD 700	**Case Management**
	Describes the role of case management in helping the offenders become law-abiding citizens through ongoing assessment, behaviour expectation, encouragement and viability of program plan.
CD 726	**Management of Correctional programs**
	Is the development and management of correctional programs, which will contribute to offenders' successful reintegration into community and are effective on reducing re-offences.

800 SERIES: HEALTH CARE

CD 800	**Health Services**
Paragraph 1	Ensures that inmates have access to treatment "in keeping with Accepted community practices".
Paragraph 4	Emphasis will be placed on health promotion/illness prevention provision.
Paragraph 13	Medication shall be prescribed by an institutional clinician only when clinically indicated.
Paragraph 14	Consent

Paragraph 33	Offenders with opioid addictions are eligible for methadone treatment in accordance with the Methadone Treatment guidelines (CD 800-1).
Paragraph 49	Provincial medical coverage shall be arranged as part of pre-release planning.
CD 803	**Consent to Health Service Assessment, Treatment and Release of Information**
Paragraph 1	Policy objective
Paragraph 2	Application
	Disclosure of Information
Paragraph 15	Confidentiality shall be maintained if information is not relative to risk management.
Paragraph 16	Health and medical information can be released without Consent of the offender - part b - when the information is released for a use that is consistent to the use for which it was initially obtained.
CD 805	**Drugs and Medical supplies**
	Ensure the safe and legal management, storage, recording, dispensing and administration of pharmaceutical supplies.
	Narcotic and led Drugs
	Describes procedure for reporting discrepancies, medication incidents, recording of medication and audit conducted at the change of each shift.
CD 821	**Management of inmates with Human Immunodeficiency**
	Virus (HIV) infections
	Ensure that all appropriate and necessary precautions are taken to prevent the transmission of the virus through effective medical management of infected inmates.
CD 835	**Health Care Records**
	Discusses documentation and principles or records management.

The Health Services Manual, 1996

Section 1-108	Consent for release of information.
Section 1-115	Purposes of the health care record.
Section 3-303	Drugs and medical supplies
Section 7-703	Health needs of the substance abuser

The Privacy Act

Purpose	Protecting the privacy of individuals with respect to personal information about themselves held by a government institution.

Appendix D: DSM IV Diagnostic Criteria for Substance Dependence

The fourth edition of The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*, 1994) provides the cognitive, behavioural and physiological definition to substance dependence indicating that the individual continues use of the substance despite significant continued substance-related problems. Their diagnostic criteria follow.

> A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

Criteria for Substance Dependence

1. Tolerance, as defined by either of the following:
   a) the need for markedly increased amounts of the substance to achieve intoxication or the desired effect
   b) markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
   a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   b) the same (or a closely related) substance is taken to relieve (or avoid) withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain smoking), or recover from its effects.
6. Important social, occupational or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was worsened by alcohol consumption).

Specify if: **With Physiological Dependence:** evidence of tolerance or withdrawal (i.e., neither Item 1 or 2 is present)
Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

Appendix E: DSM IV Diagnostic Criteria for 292.0 Opioid Withdrawal

Criteria for Opioid Withdrawal

A. Either one of the following:
   1. cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)
   2. administration of an opioid antagonist after a period of opioid use

B. Three (or more) of the following: developing within minutes to several days after Criterion A:
   1. dysphoric mood
   2. nausea or vomiting
   3. muscle aches
   4. lacrimation or rhinorrhea
   5. pupillary dilation, piloerection or sweating
   6. diarrhea
   7. yawning
   8. fever
   9. insomnia

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Appendix F: Resource — Introduction to Urine Drug Testing

By Doug Gourlay, MD, MSc, FRCPC, ASAM, MRO

The following contains a general overview of testing methods and strategies as they apply to drug treatment. This is only an overview solely for the purposes of introducing this topic to the reader. The term "donor" refers to the individual providing the sample. The "collector" refers to the person who actually collects the sample.

Purpose:
Urine drug testing generally serves two purposes. The first is to assess the donor for illicit use of prohibited substances. The second purpose is to assist in confirming (by detection) the appropriate use of prescribed medications. These two uses can compliment one another when applied properly in the treatment context. They do have intrinsic limitations which must be considered when interpreting the results to avoid arriving at inappropriate conclusions which might be harmful to the donor. In general, there are two main testing strategies which are applicable in the drug treatment setting.

1) Forensic Testing
In this strategy, this term refers to the collection of a sample for detection of illicit or unprescribed substances. Here, there are only two requirements: One is to ensure that the drug being tested for is actually present (true positive) and second, that the sample actually belongs to the donor (chain of custody, clerical accuracy etc). Negative results (absence of illicit substances) never harm the donor. There are many reasons why a test may be negative besides the donor not having used the drugs being tested for. They include:

- testing outside the window of detection
- incorrect choice of test (inadequate sensitivity)
- lab error (ie. wrong sample being tested)
- clerical error (entered (-)ve when (+)ve was the correct result)
- physiologic differences in the donor (urine pH, low urine Creatinine etc)

This is the safest form of testing and the one least likely to falsely accuse a donor.

2) Compliance Testing
In this testing strategy, we are actually looking for the absence of a drug as the "positive" result. This is commonly seen when there is concern about diversion of prescribed drugs with abuse liability. In this setting, all the reasons listed above for why a test result might be falsely negative apply with one important difference. The absence of a drug being tested for is the "positive" on which the donor will be assessed.

This is the most dangerous form of testing and the one most likely to falsely accuse a donor.

Testing Techniques
In general, tests can be divided into two main classes. These are screening tests and confirmatory tests. In both the screen and confirmation techniques, thresholds of reporting are used to reduce the risk of false positives. A threshold is not the lower limit of detection, but rather an agreed upon level below which, the sample will be reported as 'not detected'. Thresholds vary depending on what is being tested for, and the reason for the test.

1) Screening Tests

In the case of screening tests, we are usually applying a technique which is highly sensitive but generally not very specific for any particular drug. In this context, we often refer to classes of drugs, rather than specific drugs. Examples of this are the Opioids, Amphetamines, Barbiturates and Benzodiazepines. Exceptions to this are THC (marijuana), Cocaine metabolite (benzoylecgonine), PCP (phencyclidine) and Methadone. In the case of the exceptions, the tests are for drug-specific rather than class-specific detection of drugs (parent) or their metabolites.

The most commonly used screening tests are based on Immunoassay technology. A common example is the **E**nzyme **M**ultiplied **I**mmunoassay **T**echnique (EMIT). All of the point-of-care (dip stick) testing devices rely on this technology and may be thought of as a "lock and KEYS" method of detection. As an example, a sample obtained from a donor who recently used codeine would be positive for opioids by the immunoassay technique if there was sufficient codeine (or one of its metabolites, morphine) to reach the threshold of detection. Since the immunoassay does not distinguish between morphine and codeine, it is the sum of all the morphine and codeine present that is used to reach the threshold of detection. In the case of opioids, the most commonly used therapeutic threshold is 300ng/mL. A combined level of codeine and morphine of 301ng/mL would be reported as detected while a level of 299ng/mL would be reported as not detected.

If the test is for the Department of Transportation (DOT-Testing), the threshold for opioids is 2000ng/mL. This is entirely appropriate where the vast majority of donors will not be using opioids. However, this threshold is inappropriate for use in a testing population of known opioid users since all but the most recent use would likely be below threshold and so be reported as not detected.

With Point-of-Care testing, the results are either positive or negative. There is no indication of the actual quantity of drug present or the specific drug within a given class, simply that the sample was above or below the cut-off. In these systems, it is difficult or impossible to determine what effect concentration may have on the results. Unless pH is assessed, it is impossible to determine acid-base effects on drug detection.

The commonly tested for drugs or drug metabolites and their thresholds are:

Cocaine metabolite (benzoylecgonine)	– 300ng/mL cutoff
Opioids	– 300ng/mL cutoff
Amphetamines	– 1000ng/mL cutoff
THC (cannabis)—variable cutoff	– 50ng/mL cutoff
PCP (phencyclidine)	– 25ng/mL cutoff

These are known collectively as the NIDA-5 (the 5 drug classes that the **N**ational **I**nstitute on **D**rug **A**buse has identified for the purposes of testing). There is also another panel sometimes referred to as the NIDA-8 which includes benzodiazepines and two specific opioids.

The time a sample will remain positive depends on several factors including amount used, chronicity of use (ie. THC), solubility of drug (ie. THC, Valium) and cutoff used. These will depend on the lab or testing system used.

2) Confirmation Tests
By accepted forensic standards, a confirmatory test identifies the drug or metabolite by a second scientific method. Repeating a screen test using immunoassay technique does not confirm the presence of a drug.

The commonly used confirmatory tests include chromatographic techniques such as thin layer chromatography (TLC) and High Performance Liquid Chromatography (HPLC) or combined techniques such as HPLC-REMEDI (combined chromatography with UV spectrophotomitry) and Gas Chromatography/Mass Spectroscopy (GC/MS). In the case of the HPLC-REMEDI, this technique serves to identify a large number of specific drugs by comparison to a computerized library of data.

In general, the confirmation tests have a lower sensitivity but much higher specificity for any given test.

In the context of therapeutic testing for drug monitoring, it is often unwise and certainly not cost effective to aggressively apply confirmatory testing to all specimens. In the context of complex cases where specific drugs must be identified within a particular class (the pain patient on prescribed opioids who also abuses heroin), HPLC-REMEDI can be very useful to help distinguish between prescribed and unprescribed opioids.

Collection Issues
Therapeutic drug testing does not require chain of custody. This level of security is reserved for results which may be acted upon in a legal setting. The results of therapeutic testing do not meet the level of reliability required to act in a punitive fashion toward the donor. This fact must never be forgotten and plays a key role in the fundamental testing strategy for any testing program.

Clearly one of the most controversial issues in urine drug testing is that of witnessed collections by a same-sex attendant. While this does increase the reliability of the test, the use of alternative strategies to ensure reliability is worth exploring. The first of these is the monitoring of sample temperature.

The sample is considered acceptable under the following circumstances. The sample is between 32º and 38ºC and the specific gravity >1.003 and the Creatinine is >.2g/L. It is important when determining temperature that the sample be at least 30mL volume and the time to determination less than 4 minutes to ensure that cooling due to environmental effects is minimized.

In general, it is advised that sources of running water be eliminated from the collection area, and that standing water be tainted with a marking agent such as methylene blue. This reduces the risk of ‘scooped’ water from a toilet bowl or from a running tap being used to dilute the sample below the detection threshold.

The second relates to the testing of companion markers which might cast doubt on the reliability of the test result. These include urinary Creatinine which indicate concentration of sample as well as pH which may be useful in explaining the absence of certain prescribed drugs from the urine. In the context of dilute urine, a positive urine screen for cocaine is clearly interpretable (as long as there are no medical reasons for the positive) regardless of concentration. In fact very dilute urine in the face of a denied use may support a consciousness of guilt and is consistent with ingestion of a large amount of oral fluids to try and wash out the drug from the donors system. On the other hand, moderately alkaline urine that is negative for prescribed methadone may be explained on the basis of methadone parent re-absorption in the kidneys. Since the

excretion of the metabolite of methadone, EDDP is not pH dependent, its presence can help to confirm the ingestion of methadone as prescribed.

A final issue relates to the frequency of testing. Most would agree that random testing provides the best indication of use and non use of monitored drugs. An alternative approach, which is to be decried, is regular multiple testing of donors to ensure compliance with treatment. The use of twice or three times weekly testing can best be described as 'paranoid' and puts an undo (sic) emphasis on the testing program, often at the expense of the therapeutic components of a treatment program. Similarly, regular scheduled urine testing serves to 'catch' only the most heavily dependent who can not time their use to ensure negative urine screens. This can relegate the urine testing program to being a game to be beaten.

Test Result Interpretation

Clearly the most rational use of urine test results in the context of a drug treatment program is to open a dialogue between the patient and practitioner to facilitate progress within treatment. One of the most useful purposes is to help assess adequacy of methadone dose as evidenced by ongoing use of illicit opioids. Due to the blocking effect of methadone treatment, continued use of opioids typically indicates an inadequate methadone dose. Another goal of therapeutic drug testing is to provide objective evidence of non-use in program participants. Positive contingency contracting (increased privileges associated with non-use) can be a strong motivator to help effect change in the patient.

Interpretation Pitfalls

One major shortcoming in any testing program is the inability to relate a given level of drug present in the urine to the dose prescribed. In other words, any member of a class of drug that is being monitored, whether prescribed or illicit will make interpretation of positive results exceedingly difficult. As an example, a donor who is prescribed any codeine-containing product (ie Tylenol #3) will be very difficult to monitor for the use of Heroin since both Heroin and Codeine metabolize into morphine. The primary difference is the brief appearance of the first metabolite of Heroin, 6-**MAM** (6-monoacetylmorphine), which can only be detected by confirmatory techniques such as HPLC or GC/MS.

Similarly, some commonly prescribed drugs can cross-react with the immunoassay screen to give false positive results. An example is the cross reaction of the quinolone antibiotics (ie Cipro®) with the EMIT opioid test. This will not confirm as an opioid by any of the confirmatory tests.

A final confounder in drug testing is the unknown use of medically appropriate drugs that result in a positive drug test. An example is the donor who is treated for a bleeding nose testing positive for cocaine. The medical management of epistaxis may include the use of topical cocaine to stop the bleeding. The result is a true positive for cocaine that will confirm by chromatographic testing that does not represent illicit use.

Summary

Urine drug testing can play an important role in the medical management of drug dependent individuals. With a clear understanding of the strengths and limitations of the technologies used, a cost effective testing program can be implemented that will compliment (sic) any treatment program. It is important that a standardized approach to testing and interpretation be implemented from the outset to ensure appropriate use of this technology.

Appendix G: Criteria for Selection of OPI

The Warden has the responsibility of selecting the individual who will assume the role of the Officer of Principal Interest (OPI) within the institution, based on the following criteria:

1. The individual selected as the institutional OPI must have a classification equal to or exceeding a Manager within the institution.
2. Personal suitability characteristics including the following.
    - Support for the principles of harm reduction generally, and MMTspecifically.
    - Excellent organizational skills.
    - Excellent communication skills.
    - Good negotiation and mediation skills.
    - Ability to work well on a multidisciplinary team.
3. The person delegated as the OPI must not sub-delegate the duties of the OPI to any individual below the level of Manager in the institution.

Appendix H: Qualifications of MMT Substance Abuse Program Providers

Qualifications of MMT Substance Abuse Program Providers

The MMT substance abuse intervention is to be conducted by people with appropriate knowledge and skills to effectively deal with MMT high need/risk inmates. At a minimum, MMT intervention providers must have the following abilities.

- Able to establish and maintain the kind of credibility and rapport that is demanded by the inmates participating in MMT.
- Extremely skilled in being able to analyze each inmate's on-going needs and be able to respond appropriately.
- Well versed in the dynamics of the relapse process.
- Very knowledgeable of all aspects of MMT.
- Very knowledgeable of the usual concerns, ambivalence and tactics commonly found with the chronic heroin addict, and skilled to deal with them effectively.
- Extremely skilled with group dynamics, guided-learning and group facilitation skills.
- Very knowledgeable of all programs and support agencies that are available to inmates.
- Conversant with the social learning approach to substance abuse intervention.
- Very skilled in the use of motivational interviewing techniques.
- Very knowledgeable of the concerns and roles of parole officers and other MIT members.
- Able to complete comprehensive and meaningful reports, as required.
- Able to work well with other staff and members of the MIT.
- Able to function in a way that enhances free and open communication.
- Able to effectively deliver the program content according to program design.

In most cases, it is expected that **program facilitators** who are certified in core substance abuse programs (HISAP, OSAPP, Choices) will be sufficiently knowledgeable and skilled to effectively conduct MMT individual and group sessions. Sites that do not have, or cannot involve certified facilitators would have to use other **substance abuse specialists**. It is recommended that Regional Coordinators of Substance Abuse Programs be involved in the identification of potential MMT substance abuse intervention providers.

Training:
All MMT facilitators must receive sufficient training and on-going support and monitoring to ensure their on-going effectiveness.

Appendix I: Guidelines from Provincial Colleges of Physicians and Surgeons

This space has been provided to insert your provincial guidelines.

- College of Physicians and Surgeons of Ontario
- College des Medécins du Québec.
- College of Physicians and Surgeons of Saskatchewan
- College of Physicians and Surgeons of British Columbia
- Health Canada (for all other provinces/territories)

➢Where mandatory, forward documentation to College on initiation, cessation; or conditional release from CSC.

Appendix J: CSC Forms for MMT