

# Victorian Prison Opioid Substitution Therapy Program Guidelines

2015

Department of Justice & Regulation

## Acknowledgements

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# Foreword

Opioid addiction is a recognised disease requiring therapeutic intervention. The Opioid Substitution Therapy Program is just one initiative available to prisoners to address drug related harm in the prison population. The program aims to decrease the harm associated with opioid use in prison and reduce the likelihood of substance use upon return to the community.

Other objectives of the program include the reduction of drug-related criminal activity post-release and the transmission of blood-borne viruses. The program therefore has potential health and criminogenic benefits for both the offender and the broader community.

The updated 2015 guidelines build upon the 2003 Clinical and Operational Policy and Procedures manual, which guided the program in its infancy. The embedding of this program into everyday health service delivery demonstrates a commitment to harm reduction and provision of community equivalent healthcare.

The revised guidelines provide a clinical focus for the delivery of Opioid Substitution Therapy in Victoria's prisons and provide a resource for clinicians delivering this form of pharmacotherapy in a correctional setting.

Detailing the clinical and operational procedures and the policy framework underpinning the program, the document provides the information necessary to execute the program in a correctional setting.

The 2015 guidelines reflect the contemporary evidence base for the delivery of Opioid Substitution Therapy and incorporates the experience of both correctional staff and health professionals. The update also aligns Victorian prison based practices with state and national guidelines.

I would like to take this opportunity to thank the team at Turning Point/Eastern Health, the Expert Advisory Group and the project Steering Committee for their contributions to the revised guidelines.



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# Preface

Opioid Substitution Therapy (OST) is a widely accepted approach to managing opioid addiction (a recognised chronic disease) and is an integral part of the response to prisoner drug use. OST aims to reduce the demand for and misuse of opioids and reduce the harms caused by their use. A review of the literature on the delivery of OST in corrections settings reaffirms the risks opioid use poses to prisoners and corrections environments and the value of the OST programs (Degenhardt et al., 2014; Kinlock, Gordon, Schwartz, & O’Grady, 2013; Larney, 2010; Larney et al., 2014; Larney, Toson, Burns, & Dolan, 2012). Prison drug use can compromise the safety and good order of the prison system by increasing the risk of needle-stick injuries, drug-related violence and death. Prison drug use also increases the risk of spreading blood borne viruses (BBV) and associated health problems. Post release, prisoners remain at increased risk of fatal overdose, non-fatal overdose and all-cause mortality (Degenhardt et al., 2014; Larney et al., 2014). One of the major factors contributing to drug-related deaths post release is an altered tolerance to opioids. OST initiated in prison and continued post-release is effective at reducing opioid use, overdose, infection and reoffending, especially when retention in treatment is maintained (Kinner et al., 2012).

The 2003 manual, the precursor to these guidelines, provided a framework for managing opioid substitution treatment in Victorian prisons and set a benchmark for the introduction of further pharmacotherapies. The 2015 guidelines build on the 2003 manual to reflect current best practice and evidence and to align with the updated state and national guidelines. The 2015 guidelines were developed in consultation with corrections and health staff across the Victorian prison system and addiction medicine specialists.

Key changes in the 2015 guidelines include:

- updating of dosing and clinical procedures in line with state and national guidelines
- reframing contextual information to reflect the continuation of the program from its initial pilot phase in 2003
- a restructure of the guidelines for greater clarity and reduction in duplication.

The guidelines have five main sections:

- Policy
- Program Overview and Key Components
- Induction
- Maintenance
- Transitions.

These guidelines reflect the contemporary evidence base for the delivery of OST in corrections settings and the extensive knowledge base and experience of custodial staff and health professionals. These guidelines are designed to provide clinicians and custodial staff with a practical and professional resource to guide delivery of the OST Program in Victorian prisons. Further, underpinned by a harm minimisation approach, they contribute to the fundamental purpose of the corrections system: helping to make the community a safer place through positive interventions in the lives of prisoners.

These guidelines are designed to be a living document that is regularly updated to reflect current best practice and evidence. They will be reviewed in line with the Justice Health Policy review cycle, on a biennial basis. It is anticipated that a major review, including a review of the impact and effectiveness of the program be undertaken within five years of release of this document.

For further information about this guidelines document, please contact Justice Health.

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# 1 Introduction

## 1.1 Background

Drug use remains common among prison populations. An international systematic literature review suggested that the prevalence of drug abuse and dependence ranged from 10 to 48% among male prisoners and 30 to 60% among female prisoners (Fazel, Bains, & Doll, 2006). The 2013 National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey (NPEBBVS) identified that 45% of the Australian prison entrants surveyed reported a history of injecting drug use. Of the Victorian prison entrants surveyed as part of this survey, 35% reported a history of injecting drug use. In relation to opioid use, 37% of Victorian prisoners surveyed (and 20% of all Australian prisoners surveyed) who had a history of injecting drug use reported heroin as their last drug injected prior to entering prison (Butler, Callander, & Simpson, 2015). Harms associated with opioid use/misuse in prison settings include death by overdose, increased risk of suicide or self-harm, blood-borne virus (BBV) infection due to shared injecting equipment, and increased likelihood of engaging in or being a victim of violent behaviour (Stover & Michels, 2010).

Although the prevalence of heroin has decreased in recent years, the social and economic harms associated with opioid misuse (including heroin and pharmaceutical opioids) are disproportionately high (Ministerial Council on Drug Strategy, 2011). In the community, opioid-related hospitalisations in Australia increased from 605 cases in 1998 to 1464 cases in 2009, with pharmaceutical opioids indicated in more opioid overdoses than heroin since 2001. Deaths due to overdose have increased from 151 in 2002 to 266 in 2011, with the death rate due to opioid overdose rising from 0.78/100 000 population to 1.19/100 000 population over 10 years (Justice Health, 2012). Drug-related harms including acquisitive crime, violence, overdose and other unexpected mortality not only introduce burden due to premature deaths and disabilities, but also contribute to costs for the health system (e.g. emergency department, hospitals, ambulance services) and the forensic system (e.g. police and coroners).

Following release, prisoners are at increased risk of fatal overdose, non-fatal overdose and all-cause mortality. Mortality rates are high among former prisoners, with mortality rates in the first 1–2 weeks post-release

between 12 to 69 times higher than in the general community (Binswanger et al., 2007; Farrell & Marsden, 2008). A meta-analysis found that drug-related deaths accounted for 59% of deaths within 3 months of release and 76% within 2 weeks of release (Merrall et al., 2010). One of the major factors contributing to drug-related deaths after release seems to be an altered tolerance to opioids (Andrews & Kinner, 2012). Non-fatal overdoses are also common among former inmates (Kinner et al., 2012).

### 1.1.1 Changing patterns of opioid use

Drug use patterns change over time. Heroin use has declined over the last decade however pharmaceutical opioid misuse (including prescribed and diverted medications) appears to have increased. Recent research suggests that there has been a nationwide shift in the type of opioids used by the general (non-prison) population seeking drug treatment. There has been a significant decline in the number of treatment seekers who reported heroin as the primary drug of concern falling from 18% of cases closed in 2003–04 to 8% of cases in 2012–13. In comparison, the rate of treatment seekers reporting pharmaceutical opioids (such as over-the-counter analgesics containing codeine and those available by prescription like oxycodone) as their primary drug of concern has increased since 2008 (Australian Institute of Health and Welfare, 2014a). Since 2001, pharmaceutical opioids have been more frequently involved in opioid-related hospitalisations than heroin each year (Justice Health, 2012).

This shift towards pharmaceutical opioid misuse has also been observed in prison populations. For example, in 2012 it was reported that 30% of prisoners used pharmaceutical opioids for non-medical purposes in the 12 months leading up to incarceration (17% analgesics/painkillers and 13% other opioids) (Australian Institute of Health and Welfare, 2013). These statistics suggest an increase in use from the 2009 report where 18% reported using pharmaceutical opioids prior to incarceration (Indig et al., 2010). Irrespective of the type of opioid used, the research indicates that opioid use among prisoners remains problematic while the dangers of opioid misuse have not dissipated.

Other drug types have also increased in prevalence as has the level of polydrug use (Australian Institute of Health and Welfare, 2014a). Data from the 2013 Kirby Institute's NPEBBVS indicates that 342 of the 767 (45%) Australian prison entrants surveyed reported ever injecting drugs. Of this group, heroin was the second most common drug to be last injected (20%) prior to entry into prison (25% in 2010), with amphetamines the most common drug to be last injected (68% in 2013 vs 59% in 2010) (Butler et al., 2015; Butler, Lim, & Callander, 2011). This trend is also evident in Victorian prisons, with 35% of Victorian prison entrants surveyed (60 of 173) reporting having ever injected drugs; heroin was the second most common drug to be last injected (37%) prior to entry into prison (45% in 2010); and amphetamines were the most common drug to be last injected (52% in 2013 vs 39% in 2010) (Butler et al., 2015; Butler, Lim, & Callander, 2011).

### 1.1.2 Treatment options

Treatments for opioid misuse can take a variety of forms, depending on the individual needs and circumstances of the person seeking treatment. The spectrum of treatment options range from psychosocial (e.g., counselling) to medical (e.g., detoxification/withdrawal, pharmacotherapy, antagonist treatment (e.g., oral Naltrexone<sup>1</sup>)). A stepped care approach is recommended to determine the most appropriate treatment for an individual.

Within this spectrum, OST sits as a pharmacotherapy treatment option that can be delivered as a stand-alone treatment or in conjunction with other treatment types such as psychosocial support.

Patients prescribed OST receive a long-acting opioid analgesic (e.g. methadone or buprenorphine) as a replacement drug. Substitution treatment is generally considered for opioid users who have difficulty in stopping their drug use and completing withdrawal. It provides an opportunity for dependent drug users to reduce high-risk behaviour, stabilise their health and focus on normal life activities without the need to obtain drugs.

## 1.2 OST in community and prison settings

In the community, OST can be prescribed by authorised health professionals for individuals who meet eligibility criteria. Federal and state governments share responsibility for the provision and cost of OST services (Australian Institute of Health and Welfare,

2014b). Approximately 47,442 people were receiving OST in Australia on a snapshot day in 2013. Though the number of individuals on OST continues to increase each year, the rate of increase appears to have slowed from 2010 to 2012, with the number of individuals receiving OST increasing by approximately 1% (Australian Institute of Health and Welfare, 2014b).

In 2012, approximately 62% of patients receiving OST in Australia were prescribed methadone, 7% mono-buprenorphine (Subutex) and 31% buprenorphine-naloxone (Suboxone) (Australian Institute of Health and Welfare, 2014b).

Methadone is the most common form of OST in Australian prisons, with substitution treatment available in all states and territories (availability is usually limited to pregnant women in Queensland), and induction available in all states and territories except Queensland, Tasmania and the Northern Territory (Australian Institute of Health and Welfare, 2014b).

### OST medications in Victorian prison settings

Methadone is the preferred medication for OST in Victorian prisons. Since the introduction of OST in Victorian prisons in the late 1980s, the majority of prisoners participating have been prescribed this medication. The preference for methadone over buprenorphine in Victorian prison OST programs is due to issues with prisoner compliance with Program rules and the risk of diversion associated with buprenorphine. While recent statistics confirm illicit use of buprenorphine in Victorian prisons, it is clear that high rates of illicit buprenorphine use among prisoners are not solely due to diversion from OST programs (Justice Health, 2012).

Currently, 90% of Victorian offenders participating in OST programs are prescribed methadone, with the remainder being prescribed the film preparation of buprenorphine-naloxone (for example, Suboxone®). Methadone is the preferred medication used to induct Victorian prisoners to OST. Buprenorphine-naloxone can be used as an induction agent in rare case-by-case exceptions. These exceptions should be supported by clinical evidence. Prisoners receiving buprenorphine via a community-based OST program prior to incarceration may be maintained on this agent following the required assessment and verification processes.

1 The insertion of a naltrexone implant and the preparation to have a naltrexone implant inserted on release is a medical intervention outside of community norms and against current expert opinion (National Health and Medical Research Council, 2010; The Royal Australasian College of Physicians, 2013). Process for dealing with existing Naltrexone implants is included in Section 2.4.4. Treatment Planning.

## 1.3 Benefits and risks of OST

### Benefits of treatment

There is currently strong evidence surrounding the effectiveness of OST for reducing drug-use related harms (both during and after imprisonment) in prison populations. Benefits of OST in prisons included significantly lower use of opioids whilst incarcerated, greater retention in OST following release, and lower rates of mortality, hepatitis C and re-incarceration at a four year follow up for individuals who participated in OST whilst in prison (Kinlock et al., 2013). OST is also effective at reducing the rate of human immunodeficiency virus (HIV) in prison populations, because it reduces the rates of needle sharing (Larney, 2010). OST has been associated with lower mortality rates in prison due to reduced high risk drug use among prisoners (Larney et al., 2014). The period immediately following release from prison is recognised as a high-risk period for mortality for newly-released prisoners due to overdose and suicide, and participating in prison OST and continuing in community OST post-release appears to reduce this risk (Degenhardt et al., 2014). Participation in OST post-release also reduces the risk of re-incarceration by one-fifth (Larney et al., 2012).

### Side effects of medication

Like all medications, buprenorphine and methadone can have side effects. Treatment with buprenorphine or methadone typically results in a range of opioid-like side effects, including disturbed sleep, constipation, drowsiness, sweating, headaches, nausea and decreased libido. Some longer term side effects, including sleep apnoea, impact on sex hormones and prolonged corrected QT interval are more common with methadone use (Gowing, Ali, Dunlop, Farrell, & Lintzeris, 2014).

Studies have focused on the harms related to the potential toxicity of the drugs used for OST, particularly when combined with other drugs. The use of sedative drugs in combination with methadone or buprenorphine is of particular concern due to risk of harms including intoxication and overdose (Gowing et al., 2014). For example, a systematic review of the risks associated with concurrent use of buprenorphine or methadone and benzodiazepines in the broader community found a variety of harms, including:

- lethargy (up to 71%)
- respiratory depression (up to 29%)
- coma (up to 22.4%)
- respiratory arrest (up to 4.5%)
- hypotension (up to 11.8%)
- cardiac arrest (1.9%) (Lee, Klein-Schwartz, Doyon, & Welsh, 2014).

### 1.3.1 Benefits and risks of long-term OST

Improvements in psychosocial stability and reduced use of illicit opioids and associated drug-related harms tend to occur after at least three months of OST, with maximum benefits gained after at least one year of continuous OST (Gowing et al., 2014). Longer-term OST (longer than one year) is associated with better sustained outcomes, including an increased likelihood of abstinence from illicit opioids and increased stability, compared to shorter time in OST or premature termination of OST (Gossop, 2011). A 30-year follow-up of participants in a community methadone program found that participants who had achieved abstinence from illicit opioids had been in OST for an average of five to eight years (Grella & Lovinger, 2011). Imposing time limits on OST has been associated with increased rates of relapse to opioid misuse, increased rates of acquisitive crime, and increased drug-related harms including transmission of BBV and overdose (Advisory Council on the Misuse of Drugs, 2014).

Long-term OST has not been found to cause damage to major organs or systems of the body, and the side effects associated with methadone or buprenorphine use are considerably less harmful than the harms associated with opioid misuse (Gowing et al., 2014). While methadone has been associated with prolonged QTc interval in specific sub-populations (e.g. those with HIV infection, heart disease or renal failure), there is little risk of serious prolongation with long-term use (Cruciani et al., 2005).

## 1.4 Guiding frameworks for the provision of OST

Current international policies surrounding the delivery of OST in prison populations focus on the provision of equivalent health care as a human right, harm minimisation and an integrated approach between health and justice services (Bruce & Schleifer, 2008; College of Physicians and Surgeons, 2014). From a health perspective, it is recognised that opioid dependence (arising from either illicit use or legally prescribed therapies such as methadone) is a complex medical problem and forced withdrawal from the substances upon incarceration can be associated with a number of harms. For example, physical and psychological symptoms of withdrawal can be associated with a reduced capacity to make informed decisions, and increased risk of exposure to and contracting of HIV and other blood borne viruses (Bruce & Schleifer, 2008). Finally, OST in prisons can be associated with the reduction of a wide range of drug related harms, both while individuals are incarcerated and after release when re-integrating into the broader community (Kinlock et al., 2013).

The current policies for the provision of OST in Australia focus on harm minimisation, individual choice and integration of the health and justice systems. Most states and territories of Australia have developed policies and guidelines for delivering OST, and these align with the recently revised *National Guidelines for Medication-assisted Treatment of Opioid Dependence* (hereafter referred to as the *National Guidelines*) (Gowing et al., 2014). The *National Guidelines* primarily describe practices that should be applied for delivery of OST in community settings, although there are also sections specific to the delivery of programs to special populations, including prisoners. These guidelines seek to provide a context for policy and improve national consistency in the approach to provision of OST. They are underpinned by a harm minimisation approach that recognises that in order to overcome opioid dependence, individuals should be supported to address the compulsion to use drugs and to manage ongoing cravings. The guidelines also recognise that dependent individuals should be supported to address the social and psychological issues underlying their drug use in order to recover.

### 1.4.1 Victorian policy

Delivery of OST in Victoria is governed by the *Policy for Maintenance Pharmacotherapy for Opioid Dependence* (Department of Health, 2013). This policy is currently being reviewed to more closely align with the *National Guidelines*. The policy approaches OST programs from a harm minimisation and individual choice perspective.

The Victorian pharmacotherapy policy outlines several guidelines for the delivery of OST to clients on remand or incarcerated in Victorian prisons. Aligned with the national policy about offenders' rights to continue or begin OST whilst incarcerated, the Victorian pharmacotherapy policy states that both induction and maintenance programs are to be made available in the Victorian prison system. For a description of the maintenance and induction programs see Section 2 (page 8).

In 2002, OST in Victorian prisons was included in *Victorian Prison Drug Strategy* as a key strategy for meeting the performance objectives of the Treatment Goal: Providing effective treatment opportunities and harm reduction initiatives (Office of the Correctional Services Commissioner, 2002). OST remains a central feature of the current Corrections Victoria Alcohol and other Drug Strategy.

## 2 Program Overview and Key Components

### 2.1 Aims of the Program

The OST Program aims to:

- reduce illicit opioid drug use within prisons and upon a prisoner's release to the community
- reduce the transmission of blood-borne viruses (BBV) among prisoners
- prevent/reduce deaths associated with illicit opioid use in prison, and especially upon release to the community
- reduce drug-related criminal activity after release from prison.

To achieve the aims of the Program, OST in prisons needs to be of high quality, reflect evidence regarding best practice and effective opioid substitution treatment, and address individual prisoner needs.

### 2.2 Principles of the Program

The key principles of the Program are as follows:

- Prisoners prescribed methadone and buprenorphine should be treated in the same way as other prisoners accessing a health service.
- Illicit diversion can occur and everything possible should be done to reduce this risk and maximise the safety of the prison environment for prisoners and staff.
- Entry and continuation in the Program should be on the basis of voluntary informed consent by the prisoner. Prisoners should be provided with adequate information about the Program (and other treatment options for opioid dependence, such as prison drug treatment programs) prior to entering treatment.
- All aspects of the Program (including medical records) should be subject to the same confidentiality requirements as other health services in prison.
- The Program should be part of an integrated approach to the management of drug issues which includes treatment planning and access to available psychosocial services, health services, and drug and lifestyle education programs.
- Preparation for continuity of treatment for prisoners as they re-enter the community may help reduce opioid-related harms.
- Prisoners will be removed from the Program as a result of non-compliance.

Other considerations when managing individuals prescribed OST include:

- Doses should be individualised.
- A therapeutic relationship should be developed between the service user and the service provider.
- Treatment should combine the use of medication with available psychosocial services.
- All health staff involved with the Program should receive ongoing training and skills development.

### 2.3 Induction and maintenance

Eligible prisoners may enter the program in one of two phases: induction or maintenance.

**Induction** – Eligible prisoners at high risk of opioid-related harm in prison or upon release to the community may have an opportunity to begin treatment while in prison.

**Maintenance** – Prisoners who enter prison while currently enrolled on a community methadone or buprenorphine substitution therapy have the option to continue treatment.

The majority of prisoners entering the Program will have been prescribed OST in the community prior to entering the prison system.

### 2.4 Key components of the program

This section provides information that is relevant to both Induction and Maintenance phases of the Program.

#### 2.4.1 Assessment and verification

All newly received prisoners undergo a health assessment to identify any health or psychiatric issues. This assessment includes the use of prescribed medications such as methadone and buprenorphine.

Prisoners identified as being prescribed methadone or buprenorphine substitution therapy should have their treatment verified by the health professional performing the assessment. Following the verification of the treatment, the health professional will inform relevant persons (e.g., prison management) in accordance with local operational policies and procedures.

This process also applies to prisoners transferring between prisons.

Prisoners who wish to commence OST while in prison will undergo an assessment to check eligibility. An Eligibility Checklist is provided in Appendix 1.

The OSTP Assessment form, available in JCare (the electronic health records system used in Victorian prisons), is provided in Appendix 2.

## 2.4.2 Informed consent

### Informed consent for treatment

Ensuring prisoners provide voluntary informed consent before commencing OST is part of standard clinical practice. This process is facilitated by providing information and assistance to each prisoner to help them understand the treatment. All prisoners should be made aware of the purpose, benefits and risks associated with treatments such as OST. It is important that prisoners also be given the opportunity to discuss issues concerning OST with correctional health service staff.

General issues for discussion:

- What is methadone or buprenorphine, the advantages and disadvantages of being in treatment, and alternative treatment options.
- That methadone or buprenorphine substitution therapy can increase an individual's physical dependence on opioids.
- Side effects and potential risks associated with methadone or buprenorphine treatment.
- If a prisoner wishes to withdraw from OST, the withdrawal syndrome from methadone or buprenorphine may be more severe than that experienced with heroin.
- Pregnancy and contraception issues associated with withdrawal and OST (e.g. the risk of antenatal complications).

Prison specific considerations:

- The routine involved in OST, including daily dosing procedures and the impact of methadone or buprenorphine treatment upon prison life.
- Procedures for protecting personal information.
- Dangers of additional drug use, risk of overdose, risk of standover or violence, and potential impact upon occupational activities in prison.
- Availability of support services.
- Program rules, rights and responsibilities, and conditions of involuntary discharge.

Post-release considerations:

- After release, the out of pocket expenses involved in community OST programs. At the time of writing, the approximate cost was \$25 to \$35 per week, payable to the community pharmacy.
- The daily commitment to attend the nominated community pharmacy for dosing. This may

impact on living arrangements (i.e., choice of place of residence) and travel plans.

- Depending on where the prisoner plans to reside post release, there may be difficulty arranging a community prescriber and/or pharmacy.
- Implications if deportation is likely, or if planning to live interstate or in a remote or rural area with limited access to required health services (e.g., prescriber and/or pharmacist).
- The information to be shared with community prescriber or relevant health professionals in preparation for release, and post-release (including date of last dose, etc.).

As specified in the *National Guidelines* (Gowing et al., 2014), informed consent requires ensuring a prisoner understands all information provided:

In providing information to potential patients, there needs to be a balance between ensuring appropriate informed consent, whilst avoiding overwhelming the person and making this step a deterrent to treatment engagement. Information provision should be repeated at intervals throughout treatment. Note that renewal of consent at specified intervals may be a jurisdictional requirement. The nature of the information provided and the engagement of the patient in the decision-making process is likely to change as treatment progresses.

The *Methadone Treatment in Victoria User Information Booklet* or *Buprenorphine Handbook* will be offered to prisoners continuing or commencing OST in prison, along with an explanation of the Opioid Substitution Therapy Consent and Agreement Contract (see Appendix 3).

### Information sharing

Prisoners should be advised that local procedures will apply for sharing information related to prisoners on the OST program within the constraints of the *Information Privacy Act 2000* (Victoria), the *Health Records Act 2001* (Victoria) and the *Corrections Act 1986* (Victoria). An example of information sharing beyond the OST program within the prison is the provision of a medical certificate to prison industry management.

### Illiterate and non-English speaking prisoners

In accordance with the *Standards for Health Services in Australian Prisons* (The Royal Australasian College of Physicians, 2011), correctional health service providers should ensure that there are policies and procedures for communicating with prisoners who have a limited knowledge of English.

Correctional health service staff should take all reasonable steps to ensure that prisoners who cannot read or speak English understand all information provided on methadone or buprenorphine treatment, including the responsibilities of being treated in prison and after release to the community.

Correctional health service providers should:

- Use interpreter services and receive confirmation via the interpreter that the prisoner appears to have understood all the information provided
- Read and explain the information to illiterate prisoners who cannot read. The prisoner will need to verbally confirm that the information has been understood.

Prisoners must sign the Program Consent and Agreement Contract in the presence of the authorised prison medical practitioner or correctional health service staff before receiving OST in prison. If they do not sign the contract their treatment will not be provided.

### **Impaired capacity to provide informed consent**

For prisoners with impaired capacity to provide informed consent due to acute psychotic illness or affective disorder, adequate treatment for the psychiatric condition should be provided before seeking informed consent and commencing OST (Gowing et al., 2014).

### **2.4.3 Notification of drug dependent person**

Section 33 of the *Drugs, Poisons and Controlled Substances Act 1981* requires a registered medical practitioner (or nurse practitioner) who has reason to believe that a patient (i.e. prisoner) is drug dependent to notify, via completing and submitting the Notification of Drug Dependent Person form (Appendix 4) to the Department of Health and Human Services Drugs and Poisons Regulation, where:

- a) The patient requests or seeks prescription of a drug of dependence  
or
- b) The prison medical practitioner intends to treat or is treating the patient with a drug of dependence.

### **2.4.4 Treatment planning**

The relationship between the prisoner and correctional health service staff is important in all areas of chronic health care planning, particularly when working with prisoners with drug problems. Components of a sound therapeutic relationship include genuineness, empathy, and positive regard (Vancouver, 2002). Ultimately, correctional health service staff should work in collaboration with the prisoner, helping them to help themselves.

According to the *National Guidelines* (Gowing et al., 2014), treatment planning should:

- Be a continuous process
- Involve the patient and reflect the patient's circumstances and case complexity
- Be based on coordinated care across service providers to address multiple domains
- Be documented so as to be meaningful to the patient, and service providers.

Correctional health service staff will be responsible for treatment planning for prisoners in relation to OST. This will include (but not be limited to) the following activities:

- For induction: ensuring that the assessment process is completed for prisoners who are referred for induction onto the Program.
- For maintenance: verifying that prisoners entering prison are currently being prescribed either methadone or buprenorphine.
- In the event of a Naltrexone implant being present: if possible, verifying the date of implant and the status of the implant prior to commencing prescription of methadone or buprenorphine.
- Working with the prison medical practitioner to obtain voluntary informed consent from each prisoner to commence OST in prison, or continue their treatment in prison.
- Outlining the rules and conditions to prisoners as part of the orientation for entering the Program.
- Administering treatments as prescribed and monitoring prisoners' progress.
- Conducting ongoing management of prisoner reviews, dose alterations, consultations with the prison medical practitioner, prison management, and liaising with alcohol and other drug (AOD) service providers to ensure the development of coordinated treatment plans and referral to psychosocial services.
- Identifying circumstances that may lead to a prisoner's unplanned release, involving regular reviews of a prisoner's earliest release date, forthcoming court bail/appeal hearings, eligibility for parole and parole hearing dates.
- Ensuring continuity of treatment for prisoners who are transferred between prisons.
- Managing Department of Health and Human Services Drugs and Poisons Regulation notifications.
- Planning and arranging pre-release referral to a community OST prescriber and pharmacy.

Management and monitoring of prisoners prescribed methadone or buprenorphine treatment will continue until the prisoner has been released into the community or is voluntarily or involuntarily withdrawn from the Program.

### 2.4.5 Dosing procedures

Staff authorised to administer Schedule 8 drugs, in accordance with the *Victorian Drugs, Poisons and Controlled Substances Act 1981* and the *Drugs, Poisons and Controlled Substances Regulations 2006*, can administer methadone and buprenorphine in prisons through an OST program, following procedures that are in line with community practice.

A detailed description of the pharmacology of methadone and buprenorphine are provided in Section 2.1.1 of the *National Guidelines* (2014).

Post-dose supervision is recommended as a strategy to prevent dose diversion. Where there is no clinical imperative for post-dose supervision, the Deputy Commissioner's Instructions (DCIs)<sup>2</sup> provide direction regarding the specific processes and timeframes required for post-dose supervision.

### Administering doses

The following actions must occur before administering doses:

- Prisoners must bring their identification card to the dosing area. A dose will not be administered without this card.
- Correctional health service staff must confirm that the prisoner is not intoxicated.
- Correctional health service staff must check the prisoner's name and Corrections Reference Number (CRN) with the current prescription.

### Administering methadone – required actions

When administering methadone:

- Add at least 150 mls of water to the dose.
- Observe the prisoner drinking the solution (i.e. water and methadone dose). Ensure that they are facing forward and do not allow them to turn sideways or move out of direct sight.
- Talk to the prisoner directly after they have swallowed the solution.
- Ensure that the prisoner signs that they have received the solution.
- Complete relevant documentation.

### Administering buprenorphine – required actions

When administering buprenorphine:

- Check that the current day is included on the prisoner's regime.
- If it is an alternate-day or three-times-a-week program, confirm the dose for the current day.
- Ask the prisoner to place the dose (or the first two films of the dose) under their tongue.
- Ensure the prisoner signs that they have received the dose.
- If the prisoner's prescribed dose is more than two films, ensure that they are supervised and drink at least 150mls of water before receiving next two films (no more than two films at a time). Repeat this process until full dose is administered.
- Complete relevant documentation.

Where practical, methadone and buprenorphine dosing should be completed before midday.

### Take away doses

Take away doses refer to the community practice where an individual prescribed methadone or buprenorphine is given permission by their treating doctor to be given a pharmacy prepared pre-packaged dose or multiple doses of either methadone or buprenorphine to take away from the pharmacy.

Prisoners participating in the Custodial Community Permit Program (CCPP) who have been prescribed methadone or buprenorphine treatment **will not be permitted to receive take away doses under any circumstances.**

### 2.4.6 Clinical monitoring and review

Regular monitoring and review is an important component of effective OST in Victorian prisons.

Effective monitoring requires regular communication between correctional health service staff (medical practitioner, nurses, and pharmacists), AOD treatment staff and prison management, including referral to appropriate services.

All prisoners in Victorian prisons are reviewed by the prison medical practitioner upon reception into the prison system. For prisoners prescribed OST, this initial session will be followed by regular reviews.

2 See Section 2.6.2 for further information on Deputy Commissioner's Instructions (DCIs)

According to the *National Guidelines* (Gowing et al., 2014) clinical reviews should assess:

- The patient's general presentation, the quantity and frequency of any substance use since the last review, general health and wellbeing, social circumstances, living environment and relevant risk factors (harm to self or others, overdose, BBV risk)
- The current medication conditions, including attendance for dosing, adequacy of medication dose, side effects, frequency of reviews, monitoring and counselling services
- Treatment progress against the treatment plan.

It is, however, highly recommended that medical practitioners reviewing changing dose, or inducting prisoners onto OST have completed an accredited training program and are registered with the Department of Health and Human Services Drugs, Primary Care and Community Programs Branch. This is in line with community practice requirements.

### Urine testing

Corrections Victoria conducts random urine tests within prisons. These include random general, random Identified Drug User (IDU) and targeted urine tests. If a prisoner on the Program returns a positive test, or is involved in other drug-related incidents, they will be given an IDU status and be subject to the management measures outlined in the Victorian Prison Identified Drug User Program. The prisoner will be directed to undergo an IDU review with the prison based AOD provider within five days. As part of this review, the prisoner should be referred back to the correctional health service provider for a review of their OST treatment regime with the prison medical practitioner.

### 2.4.7 Safety concerns

There are four primary safety concerns in the delivery of the Program – incorrect dosing, side effects of treatment, diversion of medications and standover. Standover refers to prisoners being intimidated into diverting their OST dose. Issues pertinent to dosing and diversion are discussed in further detail below. Detailed information relating to side effects is contained in Appendix 5.

### Incorrect dosing or overdose

The *National Guidelines* (Gowing et al., 2014) provide the following procedures for incorrect dosing or overdose:

### Methadone overdose<sup>3</sup>

If a patient in the first two weeks of induction is accidentally given a higher dose, observation (by health staff) is required for at least four hours. If signs of intoxication continue, prolonged observation is required.

If there is any doubt regarding tolerance (e.g. if there is uncertainty that the patient has taken their dose daily) observation for at least four hours is required in situations involving an accidental dose greater than double the usual daily dose.

The following procedure should be followed in all cases of dosing error:

#### Doses up to 50% in excess of the regular daily dose:

- Advise patient of the error and explain possible consequences.
- Inform patient about signs and symptoms of overdose and advise him/her to seek medical treatment if symptoms develop.
- Correctional health service staff must advise the prescribing doctor of the error and record the event.

#### Doses higher than 50% of the regular daily dose:

- Advise patient of the error and explain possible consequences.
- Correctional health service staff must contact the prescribing doctor immediately.
- The prescribing doctor will advise if the patient requires hospitalisation. If so, the reasons for hospitalisation must be explained to the patient and they must be accompanied to hospital to ensure admitting staff receive clear information on what has occurred.

#### Caution regarding inducing vomiting

- Inducing vomiting can be dangerous and is contraindicated if the patient has any signs of CNS depression.
- Vomiting after the first 10 minutes post dose is not satisfactory for dealing with overdose as it is impossible to determine how much of the dose has been eliminated.
- Induction of vomiting by stimulation of the pharynx within 5 – 10 minutes of dosing may be appropriate as a first aid measure only. Ipecac syrup is contraindicated as its action may be delayed.

3 Some role titles included in the 'methadone overdose' extraction from the National Guidelines have been changed to reflect prison setting.

## Buprenorphine overdose

Risks associated with an incorrect buprenorphine dose are not as severe as with methadone. If an incorrect dose is administered:

- Health staff should immediately notify the patient and prescriber of the error.
- The patient should be warned of likely consequences (increased sedation or drowsiness may occur for several hours after dosing) and warned against any additional drug use, operating machinery or driving for the rest of the day.

If any of the following apply the patient should be monitored for at least six hours by trained health professionals:

- The patient is sedated for any reason following the dose.
- The patient is in the first two weeks of induction.
- A dose of 64mg or higher was taken.

The patient should be reviewed by the prescribing medical officer prior to the next dose, as a lower dose or no dose may be required.

(Gowing et al., 2014)

## Vomited methadone dose

Unintentional vomiting can be a side effect of methadone treatment, particularly at the start of the treatment. Alternatively, prisoners may claim to have vomited their methadone in an attempt to get an additional dose.

If a prisoner regularly reports vomiting after a dose of methadone, the correctional health service staff must be informed and should:

- Observe the vomit and document its contents (estimate volume, colour, and contents). If the vomit is not observed, a further dose cannot be authorised.
- Document the time that the prisoner reported vomiting and the time of the methadone dose (information regarding other medication and time of last meal should be collected for the prison medical practitioner).
- Contact the prison medical practitioner, who may authorise the re-administration of up to half of the regular dose with directions that the prisoner be observed for at least 30 minutes after the second dose. A direct or phone order must be obtained in order to give this dose.
- Consider strategies to prevent repeated vomiting. For example, a small meal (e.g. biscuits) immediately prior to dosing, or a parenteral dose of an antiemetic (e.g. metoclopramide) at least 15 minutes prior to dosing, can prevent repeated vomiting.

Prisoners who report repeated vomiting should be referred to the prison medical practitioner for review. Persistent vomiting may require review of the methadone treatment.

## Reducing the risk of diversion of methadone or buprenorphine

Prisoners may divert prescribed medications to trade, sell or consume. As a result, treatments such as methadone and buprenorphine are in demand.

To prevent prisoners diverting their OST to others or into secreted containers, prisoners must be supervised in a specific area next to or near the dosing area. The DCI provides direction on regarding the specific processes and timeframes required for post-dose supervision.

**Custodial officers** will be responsible for supervising all pre and post-dosing to reduce the risk of diversion or personal concealing of medications by prisoners. This will require the pat-searching of all prisoners prior to each dose and supervision of prisoners in the designated post-dosing supervision area.

**Custodial officers** can reduce the opportunity for diversion by engaging/communicating with prisoners during the supervision period and maintaining eye-to-eye contact whenever possible to help reduce diversion opportunities.

Prisoners suspected of diversion may be supervised separately from other prisoners and pat-searched again prior to leaving the supervision area.

The pre-dose responsibilities of custodial officers include:

- Enabling prisoners to attend the prison health service at the required time to receive their prescribed dose of either methadone or buprenorphine.
- Allowing only one prisoner to attend dosing at a time and separating prisoners from the dosing location.
- Asking the prisoner to present their ID card and positively identifying them against the medical photograph held by the health staff.
- Having the prisoner roll up their sleeves and empty their hands (except for their ID card).
- Pat-searching for anything in which medication could be secreted. Where necessary, removing all items found and reporting the prisoner to the correctional health service provider.
- Visually inspecting inside the prisoner's mouth to ensure that there is no absorbent material or other items that may be used to secrete medication.

The post-dose responsibilities of custodial officers include:

- Placing prisoners in the nominated supervision area for supervision. A custodial officer must be present at all times in this area to deter prisoners from diverting their medication.
- Checking prisoners' mouths for withheld medication and making verbal contact with prisoners before they leave the post-dosing supervision area.
- Informing correctional health service staff and custodial officer if a prisoner is suspected of, or discovered to be, diverting their medication.
- Performing general checks of the dosing areas before and after dosing for items that may have been secreted for the purpose of diverting medications.

#### 2.4.8 Services for prisoners receiving OST

Prisoners prescribed methadone or buprenorphine treatment should be encouraged by correctional health service staff to participate in available prison services, such as alcohol and other drug treatment programs and psychosocial services, to help enhance their opioid treatment goals in prison and after release into the community.

These services can help prisoners address issues that relate to the negative aspects of their drug use.

#### 2.4.9 Medication transfers

##### Transfers from buprenorphine to methadone

The most common medication transfer that may occur is from buprenorphine to methadone. It is not recommended that prisoners are transferred from methadone to buprenorphine.

Transfers are assessed on a case-by-case basis. For example, transferring from buprenorphine to methadone may be appropriate for prisoners experiencing or at risk of pressure to divert their pharmacotherapy medication.

To transfer a prisoner from buprenorphine to methadone:

- Wait 24 hours after last buprenorphine dose
- Doses of 20 – 30 mg of methadone per day are appropriate for patients transferring from 8 mg or less of buprenorphine per day
- Doses of 40 – 60 mg of methadone per day are appropriate for patients transferring from 12 mg or more of buprenorphine per day
- Avoid rapid dose increases, where possible.

(Gowing et al., 2014)

#### 2.4.10 Withdrawal from OST

Prisoners engaged on the Program will be provided a stable dose of either methadone or buprenorphine, however some prisoners will choose to voluntarily withdraw from their treatment and others may not comply with the Program's rules and will be removed from the program (involuntary withdrawal).

##### Voluntary withdrawal

Prisoners who wish to voluntarily withdraw from treatment should be provided with information about cessation of methadone or buprenorphine. Where possible, it is best to plan for voluntary withdrawal only after unsanctioned drug use has ceased, and other aspects of the prisoner's health and wellbeing have stabilised (Gowing et al., 2014).

##### Predictors for successful withdrawal from OST include:

- How withdrawal is attempted, e.g. gradual rather than rapid dose reductions (over months rather than days or weeks) or sudden cessation
- Good patient understanding of the process and involvement in decision making
- Participation in psychosocial approaches addressing coping strategies, risk behaviours, support systems
- Regular review of progress and plans
- No unstable or problematic use of alcohol or other drugs
- Stable medical and psychiatric condition
- Attention should be paid to mental health (depression, anxiety) or chronic pain disorders that may be destabilised by withdrawal
- Stable social conditions, particularly activities and supports for a drug-free lifestyle
- Duration in treatment.

(Gowing et al., 2014, p. 141)

Prisoners with a poor prognosis should be warned against withdrawal from treatment. They should not be refused dose reductions, as the prisoner must consent to treatment. Dose reductions can commence with regular reviews to assess the prisoner and review treatment plans.

If the prisoner wishes to continue their withdrawal from the Program against medical advice, this should be clearly noted in their medical record.

### Process for withdrawal from methadone substitution treatment

Treatment approaches that gradually reduce the methadone dose generally have better outcomes (higher completion rates and less withdrawal discomfort) than rapid reductions. Contemporary treatment guidelines generally recommend gradual reductions in methadone dose over weeks to months. An example of methadone dose reduction rates are outlined below in Table 1.

**Table 1: Example of Methadone Withdrawal Regime**

Methadone dose	Rate of withdrawal
Over 50 mg	5 mg per week
30 – 50 mg	2.5 mg per week
Less than 30 mg	1 – 2.5 mg per week

Reductions in methadone dose may be temporarily halted (or even temporarily increased) in response to opioid use or severe withdrawal discomfort. Such interruptions are common. Consequently, the reduction from methadone may take several months, depending on the original maintenance dose.

The goal of withdrawing from methadone should always be open for review by the prisoner and correctional health service staff. A decision may be made to continue OST rather than proceeding with dose reductions.

### Withdrawing from buprenorphine substitution treatment

There is evidence that withdrawal from buprenorphine is less severe than methadone withdrawal, but the research is not conclusive. Withdrawal does appear to be milder during buprenorphine dose reductions and the rate is normally more rapid than methadone. The symptoms and signs of withdrawal are similar to withdrawal from other opioids (see Appendix 6).

### Rate of buprenorphine dose reduction

A gradual reduction over weeks has better outcomes than rapid reductions, and is less likely to result in a relapse to opioid use. The following dose reduction rates are proposed, although reduction can occur either more rapidly or more slowly. An example of buprenorphine dose reduction rates are outlined below in Table 2.

**Table 2: Example of Buprenorphine Withdrawal Regime**

Buprenorphine dose	Rate of withdrawal
Above 16 mg	4 mg per week
8 – 16 mg	2 – 4 mg per week
Less than 8 mg	2 mg per week

### Psychosocial support

The provision of psychosocial support during withdrawal has been shown to result in higher completion rates and greater abstinence rates. It has also been shown that providing information regarding withdrawal symptoms and coping strategies improves outcomes for patients withdrawing from opioids.

Patient information materials have been produced specifically for methadone withdrawal including the *Methadone Treatment in Victoria User Information Booklet*, which explains methadone withdrawal and should be given to prisoners withdrawing from the Program.

### Additional medications

There are a number of symptomatic medications that can assist with withdrawal from methadone or buprenorphine. The use of benzodiazepines requires specific mention, as this class of drugs is sometimes used to manage symptoms after cessation of opioid pharmacotherapy. Due to the risks associated with benzodiazepines, particularly non-medical use and addiction, benzodiazepines are not recommended for the routine management of symptoms in prisoners ceasing pharmacotherapy. In rare cases where benzodiazepines are indicated, they should be prescribed at low doses for no more than three days, and only after complete cessation of a prisoner's methadone or buprenorphine treatment.

Peak withdrawal symptoms usually occur after the last dose of methadone or buprenorphine. All prisoners should be reviewed during this period to assess withdrawal severity and management.

### Involuntary or rapid withdrawal

All eligible prisoners wishing to participate in the Program must provide their voluntary, informed consent to continue or commence OST in prison, and must abide by the Program's rules. The rules of the Program have been developed in line with community practice and to promote acceptable behaviours among prisoners on the Program. They also promote acceptable behaviour to encourage participation in community OST programs after release from prison. Failure to comply with these rules may lead to a prisoner being withdrawn from the Program. In these instances a 'rapid withdrawal' approach may be followed.

Prisoners may be involuntarily withdrawn from the Program if they:

- Attempt to trade, sell or divert methadone or buprenorphine.
- Use heroin or other drugs not prescribed by the prison medical practitioner.
- Fail to abide by dosing protocols.
- Fail to collect their methadone or buprenorphine at the time specified by correctional health service staff.
- Miss three consecutive doses of either methadone or buprenorphine.
- Fail to treat the correctional health service staff with courtesy and respect, e.g. by using abusive language.
- Refuse to provide a urine drug test sample as required.

In some instances, where diversion is a concern, problems can be resolved by transfer to another treatment option (e.g. from buprenorphine to methadone).

### **Process for involuntary withdrawal**

For methadone, a reduction rate equivalent to 5 mg every three days can be used. If the prisoner is showing signs of severe physical withdrawal, the rate of reduction may be slowed at the discretion of the authorised OST prescriber.

For buprenorphine, a reduction rate of up to 4 – 8 mg every three to four days has been outlined in the *National Guidelines* (Gowing et al., 2014). Prisoners who pose a risk to others may be withdrawn more rapidly.

### **Authorisation of involuntary withdrawal**

The decision to withdraw a prisoner from the Program should be authorised by the prison methadone and buprenorphine prescriber in consultation with the correctional health service staff.

If a prisoner breaches the Program Contract of Consent and Agreement, health staff should:

- Clearly document failure to comply and recommended actions in the prisoner's medical record.
- Attempt to address the issue with the prisoner.
- Inform the prisoner that their continued behaviour may lead to them being withdrawn from the Program.
- Where necessary, consult with operational staff to gain further information regarding the prisoner's behaviour in the prison.

- Review the case with the prescriber and other correctional health service staff to determine the most appropriate plan of action. This may include a case conference with the prisoner's contact officer, correctional health service staff and other relevant staff to determine the appropriate course of action. It may also result in immediate withdrawal from the Program.
- Consult with an addiction medicine specialist or DACAS, if required.
- Outline the plan of action to the prisoner and clearly inform them of the consequences if they continue to breach the conditions of the Program.

If a prisoner's unacceptable behaviour continues, health staff should:

- Clearly document failure to comply in the prisoner's medical record.
- Review the case with the prison medical practitioner and other correctional health service staff to confirm that the prisoner will be removed from the Program.
- Ensure the reduction program is prescribed by the authorised prison medical practitioner.
- Administer reduced methadone or buprenorphine doses as prescribed.
- Inform relevant custodial officers that the prisoner is being removed from the Program and the estimated date of withdrawal completion.

### **Diversion of methadone or buprenorphine**

Where a prisoner is confirmed to be diverting their methadone or buprenorphine dose, correctional health service staff should inform the prisoner that they will be withdrawn from the Program once the prison medical practitioner has been notified and made the necessary changes to the methadone or buprenorphine prescription.

Health staff may use their discretion if it is clear, after discussion with custodial officers, that a prisoner is the victim of intimidation and standover for their methadone or buprenorphine. In these cases health staff should:

- Consult with custodial officers to look at options to rectify the situation.
- Consider options in terms of available resources. For example, the prisoner may be offered the opportunity to be supervised in the medical centre, if practical. This may reduce the threat of standover, as the dose will be more difficult to divert.
- Offer transfer from buprenorphine to methadone if appropriate.

### Other breaches of the contract

Breaching prison rules or exhibiting unacceptable behaviour unrelated to the prisoner's methadone or buprenorphine contract, such as trading/trafficking medications or illicit substances, may not automatically result in a decision to withdraw a prisoner from the Program.

The prison medical practitioner prescribing the prisoner with methadone or buprenorphine has the authority to decide whether a prisoner will be withdrawn from the Program after consultation with the correctional health service staff and prison management.

### Re-admission to OST Program

A prisoner request to be re-admitted to the OST Program will be reviewed by correctional health service providers. For consideration, prisoners must be considered to be at high risk of opioid-related harm in prison or upon release to the community.

In addition, correctional health service staff and custodial officers must be reasonably satisfied that the prisoner can abide by the rules of the Program. More detailed local policies and procedures may apply.

### 2.4.11 Transitions

Correctional health services ensure prisoners participating in the OST Program are connected with community OST services when released from prison. This will ensure that the prisoner can continue their treatment after release. Further guidelines are contained in Section 5.

## 2.5 Treatment considerations

This section considers information on treatment considerations relevant to specific conditions or populations.

### 2.5.1 Use in conjunction with other sedating medications

OST should be used with caution in prisoners prescribed other sedating drugs, particularly benzodiazepines, some antidepressants and some anti-psychotic medications.

Prisoners being prescribed such medications should have a comprehensive review of their medication before beginning OST, with referral to a relevant specialist (e.g. addiction medical specialist or psychiatrist), if required.

Refer to [www.opioiddruginteractions.com/](http://www.opioiddruginteractions.com/) for detailed listing of drug interactions.

### 2.5.2 Current psychiatric conditions

OST should not be started in prisoners with acute psychosis, severe depression or other psychiatric conditions that compromise the individual's capacity to provide informed consent without consulting the prisoner's treating psychiatrist or other relevant mental health specialist.

Attempts to manage and stabilise the psychiatric condition should be made before OST is started. Individuals at risk of suicide should not be inducted in to treatment without adequate medical supervision and specialist consultation (medical and/or mental health) may need to be sought.

### 2.5.3 Current medical conditions

Methadone and buprenorphine are opioid medications and should be used with caution in the following situations:

**Compromised respiratory function.** Use methadone or buprenorphine with caution in prisoners with severe respiratory illness. In such patients, therapeutic doses of opioids may decrease respiratory drive while simultaneously increasing airways resistance to the point of apnoea.

**Severe hepatic disease.** Caution must be used when treating prisoners with clinically significant hepatic failure. This may reduce the metabolism of methadone, necessitating low initial methadone doses and greater caution in subsequent dose increases. The presence of elevated enzyme levels on liver function testing without clinical evidence of liver failure is not cause for exclusion from treatment with methadone.

**Special risk patients.** Opioids should be prescribed with caution and at a reduced initial dose in certain patients, such as the elderly or debilitated, and those with prostatic hypertrophy, urethral stricture, recent head injury or acute abdominal conditions.

**Infectious Diseases.** Treatment of HIV, hepatitis C and chronic hepatitis B is as effective in people with a history of opioid dependence who are currently engaged in OST as in other population groups.

In people with advanced HIV, hepatitis C or hepatitis B and ongoing opioid dependence, substitution treatment is recommended in conjunction with antiretroviral treatment to facilitate treatment adherence and improve outcomes for both conditions.

Drug interactions between antiretroviral medications and methadone, and to a lesser extent buprenorphine, need to be monitored and may necessitate adjustment of medication regimens

### 2.5.4 Chronic pain

The management of prisoners with opioid dependence and/or chronic pain is complex. Some forms of methadone or buprenorphine can be used as analgesics in the management of acute and chronic pain conditions. In some of these cases, prisoners may not be participating in an OST program. Whether these drugs or other opioids are being used solely for acute or chronic pain conditions should be based on the assessment of the admitting prison medical practitioner. Referral or consultation with a pain specialist or addiction medicine specialist may be considered to assist in treatment planning. The *National Guidelines* also provide further guidance on this issue (see Section 2.6.10 of the *National Guidelines*, 2014).

### 2.5.5 Culturally and linguistically diverse prisoners

As previously stated in regard to informed consent, correctional health service providers must ensure that there are policies and procedures for communicating with prisoners who have a limited knowledge of English. Prisoners must be made aware of the purpose, benefits and risks associated with treatments.

Correctional health service staff must take all reasonable steps to ensure that prisoners who cannot read or speak English understand all information provided on methadone or buprenorphine treatment, including the responsibilities of being treated in prison and after release to the community.

### 2.5.6 Pregnancy and breastfeeding

For pregnant women who are using or at risk of using opioids, OST is associated with improved outcomes for mother and baby. Both methadone and mono buprenorphine are effective during pregnancy. Buprenorphine-naloxone is contraindicated, as the effect of naloxone on the foetus is unknown.

Considerations include:

- Dose reductions or withdrawal should not take place in the first or third trimester of pregnancy.
- If dose reductions are required, reductions of 2.5 – 5 mg of methadone or 2 mg of buprenorphine per week are acceptable. Prisoners should be monitored during dose reduction.
- Split dosing (one dose of methadone every 12 hours) may be necessary due to increased metabolism and circulating blood volume. Split doses of buprenorphine are not usually required.
- Transferring from methadone to buprenorphine is not recommended during pregnancy due to the risk of precipitated withdrawal.

(Gowing et al., 2014)

### 2.5.7 Older prisoners

The *National Guidelines* (Gowing et al., 2014) identify that older people with a history of drug misuse may experience health issues that impact on the natural ageing process associated with long term opioid use. These health issues can include:

- Osteoporosis
- Sex hormone deficiencies
- Reduced cognition due to repeated hypoxia
- Risk of falls
- Prescription of multiple medications.

Further to this, older people with a history of drug misuse may also have:

- High rate of lifetime psychiatric diagnosis
- Recall impairment or dementia (early or late stages)
- Physical deterioration
- Decreased ability to metabolise opioid or other drugs.

(Lofwall, Brooner, Bigelow, Kindbom, & Strain, 2005)

## 2.6 Service delivery roles and responsibilities

### 2.6.1 Correctional Health Service Providers

Correctional health service providers will be responsible for treatment planning for all prisoners prescribed OST within Victorian prisons.

Responsibilities include but are not limited to:

- Identifying and verifying prisoners being prescribed treatment
- Obtaining informed consent from prisoners prior to treatment
- Directing the administration of each prisoner's prescribed treatment
- Case managing each prisoner's prescribed treatment
- Conducting ongoing reviews of all prisoners prescribed treatment, including medical specialist referrals as required
- Managing prisoners transferred to other prisons, courts or police cells
- Documenting and maintaining prisoner medical record (including submission of the Notification of Drug Dependent Person and Notification of Release from Prison of a Patient Treated with Methadone or Buprenorphine for Opioid Dependence forms to Department of Health and Human Services, Drugs and Poisons Regulation), reporting and managing all OSTP-related medical incidents
- Managing prisoners withdrawing from the program either voluntarily or involuntarily

- Planning pre-release discharge for all prisoners prescribed methadone or buprenorphine as part of an OST Program, including referral to a community pharmacotherapy prescriber and pharmacy prior to their release
- Referring prisoners to available prison drug treatment programs and psychosocial support services.

Correctional health service providers will record information pertaining to prisoners prescribed methadone or buprenorphine in each prison for monitoring and evaluation purposes. This will include:

- Number of prisoners prescribed OST on any given day and average number of daily doses by month
- Aggregated dose level data (in milligrams)
- Number of prisoners voluntarily or involuntarily withdrawn from the OST program and rationale for their withdrawal from treatment
- Number of prisoners referred to the prison AOD treatment provider
- Number of prisoners referred for assessment to commence OST in prison, including referral source
- Number of prisoners found not eligible for treatment at stage one, two or three of the assessment process (see Section 3.5), including rationale
- Number of prisoners inducted onto OST
- Number of prisoners failing to complete the OST stabilisation period, including rationale
- Length of waiting list to commence OST at each location
- Number of prisoners receiving OST released to the community.

### 2.6.2 Custodial Officers

The key role of custodial officers in the Program is to manage and supervise prisoners prescribed methadone or buprenorphine pre- and post-dosing.

Responsibilities will include:

- Coordinating the movement of prisoners receiving their prescribed dose of either methadone or buprenorphine at the required time and location
- Ensuring that prisoners are checked and pat-searched prior to receiving their dose in order to discover items that may be used to divert their medication
- Ensuring that prisoners are separated at the dosing location and providing an opportunity for each prisoner to be individually dosed.
- Ensuring that all prisoners are positively identified prior to their dose
- Supervising prisoners after dosing in the nominated prison area

- Checking prisoners' mouths for withheld medication prior to leaving the supervision area
- Performing general checks of the dosing and supervision areas for items that could potentially be used to divert medications prior to and after the supervision of the prisoners
- Liaising with health staff regarding any operational issues with the management of the Program or individual prisoners on the Program
- Engaging in prisoner reviews as requested by a correctional health service provider in response to specific issues around prisoners involvement in OST (e.g., suspicion of diversion activities).

Within the context of OST, the custodial case manager's role in pre-release discharge planning involves facilitating the engagement of prisoners prescribed methadone or buprenorphine with appropriate custodial staff (e.g., Transition and Pre-release worker).

### *Deputy Commissioner's Instructions*

Deputy Commissioner's Instructions (DCIs) outline tasks and practices to be carried out by prison staff in relation to a specified activity in the Victorian prison system. Each DCI outlines why, when and how a task must be done, the custodial officers responsible, and what must be completed. DCIs ensure consistent implementation of the principles enshrined in the Offender Management Framework. DCI 4.13 details the requirements of custodial officers in relation to supervising the delivery of OST, including the processes relating to post-dose supervision, and are aligned with these guidelines.

## 2.7 Consultancy and support

The Victorian Drug and Alcohol Clinical Advisory Service (DACAS) is a 24-hour specialist telephone consultancy service operated by Turning Point. **The DACAS contact telephone number is 1800 888 236.**

DACAS is designed to assist health and welfare professionals with the clinical management of drug and alcohol problems. The service helps a range of health and welfare professionals to respond in a supportive and appropriate way to a variety of clinical scenarios involving drug and alcohol issues within generalist settings.

DACAS is staffed by senior medical and pharmacy consultants who are highly experienced in providing drug and alcohol treatment. Consultants can offer information and advice on a diverse range of issues, including:

- Management of withdrawal syndromes
- Pharmacotherapies
- Medical and nursing management of intoxication
- Pain management
- Management of medical and psychiatric complications associated with drug and alcohol use
- Dual diagnosis issues
- Prescribing issues
- Behavioural problems.

All DACAS inquiries undergo a preliminary call screening process by Turning Point telephone counselling staff. This brief assessment process allows counsellors to respond to issues and queries relating to referral information, psychosocial management issues, the alcohol and drug service system and administrative enquiries. It also enables counsellors to screen inappropriate calls, e.g. calls from non-health professionals.

This service can be used to discuss clinical issues relating to the treatment and management of prisoners prescribed OST in Victorian prisons, but should not be used as the primary source of advice. In the absence of the authorised medical practitioner or an addiction medical specialist, correctional health staff can utilise DACAS for more immediate clinical support and advice.

All contact with DACAS should be clearly documented in the prisoner's medical record, including the consultant's name, advice provided and action taken by the prison medical practitioner and/or correctional health service staff.

# 3 Induction Phase – Clinical and Operational Procedures

## 3.1 Considerations for induction on to OST

As per the *National Guidelines* (Gowing et al., 2014), the goal of induction is to safely achieve an adequate dose of medication, stabilise illicit or unsanctioned opioid use and address co occurring conditions.

Other conditions that may need to be addressed include pregnancy, sexual health, blood-borne viruses, dental care, mental health (particularly suicide risk), sleep, nutrition and tobacco use.

Methadone is the preferred agent for induction to OST, due to issues of prisoner compliance and risk of diversion with buprenorphine in its current form as a sublingual film. Buprenorphine-naloxone may be used as an induction agent in rare case-by-case exceptions. These exceptions must be supported by clinical evidence (e.g. allergy to methadone).

### Indications for induction (according to DSM-V criteria)

Neuroadaptation (physical dependence) to opioids, shown by the development of tolerance and features of a withdrawal syndrome, does not have to exist for the diagnosis of opioid use disorder. However, caution must be taken when considering prisoners with low levels of neuroadaptation for OST.

Given that most prisoners being assessed for the induction phase will have low levels of neuroadaptation, the treatment team (prison medical practitioner and OST nurse) must:

- Establish a history of prior opioid dependence (see Section 3.4).
- Identify how the potential benefits outweigh the potential disadvantages of OST.
- Consider alternative treatment options.
- Use caution when initiating treatment in prisoners with low levels of neuroadaptation.

The prisoner must be able to give voluntary informed consent to treatment.

Issues relating to the assessment and induction of prisoners with low levels of neuroadaptation are discussed further in this Section.

## 3.2 Eligibility of prisoners for the induction phase

Induction is indicated for prisoners who:

- Are opioid dependent at the time of imprisonment and not receiving treatment
- Continue to use opioids (licit or illicit) in prison in a manner which constitutes a significant risk of harm
- Are at significant risk of using opioids in prison or post-release.

For the purpose of risk management, prisoners will require at least six weeks (without disruption) to complete the recommended methadone induction period.

Prisoners eligible to commence OST while in prison should:

- Be diagnosed by correctional health staff and the prison medical practitioner with an opioid use disorder according to the *American Psychiatric Association's Diagnostic Statistical Manual, Fifth Edition (DSM-V)*; or continue to use illicit opioids in prison in a manner which constitutes a significant risk of harm; or be at significant risk of using opioids in prison or post-release.
- Give voluntary informed consent to begin treatment in prison.
- Have no outstanding court matters or release date for at least six weeks to ensure there is sufficient time to complete the assessment and stabilisation period before being released.
- Have no unstable medical or psychiatric conditions.
- Agree to abide by the rules of the program and have signed the Program Consent and Agreement Contract.

If there is the possibility of unplanned release of the prisoner prior to completing the induction phase, health staff should assess the risks and benefits of beginning induction. Ideally, prisoners must not be transferred during the first week of the stabilisation period.

An Eligibility Checklist is located in Appendix 1.

### 3.3 Referral of prisoners to the induction phase

In order to be assessed for their eligibility to commence OST, prisoners will need to be referred to the correctional health service provider.

A prisoner may be referred for assessment to the Program by:

- Prisoner self report.
- Custodial officers and correctional health service staff awareness of prisoners:
  - Appearing drug affected.
  - With positive opioid urine drug screens.
  - Experiencing non-fatal overdoses.
  - Recently withdrawn from methadone or buprenorphine prior to imprisonment or while in police custody.
- Correctional health service staff.
- Prison AOD treatment staff.

Referrals will be made to the correctional health service provider, where a member of staff will coordinate all referrals and arrange appointments for a series of assessments.

Referrals for assessment for the induction phase will be the same as any primary health service referral within the prison system. They will be coordinated and case managed by the staff at the correctional health service.

### 3.4 Assessment principles and considerations

Initial assessment of a person using opioid drugs should follow standard practice for assessment of a complex clinical condition and incorporate collateral information where appropriate.

Due to concerns about prisoners starting the induction phase without a history of opioid dependence, and the difficulties of assessing prisoners who have little or no neuroadaptation, the following assessment principles are recommended:

1. Use collateral history to confirm previous episodes of opioid dependence.
2. Potential risks and benefits of commencing methadone treatment should be identified and documented for each prisoner.
3. If there is doubt regarding the suitability of a prisoner for OST, consultation with an addiction medicine specialist or DACAS may be indicated.

These assessment principles are discussed in further detail below.

#### 1. Use collateral history to confirm previous episodes of opioid dependence

Evidence of previous episodes of opioid dependence must be documented before a prisoner becomes eligible to start OST. Confirmation through collateral history can take various forms:

- Regulatory and prescription monitoring systems, according to usual standards of privacy and confidentiality and with patient consent.
- Evidence of previous opioid dependence from drug treatment providers, including community drug and alcohol services, general practitioners and general hospitals.
- Evidence of opioid dependence from Department of Justice and Regulation records, e.g. previous prison admissions, prison medical records, court reports or community treatment orders.

There are a number of procedural issues raised by this requirement, including:

- Prisoners must be able to recall previous service providers or episodes of methadone treatment.
- For prisoners with cognitive impairment, the suitability of OST and the capacity for voluntary informed consent must be confirmed, and neuropsychological assessment may be necessary.
- Prisoners must be prepared to sign the Authority for Release of Information Form (in JCare).
- Additional work and delays in the assessment of prisoners wishing to commence OST will be created. However, much of this work can be done by correctional health service staff and the absence of neuroadaptation lessens the requirement for urgent commencement of treatment.

In general, the inability to confirm prior episodes of dependence would make a prisoner ineligible to start OST. However, in some circumstances where prior opioid dependence cannot be clearly established, and the prisoner is at risk due to opioid use, the decision regarding suitability for OST may need to be made in consultation with an addiction medicine specialist or DACAS. This includes cases where the prisoner:

- Repeatedly uses opioids while in prison (as identified by clinical presentation and pathology results)
- Is deemed to be at significant risk from their opioid use in prison.

## 2. The potential risks and benefits of commencing OST must be identified and documented for each prisoner

The risks of continued opioid use in prison and after release must be identified for each prisoner being assessed. It should be established that the potential benefits of commencing OST outweigh the potential harms of increasing the prisoner's level of dependency.

High-risk drug-related practices include one or more of the following:

- Sharing injecting equipment in prison and increasing the risk of BBV infection transmission both for the individual prisoner and the broader prison population
- A history of overdose, either while in prison or when released
- A history of recidivism related to opioid use
- A history of violence in prison related to an individual's opioid use. A history of violence may be determined from medical records, prison records, or observed behaviour.

The potential benefits and risks associated with a prisoner starting OST should be documented as part of the assessment, including:

- Any indications, contra-indications and relative contra-indications.
- The extent of neuroadaptation (physical dependence), which should guide safe and effective induction procedures.

As previously identified, the primary indication for OST is opioid dependence. While neuroadaptation does not have to exist for a diagnosis of dependence, in practice, features of neuroadaptation can be assessed clinically, through:

- **History** – both from the prisoner and collateral history
- **Examination** – looking for:
  - Appearance of withdrawal or intoxication.
  - Evidence of recent opioid or other drug use, e.g. injection sites.
  - Features of complications associated with heroin or injecting drug use, e.g. venous or systemic infections or hepatitis.
- **Investigations** – in particular, the use of urine drug screens to identify recent drug use.

Assessment of prisoners for commencing OST raises a number of important clinical and procedural issues. Few prisoners seeking to enter the Program will have features of neuroadaptation, thereby complicating the clinical assessment. Specifically:

- The prisoner's history may not be reliable, either due to difficulties with memory, or the prisoner deliberately falsifying information in order to be accepted on to the Program.

- Examination findings may be unhelpful, e.g. 'old' injection scars may be from amphetamine injecting several years ago.

Urine drug screens are difficult to interpret in the absence of neuroadaptation – a positive opiate urine drug screen can be provided by simply using an opioid (e.g. codeine) on one occasion. Urine drug screens should be interpreted in conjunction with the findings of the history and examination.

## 3.5 The assessment process

The assessment process should include:

- Reason for seeking treatment.
- Drug use history.
- Physical and mental state examination.
- Investigations (e.g. urine drug tests, blood tests for liver disease etc.).
- Diagnosis of substance use disorder.
- Other health and social issues.

(Gowing et al., 2014)

Prisoners must either be diagnosed with an opioid use disorder, as outlined in the DSM-V, continue to use illicit opioids in prison in a manner which constitutes a significant risk of harm, or be at significant risk of using opioids in prison or post-release prior to the commencement of OST.

The assessment process has a three phased approach, outlined below. Correctional health service staff should conduct assessments in a timely manner to ensure eligible prisoners gain access to the Program according to their clinical need and to ensure that the prisoner is available for the required six weeks.

### Phase One: Triage assessment

The initial triage screening of a prisoner will be conducted by a health professional using the Eligibility Checklist (Appendix 1). If a prisoner satisfies the eligibility criteria, a further assessment will be required to collect collateral information to confirm the prisoner's self report.

An Authority for Release of Information form (in JCare) must be signed by the prisoner in order for correctional health service staff to access information from prison records, Department of Health and Human Services Drugs and Poisons Regulation, community alcohol and drug treatment providers and other nominated agencies to determine the opioid dependence status of the prisoner.

### Phase Two: Drug use history assessment

Correctional health service staff will arrange an appointment for the prisoner to conduct a second assessment using the Program's Alcohol and Drug Assessment (Appendix 2). The collateral information will be used to confirm the prisoner's alcohol and drug dependence history.

Correctional health service staff should identify the risks and benefits of commencing the prisoner on methadone and document all assessment information in the prisoner's medical record.

### Phase Three: Medical assessment

The correctional health service staff will arrange an appointment for the prisoner to attend an assessment with the prison medical practitioner.

The medical practitioner will consider all assessment information compiled by correctional health service staff before completing the medical assessment of the prisoner.

In the absence of neuroadaptation (physical dependence), the prescribing medical practitioner should clearly demonstrate the potential benefits to the prisoner's health and well being, and confirm that the benefits outweigh the potential risks of the prisoner commencing methadone treatment.

### Other assessment considerations

Prisoners should be informed that every effort will be made by a correctional health service provider to refer the prisoner to a community pharmacotherapy prescriber and authorised dispensing pharmacy near their proposed post-release address.

However, this may not always be possible and may require the prisoner to commit to travelling to pick up their daily dose post-release. Difficulties in maintaining participation in OST may result if the prisoner is, upon release:

- Planning to live outside of Victoria (i.e., another state or territory, or overseas).
- Planning to live in Victoria in an area that does not have access to a registered community pharmacotherapy prescriber and pharmacy.
- Unable to commit to travelling to pick up their daily dose post release.
- Unable to meet financial costs of OST in the community post release (\$25 – \$35 a week).

If these circumstances are foreseeable, induction to OST may not be the most appropriate response.

### Prisoners not eligible for treatment

If a prisoner is found to be ineligible or unsuitable for the induction phase, the rationale and all relevant information should be clearly documented in the prisoner's medical record at each stage of the assessment process. For example, if a prisoner does not meet the eligibility criteria at the triage phase of the assessment process, the assessor should clearly document the reason of ineligibility for the induction phase and discuss all referrals in the weekly review meeting.

## 3.6 Authority for induction

The decision to prescribe methadone to a prisoner is the responsibility of the prison medical practitioner. However, all collateral information should be considered prior to commencement of treatment and all assessment information should be clearly documented in the prisoner medical record.

Once a prisoner is assessed as suitable for the induction phase, prison health service staff should ensure that all relevant documentation is completed and recorded appropriately in the prisoner's medical record.

The Sentence Management Unit and the Prison General Manager (or their nominated delegate) should be informed once the prison medical practitioner has authorised the prisoner to commence the induction phase.

## 3.7 OST Program Consent and Agreement Contract

Once a prisoner has been assessed as suitable for OST, they must sign the Program Consent and Agreement Contract (Appendix 3) before treatment can commence.

See Section 2.4.2 for information regarding informed consent.

### 3.8 OST induction regimes

The general principles for safe and effective methadone induction are described below.

#### Start with low doses

Initial methadone doses should be based upon:

- Level of neuroadaptation – given that most prisoners commencing methadone treatment will have low levels of neuroadaptation, low initial methadone doses are recommended. The *National Guidelines* suggest lower doses (20mg or less per day) are suitable for those with low or uncertain levels of dependence.
- Drug interactions, particularly the use of other sedating drugs, or those taking hepatic enzyme (CP<sub>450</sub>) inhibiting medications.
- Other medical conditions (see section ‘A2 Treatment Planning’ in the *National Guidelines* (Gowing et al., 2014, p. 15)).

#### Review the patient frequently

During induction, prisoners should be reviewed daily by a trained clinician to assess for signs of toxicity (see Features of Opioid Intoxication, Opioid Withdrawal and Overdose – Appendix 6).

#### Titrate the dose

As per the *National Guidelines*<sup>4</sup> (2014) the principles of dose titration are:

- Adjust the dose according to the experience of side effects, cravings and drug use. Dose increases should be made following review of the patient and should take into account the possibility of dose-related side effects, features of withdrawal (suggesting not enough methadone) or intoxication (suggesting too much methadone or other drug use), ongoing cravings and substance use.
- Avoid large individual dose increases (i.e., no more than 10mg increases at a time).
- Avoid dose increases on successive days due to the long half-life of methadone (approximately 15–30 hours), which results in accumulation of methadone with successive doses (steady state equilibrium is achieved after approximately 5 half-lives); usually increase dose at intervals of at least 3 days.
- Dose should be individualised, although there is evidence indicating that methadone doses of less than 40 mg per day are significantly less effective at reducing opioid use and related behaviours than higher doses (and doses of > 60 mg per day are more effective still).
- The dose should be gradually increased in order to achieve cessation (or marked reduction) in unsanctioned opioid use, and alleviation of cravings and opioid withdrawal features between doses, whilst minimising methadone side effects. Daily methadone doses above 80mg will also markedly reduce the effects of any ongoing heroin or other opioid use.

The example methadone induction regime below is recommended for use with prisoners starting treatment. However, it may need to be modified if the prisoner:

- Has other significant medical conditions.
- Is using other medications/drugs.
- Has recently been frequently using opioids and has a considerable degree of neuroadaptation.

Methadone dose increases may need to be delayed, or reduced, or methadone doses withheld completely according to the prisoner's response to methadone (e.g. side effects) or continued drug use and intoxication. These decisions will be guided by clinical evidence.

4 Minor changes have been made to the extract from the National Guidelines to account for the prison context.

**Table 3: Example of Methadone Induction Regime**

WEEK 1 <b>Day 1</b> 10 mg	<b>Day 2</b> 10 mg	<b>Day 3</b> 10 mg	<b>Day 4</b> 15 mg	<b>Day 5</b> 15 mg	<b>Day 6</b> 15 mg	<b>Day 7</b> 15 mg
WEEK 2 <b>Day 8</b> 20 mg	<b>Day 9</b> 20 mg	<b>Day 10</b> 20 mg	<b>Day 11</b> 25 mg	<b>Day 12</b> 25 mg	<b>Day 13</b> 25 mg	<b>Day 14</b> 25 mg
WEEK 3 <b>Day 15</b> 30 mg	<b>Day 16</b> 30 mg	<b>Day 17</b> 30 mg	<b>Day 18</b> 35 mg	<b>Day 19</b> 35 mg	<b>Day 20</b> 35 mg	<b>Day 21</b> 35 mg
WEEK 4 <b>Day 22</b> 40 mg	<b>Day 23</b> 40 mg	<b>Day 24</b> 40 mg	<b>Day 25</b> 45 mg	<b>Day 26</b> 45 mg	<b>Day 27</b> 45 mg	<b>Day 28</b> 45 mg

Considerations concerning the example methadone induction regime above are as follows:

- This example regime is suitable for prisoners without significant medical problems, use of other sedative drugs or other drug interactions.
- This regime assumes that day one of dosing commences on a Monday, requiring less capacity for review or back up on weekends.
- It is recommended that all prisoners be reviewed at least once in the first five days of methadone induction by the authorised prescribing prison medical practitioner or OST nurse, and at least weekly during the first six weeks until the maintenance dose has been achieved.

Prisoners inducted on methadone within Victorian prisons may be stabilised on lower doses compared with individuals receiving OST in a community setting due to:

- Scarcity of illicit opioids in the prison system compared to the community.
- Very low level of neuroadaptation to opioids common among prisoners prior to induction to methadone treatment.
- Potential for doses to be adjusted by the prison medical practitioner after the stabilisation period, according to clinical presentations.

### 3.9 Monitoring during induction

The greatest risk of methadone toxicity occurs during the peak time of methadone effects (three-four hours after each dose) during the initial days of treatment. During the first five days of treatment, correctional health service staff should ensure that prisoners return to the prison health service three to four hours after dosing to be monitored by health staff for signs of methadone intoxication (e.g. sedation, constricted pupils) or withdrawal symptoms, side effects, and other substance use. The Opioid Substitution Treatment Monitoring Form (Appendix 7, also available via JCare) should be used, which monitors:

- Behavioural parameters of intoxication, with assessment of the prisoner's speech, gait and level of consciousness.
- Physiological parameters of intoxication, including pupil size, blood pressure and pulse.

The following observations, made using the Opioid Substitution Treatment Monitoring Form, may be features of intoxication:

- pupils < 2 mm
- pulse rate > 100
- respiratory rate < 12
- blood pressure < 90/60 mmHg
- slurred (or pressured) speech
- impaired gait or impaired consciousness (drowsy).

If the prisoner exhibits any features of intoxication or methadone toxicity, correctional health service staff should:

- Withhold methadone and other medication.
- Contact the authorised prison medical practitioner for instructions.

Prisoners should also be monitored (using the Opioid Substitution Treatment Monitoring Form) immediately before their dose of methadone during the first two weeks of methadone treatment. The proposed monitoring schedule is immediately pre-dose from Day 1 to Day 10, as well as 3-4 hours post-dose from Day 1 to Day 5.

The *National Guidelines* (Gowing et al., 2014) state that pharmacotherapy prescribers in the community should review patients at least once a week during the induction period. However, unlike community clients, prisoners will be monitored by correctional health service staff twice daily in the first week of induction for signs of opioid intoxication.

In light of the above, prisoners will require one medical review by the prison medical practitioner in the first five days of induction, and weekly during the one-month stabilisation period. If required, correctional health service staff can arrange a further medical review of the prisoner.

### 3.10 Treatment planning during induction

According to the *National Guidelines* (Gowing et al., 2014) as in other areas of chronic disease management, addiction treatment planning should:

- Be a continuous process.
- Involve the patient and reflect the patient's circumstances and case complexity.
- Be based on coordinated care across service providers to address multiple domains.
- Be documented so as to be meaningful to the patient, their carers and other service providers.

Treatment planning activities specific to the induction phase include:

- Ensuring that the assessment process is completed for prisoners who are referred for induction on the program.
- Working with the prison medical practitioner to obtain voluntary informed consent from each prisoner to commence OST in prison.
- Outlining the rules and conditions to prisoners as part of the orientation for entering the Program.
- Administering treatment as prescribed and monitoring progress.

### 3.11 Review of prisoners during induction

Prisoners commencing methadone treatment in Victorian prisons should be reviewed by the prescribing medical practitioner within the first five days of induction, followed by weekly reviews for the remainder of the induction period. Ideally, the prisoner should be reviewed around the time of their third dose.

The review meetings will monitor the prisoner's progress on the induction phase and address any clinical issues that may arise. Alcohol and drug treatment staff and the custodial case manager may also be required to attend review meetings to discuss issues concerning a prisoner's methadone treatment in prison or after release to the community.

If a prisoner reports or exhibits serious signs of opioid intoxication between the weekly review meetings, such as drowsiness, nausea and vomiting or allergic reactions, correctional health service staff must inform the prison methadone prescriber immediately or, if unavailable, refer to the prison medical on-call policy. This process is aligned with the *National Guidelines* (Gowing et al., 2014).

### 3.12 Participation in prison industries during induction

The *National Guidelines* state that during induction or dose changes patients should be advised not to drive or use machinery (Gowing et al., 2014, p. 37).

During the induction phase, prisoners may have a degree of psychomotor impairment. They should be prohibited from working with heavy or dangerous machinery and be restricted to 'light duties'. As individuals respond differently to treatment, the authorised prison medical practitioner may also decide to provide a prisoner with a medical exemption (i.e. medical certificate) from all prison industries if it appears that the prisoner's psychomotor ability is impaired in the short term. Prisoners must be advised of this restriction when providing consent to participate in the OST Program. The medical certificate is to be made available to the appropriate prison industry staff member in accordance with local operational policies and procedures.

Custodial officers should document in the prisoner's Individual Management File that the prisoner has started OST and will not be able to engage in duties that require the use of heavy or dangerous machinery during the four week induction period.

# 4 Maintenance Phase – Clinical and Operational Procedures

## 4.1 Treatment planning during maintenance

Treatment planning activities specific to the maintenance phase include:

- Verifying that prisoners entering prison are currently being prescribed either methadone or buprenorphine.
- Working with the prison medical practitioner to obtain voluntary informed consent from each prisoner to continue their treatment in prison.
- Outlining the rules and conditions to prisoners as part of the orientation for entering the Program.
- Administering treatments as prescribed and monitoring progress.
- Conducting ongoing management of prisoner reviews, dose alterations, consultations with the authorised prison medical practitioner, prison management, referral to available drug treatment services and psychosocial services.
- Monitoring circumstances that may lead to a prisoner's unplanned release, involving regular reviews of a prisoner's earliest release date, forthcoming court bail/appeal hearings, eligibility for parole and parole hearing dates.
- Ensuring continuity of treatment for prisoners who are transferred between prisons.
- Managing Department of Health and Human Services Drugs and Poisons Regulation notifications.
- Planning pre-release referral to a community pharmacotherapy provider and pharmacy.
- Management and monitoring will continue until the prisoner has been released into the community or is voluntarily or involuntarily withdrawn from the Program.

## 4.2 Identification of prisoners prescribed OST

All newly received prisoners undergo a health assessment to identify any health or psychiatric issues. This assessment includes the use of prescribed medications such as methadone and buprenorphine.

Prisoners identified as being prescribed methadone or buprenorphine substitution treatment should have their treatment verified by the health professional performing the assessment.

This process also applies to prisoners transferring between prisons.

## 4.3 Verification of OST treatment

Once a prisoner is identified as being prescribed OST, the correctional health service staff should verify the prescription by:

- Ensuring newly-received prisoners sign a Release of Information form (available via JCare) to enable verification with their medical prescriber, community pharmacist and the Department of Health and Human Services Drugs and Poisons Regulation of the prisoner's current permit, current dose, and date and time of last dose. The Release of Information form will also allow community medical prescribers to access patient information after release from prison.
- Arranging all relevant documentation.
- Obtaining the prisoner's consent and ensuring that they sign the *Program Consent and Agreement Form* (available via JCare).
- Arranging a medical review of the prisoner and completing all documentation required for methadone or buprenorphine treatment.
- Forwarding Notification of Drug Dependent Person and Notification of Release from Prison of a Patient being Treated with Methadone or Buprenorphine for Opioid Dependence forms to the Department of Health and Human Services Drugs and Poisons Regulation.

- Checking the prisoner's health records for the last date and time of dosing before administering further doses. If concerned about the last dosing date and time of a newly-received or transferred prisoner, health staff should contact the previous prescriber and request a confirmation and current dosing program. Methadone or buprenorphine doses should not be administered until the time and date of the previous dose has been verified. All verbal confirmations should be clearly documented. If a prisoner has missed three or more doses, dosing should recommence at a low dose (less than 40 mg) with careful titration.
- Recording documentation appropriately in the correctional health service program recording system and the medical records system.

The above procedures must be completed by correctional health service staff within 24 hours of receiving a prisoner or before the prisoner is administered their next prescribed dose.

#### 4.4 Methadone and buprenorphine dosing

Newly-received prisoners enrolled in a community OST program will usually have been prescribed a stable dose of methadone or buprenorphine prior to their incarceration.

However, the dose prescribed may not be effectively controlling the prisoner's craving for, and continued use of, illicit opioids. In such cases, the prisoner should be reviewed by the prison medical practitioner to assess the effectiveness of the treatment dose. The medical practitioner may alter the dose according to the clinical presentation of the prisoner.

Prison medical practitioners should only prescribe dose increases where there are no signs of toxicity.

The prison medical practitioner should review the prisoner within the first week of the dose alteration to assess its effectiveness according to the prisoner's clinical presentation.

The follow dosing information is based on the *National Guidelines* (2014).

##### Methadone

Doses of 60mg a day or greater are more effective than lower doses for retention in treatment, reduction in unsanctioned opioid use and associated high risk behaviours.

Most prisoners will require doses between 60 – 100mg a day to achieve stabilisation. This is considered an appropriate range for maintenance doses.

A small proportion of patients may require higher (above 100mg a day) or lower (e.g. 30 – 40mg a day) doses.

Doses above 150mg a day are associated with little additional benefit and increased risk of dose-related adverse events.

Prison medical practitioners may need to consult with an addiction medicine specialist or DACAS prior to prescribing doses above 100mg.

Some patients (chronic pain, rapid metabolisers, pregnant women) may require split or multiple daily doses.

##### Buprenorphine

Buprenorphine doses of at least 8–16 mg are superior to lower doses in terms of treatment retention, reduction in unsanctioned opioid use and associated high risk behaviours.

Most patients require at least 12mg daily for effective substitution treatment. The majority of patients will be able to be maintained on a dose of around 16mg a day.

Most patients will require daily buprenorphine doses in the range 12-24mg to achieve stabilisation, although some patients require higher (e.g. up to 32 mg a day) or lower (4 – 8mg a day) to achieve their treatment goal.

The maximum recommended daily dose in the product information is 32mg. In rare cases, higher doses may be used.

#### 4.5 Prisoner reviews

All prisoners prescribed OST treatments within Victorian prisons will be reviewed upon reception into the prison system and will require regular reviews thereafter. Areas for review include prisoner treatment goals, drug use and engagement in drug-related behaviour (self-report, urine drug screening and IDU status), general health and social status, and any difficulties arising from treatment, including side effects.

Prisoners should also receive a more comprehensive review of their treatment at regular intervals (e.g. every six months) to measure treatment progress against the agreed treatment goals. Prisoners with complex treatment issues require more frequent comprehensive reviews. Reviews will be undertaken by the appropriate correctional health service staff member (e.g. prison medical practitioner).

# 5 Transitions – Clinical and Operational Procedures

## 5.1 Transfer of prisoners on the program

### Inter-prison transfers

It is the responsibility of correctional health service providers to ensure that all relevant documentation is completed prior to an inter-prison transfer, and that the prisoner's medical record contains all relevant documentation.

### Court transfers

Correctional health service providers must ensure that prisoners transferred out of prison for court matters have received their methadone or buprenorphine dose prior to leaving the prison.

Victoria Police have procedures in place to manage the administration of methadone and buprenorphine to prisoners held in custody in police cells. If the prisoner is held in police custody overnight or for several days, correctional health service staff should forward the prisoner's prescription (or the completed Methadone or Buprenorphine in Police Custody-Prescription form) and the day/time of last dose to the appropriate police station, or directly to the dosing community pharmacist once confirmed. The pharmacist should record each dose dispensed (date dosed and dose provided) to the prisoner while he/she is held in police custody. This record (or a copy), including the details of the last dose provided, should be returned to the prison. On return, the community pharmacist may be contacted to confirm the last dose provided. Local operational policies and procedures may apply.

## 5.2 Pre release discharge planning

Appropriate liaison between correctional health service providers and community prescribers and pharmacies needs to be undertaken to ensure continuity of treatment for those released from prison.

The collection, use and disclosure of health information as part of pre-release discharging planning should be conducted in accordance with the Privacy Principles in the *Health Records Act 2001* (Department of Health, 2013).

It is important that discharge planning for prisoners prescribed methadone or buprenorphine begins as soon as possible. This makes it easier to place prisoners in community OST programs upon release from prison.

Correctional health service staff should:

- Find out where the prisoner plans to live upon release from prison.
- Refer the prisoner to their previous methadone prescriber and pharmacy, if possible.
- Call DirectLine **1800 888 236** to arrange a referral for a methadone and buprenorphine prescriber and pharmacist. DirectLine will not arrange specialist methadone referrals.
- Arrange all relevant documentation at least four weeks before the prisoner's release, including:
  - The prisoner discharge summary letter addressed to the community prescriber, outlining the prisoner's progress on the Program and the current dose.
  - A prescription from the authorised prison medical prescriber for methadone or buprenorphine:
    - The prescription should last until the scheduled appointment with the community prescriber. A prescription can be provided for up to seven days post release from prison. If a scheduled appointment with a community prescriber cannot be made within seven days of release, a permit must be obtained from the Department of Health and Human Services Drugs and Poisons Regulation.

- The prescription must be sent to the nominated pharmacy prior to or on release of the prisoner.
- An appointment and the contact details of the community prescriber and pharmacist for the prisoner (see Appendix 8).
- Notification of Release from Prison of a Patient Treated with Methadone and Buprenorphine for Opioid Dependence form, which includes details of OST treatment and the nominated community prescriber and pharmacy, to be submitted to the Department of Health and Human Services Drugs and Poisons Regulation (see Appendix 9).
- Receives the *Methadone Treatment in Victoria User Information Booklet* (if applicable), which contains information about:
  - The effects and side effects of methadone.
  - Drug interactions.
  - Withdrawal symptoms.
  - DirectLine phone number for referrals to community methadone or buprenorphine providers (Appendix 10).
- Receives the relevant booklet for prisoners prescribed buprenorphine (if applicable), which contains information about:
  - The effects and side effects of buprenorphine.
  - Drug interactions.
  - Withdrawal symptoms.
  - Direct Line phone number for referrals to community methadone or buprenorphine providers.
- Call DACAS **1800 888 236** for additional support.

### Change to release date

The release of a prisoner before their earliest release date – from a court hearing or immediately after a parole board hearing – may affect the prisoner's post-release arrangements and compromise the continuity of their treatment on a community OST program.

### Unplanned release

If a prisoner is attending a court hearing that could lead to their unplanned release, the correctional health service staff should ensure that the prisoner:

- Is administered their prescribed dose of methadone or buprenorphine before attending the court or parole board hearing.
- Receives the *Methadone Treatment in Victoria User Information Booklet* (if applicable), which contains information about:
  - The effects and side effects of methadone.
  - Drug interactions.
  - Withdrawal symptoms.
  - DirectLine phone number for referrals to community methadone or buprenorphine providers (Appendix 10).
- Receives the relevant booklet for prisoners prescribed buprenorphine (if applicable), which contains information about:
  - The effects and side effects of buprenorphine.
  - Drug interactions.
  - Withdrawal symptoms.
  - Direct Line phone number for referrals to community methadone or buprenorphine providers.
- Knows that they need to contact DirectLine to be referred to a community methadone or buprenorphine program.
- Is encouraged to tell DirectLine that they have just been released from prison and require an urgent referral to community program.
- Has the contact details of the prison health service who can verify their methadone or buprenorphine treatment in prison to a community prescriber.

In rare cases, parolees may be released from prison after being granted parole on the day of their Adult Parole Board hearing. As with other unplanned releases, this may affect the post-release referral to a community methadone or buprenorphine prescriber and pharmacy.

Prison health service providers are able to release date and amount of last dose to community prescribers.

## Interstate transfers

Arrangements for interstate transfer of patients from Victoria vary across states/territories. The Victorian prescriber is required to provide the information necessary for safe transfer to the receiving prescriber and/or pharmacy (either directly or through various clinics or agencies).

The receiving prescriber and/or pharmacist usually requires:

- Patient details (name, date of birth).
- A photograph (endorsed by the prescriber) of the patient.
- The date and amount of the final dose at the transferring pharmacy.
- The expected dates of the temporary treatment (if the transfer is temporary).
- Contact details for the transferring pharmacy.

For permanent transfers, the correctional health service provider is required to submit a Notification of Termination of Methadone or Buprenorphine form to the Department of Health and Human Services Drugs and Poisons Regulation.

Interstate regulatory agencies generally require at least 2–3 weeks notice for interstate transfers.

The Pharmacotherapy, Advocacy, Mediation and Support (PAMS) service (tel: 1800 443 844) is available to provide advice and assistance with interstate patient transfers. Further information on interstate transfers is available on the Victorian Department of Health and Human Services, Drugs and Poisons Regulation website at <http://www.health.vic.gov.au/dpcs/ort.htm> (Department of Health, 2013, p. 31).

## International transfers

Correctional health service staff should advise prisoners who will be travelling outside Australia immediately after release that they should contact the consulate of the country to which they are travelling for information. It is recommended that arrangements are made well in advance (at least one month before making travel arrangements). These transfers are not always possible.

The PAMS service (tel: 1800 443 844) is available to provide advice and assistance with international patient transfers (Department of Health, 2013, p. 31).

## 6 Glossary and Acronyms

<b>BBV</b>	Blood borne viruses
<b>Ceiling dose</b>	A property of buprenorphine whereby the effects of other opioids are blocked
<b>CRN</b>	Corrections Reference Number
<b>DACAS</b>	Drug and Alcohol Clinical Advisory Service
<b>DCIs</b>	Deputy Commissioner's Instructions
<b>Direct Line</b>	24 hour service providing information, counselling and referral on all drug related concerns managed by Turning Point, Eastern Health
<b>Diversion</b>	The voluntary or involuntary removal of a prescribed medication from the prescribed person.
<b>Drug of dependence</b>	Includes Schedule 9 poisons, Schedule 8 poisons and Schedule 4 poisons that are also a drug of dependence as specified in Schedule 11 of the DPCA Act 1981.
<b>DSM-V</b>	Diagnostic Statistical Manual Fifth Edition, American Psychiatric Association
<b>HIV</b>	Human Immunodeficiency Virus
<b>IDU</b>	Identified Drug User
<b>NPEBBVS</b>	National prison entrant bloodborne virus survey
<b>Neuroadaptation</b>	Physical dependence comprises the features of tolerance and withdrawal
<b>OCSC</b>	Office of the Correctional Services Commissioner
<b>OSTP</b>	Opioid Substitution Therapy Program, referred to as the Program in this document
<b>Program</b>	Opioid Substitution Therapy Program including both Maintenance and Induction phases
<b>QTc interval</b>	That part of a person's electrocardiogram reading that begins at the onset of the QRS complex and extends to the end of the T wave. The QTc interval represents the time between the start of ventricular depolarisation and the end of ventricular repolarisation.
<b>Recidivism</b>	Repeat offending
<b>SMU</b>	Sentence Management Unit
<b>Stepped care</b>	An approach that begins with the interventions and treatment methods that are the least intensive but that are also likely to be effective. Following a period of monitoring the interventions are either "stepped up" or "stepped down" in intensity depending on the needs of the client (Australian Drug Foundation, 2008)
<b>Suboxone</b>	Buprenorphine-naloxone
<b>Subutex</b>	Mono buprenorphine

# 7 Appendices

<b>Appendix 1</b>	Eligibility Checklist
<b>Appendix 2</b>	Assessment form
<b>Appendix 3</b>	Consent and Agreement Contract
<b>Appendix 4</b>	Notification of Drug Dependent Person form
<b>Appendix 5</b>	Pharmacology of Methadone and Buprenorphine
<b>Appendix 6</b>	Features of Opioid Intoxication, Opioid Withdrawal and Overdose
<b>Appendix 7</b>	Example Opioid Substitution Treatment Monitoring form
<b>Appendix 8</b>	OST Program Referral to Community Program form
<b>Appendix 9</b>	Notification of Release from Prison of a Patient treated with Methadone and Buprenorphine for Opioid Dependence
<b>Appendix 10</b>	Resources
<b>Appendix 11</b>	Process of Producing the Current Manual

## 7.1 Appendix 1: Eligibility Checklist

### Eligibility for induction checklist

Prisoners must:

- Be diagnosed by correctional health service staff and the prison medical practitioner with an opioid use disorder according to the *American Psychiatric Association's Diagnostic Statistical Manual, Fifth Edition (DSM-V)*; or continue to use illicit opioids in prison in a manner which constitutes a significant risk of harm; or be at significant risk of using opioids in prison or post-release.
- Give voluntary informed consent to begin treatment in prison.
- Have no outstanding court matters or release date for at least six weeks to ensure there is sufficient time to complete the assessment and stabilisation period before being released.
- Have no unstable medical or psychiatric conditions.
- Agree to abide by the rules of the program and have signed the Program Consent and Agreement Contract.

The below assessment form is available via JCare.

The below assessment form is available via JCare.

### Medication Details

Form Name: OSTP Assessment

1 of 7

Form Name: OSTP Assessment

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## Psych Assessment

### Psychological / Psychiatric Assessment

Please make note if the patient has had concerns in any of these areas. Include: hospitalisation details, whether currently being treated, counselling services, ongoing support providers - GP, NMT, , A&ES etc.

Acquired brain injury

Psychosis / DID

Mood disorders

Anxiety / Depression

SASH history

Form Name: OSTP Assessment

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## D & A History

### Drug and Alcohol History

Substance	Current Use	Past Use	Qty	Freq	Started	Last Used	How Used	Age of First Regular Use	Age First Injected	Days Used (Last 7 days)	Days Used

Alcohol  Drinks/day  ☐ Stopped Date

Are you a smoker?  Num/day  How long have you been smoking?  ☐ Stopped Date

#### History of Substance Use

Include: commencement of drug use, patterns of use, substitution, periods of abstinence, reason for relapse, financing of use, influences on drug taking behaviour, family/peer history with substances, recent residential history, recent employment history, withdrawal history and symptoms, overdose history and treatment.

#### Comments on Use in Prison

Include: identified history of use during other incarcerations, how many people they met with that currently use, is use causing harm, financing of use, how many times on the last 4 weeks has a syringe been shared, how often is bleach being used to clean the syringe, injecting self, tourniqueting.

#### Drug and Alcohol Interventions

Include: past withdrawal history - withdrawal unit, HEW service, OPO service, complications, was program completed, counselling, self-help groups.

Form Name: OSTP Assessment

4 of 7

# D & A Assessment

**Immunisations and BBV/STI History**

Have you ever been diagnosed with? ☐ HIV ☐ HCV ☐ HSV ☐ Chlamydia ☐ Gonorrhoea ☐ Syphilis ☐ Other

Would you like to undergo a DDV / STI assessment? ☐ Yes ☐ No

Drug-related risk taking behaviours:

☐ Driving under influence ☒ Polydrug use ☐ Regular source ☐ IDU Date last used  ☐ Sharing any equipment Date last shared

☐ Poor injecting technique ☐ Using alone ☐ Blackouts ☐ Violence / Assault ☐ Physical injury ☐ Unsafe (recent) tattoos or piercings ☐ Blood transfusion

Sexual partners female/male? ☐ Female ☐ Male ☐ Regular sexual partner ☐ New sexual partner (last 3 months) ☐ Sexual partners from high prevalence country ☐ Unsafe sexual practice

☐ Hep B immunisation complete ☐ Hep B immunisation commenced (incomplete) Date of last Hep B immunisation  Hep B dose taken  Date of next Hep B dose

**Drug and Alcohol Assessment**

Examination of injecting sites

**Potential Risks / Benefits for Starting Methadone**

Risks

Benefits

Patient's treatment Goals

Methadone booklet given? ☐ Yes ☐ No

Form Name: OSTP Assessment

5 of 7

# OSTP Assessment

**To be completed by the Assessor after the appointment**

**Risk / Benefit Analysis of patient**

**Pharmacotherapy Toxicity Risk Assessment**

Drug use history unclear  
High risk of polydrug abuse and dependence  
Naloxadipon clear  
Naloxadipon unclear  
Drug overdose risk  
Presence of clinically significant respiratory disease  
Presence of clinically significant liver disease  
Pr of cardiac problems / arrhythmia

**Other Factors**

Evidence of injecting sites  
Urine drug screen summary  
Identified Drug User (IDU) status  
Accuracy mentally ill patient  
Poly drug user where opiates aren't the primary drug of use  
Short opiate history  
Story cannot be substantiated by reported GP / chemist / CPU evidence

**Suitability for Treatment : patient displays 3 or more of WHO criteria for past/current dependence to opiates (please comment on the relevant criteria)**

Withdrawal syndrome  
Tolerance  
Subjective compulsion to use  
Use of opiates to avoid / relieve withdrawal  
Narrowing repertoire of behaviour  
Places increasing importance on seeking substance at expense of other activities  
Early relapse into opiate use following cessation

Form Name: OSTP Assessment

6 of 7

**Finalise**

Summary of patient and overall determination of patient's suitability for methadone at time of assessment

**Tasks**

☐ Make an appointment for EBV/STI Assessment

Task Holder

Due Date

Priority

New Referral

New Task

Finalise

Form Name: OSTP Assessment

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## 7.3 Appendix 3: Consent and Agreement Contract

The below assessment form is available via JCare.

### OSTP CONSENT AND AGREEMENT CONTRACT

<b>Name:</b>	«Letter.Patient.LastName», «Letter.Patient.FirstNames»	<b>Date:</b>	«Letter.Letter.Date»
<b>CRN:</b>	«Letter.Patient.RegistryKey("CRN").Value»	<b>MNI:</b>	«Letter.Patient.FileNumber»
<b>Date of Birth:</b>	«Letter.Patient.DateOfBirth»	<b>Gender:</b>	«Letter.Patient.Macro.GENDER»
<b>Prison:</b>	«Letter.Patient.Organisation.UnitName»		

I request to be included on the **Opioid Substitution Treatment Program (OSTP)**. In making this request I acknowledge that:

- I voluntarily engage in Methadone, Buprenorphine or Suboxone treatment for my opiate dependence.
- Methadone, Buprenorphine or Suboxone may have side effects.
- Overdose of Methadone, Buprenorphine or Suboxone may be fatal, particularly combined with alcohol, illicit or non-prescribed drugs.
- I understand that I should not drive or operate machinery whilst I am being stabilized on a dose of Methadone.
- I will become physically dependent to opiates while engaged in OSTP treatment.
- It is my responsibility to inform Health Services staff of my release date. This is required to arrange continuation of treatment in the community.

I understand that treatment is best when taken over a period of more than one year.

**I will discuss any problems arising from this drug treatment with the Health Services staff at «Letter.Patient.Macro.USEREMPLOYER».**

I AUTHORISE Health Services staff to:

- Inform Operational Management that I am on the Methadone, Buprenorphine or Suboxone Program.
- Upon release, inform the community prescriber and pharmacist to which I am returning of all relevant information pertaining to my Methadone, Buprenorphine or Suboxone treatment.

Arrange for the collection of data for research or evaluation in a confidential manner.

I AGREE to keep to the following rules of the **Opioid Substitution Treatment Program** and understand that any breach of these rules will be subject of discussion and may lead to loss of place on the Program.

I AGREE:

- That my place on the Program is for my own benefit and I will not attempt to trade, sell or give away my Methadone, Buprenorphine or Suboxone for any reason whatsoever.
- That if I divert Methadone, Buprenorphine or Suboxone, I understand that my prescribing Doctor will be notified and that I will automatically be withdrawn from the Program.
- Not to use heroin or other drugs not prescribed to me by my Medical Practitioner.
- To attend daily at the time specified by the Health Services staff to receive my dose.
- To not miss more than three (3) doses in a row.
- To treat Health Services staff with courtesy and respect and refrain from abusive language.
- To provide a urine sample for drug screening as requested.

To abide by the dosing protocols required without protest.

I sign this Consent and Agreement Contract to indicate this document has been read by, or to, me and I understand its contents.

**I understand that if I do not comply with the above, I may be taken off the Program by my treating doctor.**

**Signed:** \_\_\_\_\_ **Witness:** \_\_\_\_\_  
(Patient) (Health Staff)

**Name:** «Letter.Patient.FirstNames» «Letter.Patient.LastName» **Name:** «Letter.LoggedOnUser.FullName»

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

«Letter.Patient.LastName», «Letter.Patient.FirstNames» (CRN: «Letter.Patient.RegistryKey("CRN").Value» / MNI: «Letter.Patient.FileNumber», DOB: «Letter.Patient.DateOfBirth», «Letter.Patient.Macro.GENDER»)  
«Letter.Letter.Date» «Letter.Letter.CurrentTime»

## 7.4 Appendix 4: Notification of Drug Dependent Person form

### Notification of drug dependent person

#### **Drugs, Poisons and Controlled Substances Act 1981**

Section 33 of the Act requires a medical or nurse practitioner who has reason to believe that a patient is a drug dependent person to notify the department, using this form, where:

- the patient seeks prescription of a Schedule 8 or Schedule 9 poison, or a Schedule 4 poison which is also a drug of dependence, or
- the practitioner intends to treat or is treating the patient with a Schedule 8 or Schedule 9 poison, or a Schedule 4 poison which is also a drug of dependence.

(Please print **legibly** in block letters and provide all information)



#### **PRACTITIONER DETAILS**

SURNAME (FAMILY NAME)	FIRST NAME
PRACTICE ADDRESS (OR HOSPITAL NAME (IF APPROPRIATE))	
SUBURB/TOWN	POSTCODE
QUALIFICATIONS	TELEPHONE
FAX	
EMAIL ADDRESS	

#### **PATIENT DETAILS**

SURNAME (FAMILY NAME)	FIRST NAME			
ADDRESS				
SUBURB/TOWN	POSTCODE			
DATE OF BIRTH (DAY/MONTH/YEAR)	SEX	MALE <input type="radio"/>	HEIGHT (cm)	DPR NUMBER (IF KNOWN)
		FEMALE <input type="radio"/>		
ALIASES (IF ANY)	SOURCE OF DRUGS (LICIT/ILICIT/UNKNOWN)			
APPROXIMATE PERIOD OF DRUG DEPENDENCY	OTHER DRUGS USED BY PATIENT			

I have reason to believe that the patient is drug-dependent and my belief is based on the following grounds:

- |   |  |
|---|--|
| <input type="checkbox"/> Admits current misuse or abuse of pharmaceutical drugs   | <input type="checkbox"/> Admits current misuse or abuse of illicit drugs |
| <input type="checkbox"/> Is "doctor shopping" for prescription drugs  | <input type="checkbox"/> Has physical signs of intravenous drug use      |
| <input type="checkbox"/> Has obtained prescription drugs from illicit sources   | <input type="checkbox"/> Has been forging prescriptions                  |
| <input type="checkbox"/> Has had multiple unsanctioned dose escalations of prescribed drugs   | <input type="checkbox"/> Has been selling or sharing prescription drugs  |
| <input type="checkbox"/> Another doctor holds a permit for opioid replacement therapy (ORT) (methadone syrup or buprenorphine sublingual tablet/film) |  |
| <input type="checkbox"/> Other _____  |  |

Did the patient request a Schedule 8 poison, a Schedule 9 poison or a Schedule 4 poison that is also a drug of dependence? ☐ Yes ☐ No **If yes, specify which poison(s):**

Is it your intention to prescribe a Schedule 8 poison, a Schedule 9 poison or a Schedule 4 poison that is also a drug of dependence? ☐ Yes ☐ No **If yes, specify which poison(s):**

**If treating a hospital inpatient or prisoner with ORT, please indicate:** ☐ Methadone ☐ Buprenorphine

**Important note:** If it is your intention to treat the patient with a Schedule 8 drug you need to obtain a permit to do so before prescribing, except in certain limited circumstances. Please see explanatory notes overleaf.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### **DRUGS AND POISONS REGULATION**

tel: 1300 364 545 fax: 1300 360 830 email: [dpcs@health.vic.gov.au](mailto:dpcs@health.vic.gov.au)

Department of Health



## Explanatory notes

### (i) Permit required BEFORE treating a drug dependent person

The Act requires a medical or nurse practitioner to hold a permit BEFORE prescribing any Schedule 8 poison to a drug dependent person, except in certain exempt circumstances.

### (ii) General exemptions

Medical or nurse practitioners are not required to hold a permit where the patient:

- is an in-patient in a hospital;
- is in an aged care service;
- is a prisoner being treated in prison or for a period not exceeding 7 days after release from prison;

These exemptions also apply to the treatment of drug dependent persons, but the practitioner is still required to make a notification of drug dependence using this form if he or she intends to treat.

A practitioner working in a multiple practitioner clinic may prescribe without holding a permit if:

- the treatment is provided at the multiple practitioner clinic, and
- another practitioner at that clinic already holds a permit to treat the patient with the same drug, and
- the treatment is in accordance with that permit.

### (iii) Precautions when prescribing to drug dependent patients

A medical or nurse practitioner who prescribes a drug of dependence (listed in Schedule 11 of the Act, e.g. benzodiazepines, opioids, dexamphetamine) for a drug dependent person should take steps to ensure the drug is used to the extent and for the purpose for which it was prescribed.

The following precautions can be used to reduce potential harm:

- If you believe there may be sound clinical reasons to prescribe a drug of dependence, prescribe small quantities until you are able to validate the medical or medication history.
- Consider having the prescription dispensed at a nominated pharmacy with the doses collected daily or at other appropriate intervals.
- With permission of the patient, obtain from Medicare Australia information on the number of prescriptions, quantity, calculated daily dose and number of different prescribers for each Pharmaceutical Benefit Scheme (PBS) item obtained in the most recent 6 month period.

## IMPORTANT NOTICE ABOUT PRIVACY

It is a requirement of the *Drugs, Poisons and Controlled Substances Act 1981* (the Act) that the information set out in this form is provided to the Department of Health to meet statutory notification requirements, and for the issuing of permits as required under the Act. The collection, use and disclosure of the information provided will be in accordance with the law, including the provisions of the *Health Records Act 2001*. The information collected may be disclosed to health practitioners practising in the following health professions: medical, nursing and midwifery and pharmacy, when necessary to facilitate coordination of the patient's drug treatment and safe prescribing of drugs. For example, it may be necessary to disclose this information when another health practitioner applies for a permit or is considering prescribing a drug of dependence. The notification may not be processed if all information requested on the form is not completed.

Further information about privacy or about Victorian drugs and poisons legislation may be obtained by calling Drugs and Poisons Regulation (DPR) on 1300 364 545 or visiting the DPR website at: [www.health.vic.gov.au/dpcs](http://www.health.vic.gov.au/dpcs).

## 7.5 Appendix 5: Side Effects of Methadone and Buprenorphine

### Safety and side effects

**Methadone** (From the *National Guidelines*<sup>5</sup> (Gowing et al., 2014, pp. 78–79)

The long-term side effects of methadone taken orally in controlled doses are relatively minor, although the effect of chronic opioid use on teeth, constipation, sexuality and sleep can cause considerable distress and need to be managed. Central sleep apnoea can also be a complication of methadone treatment (Teichtahl, Prodromidis, Miller, Cherry, & Kronborg, 2001; Zutler & Holtz, 2011). Methadone does not cause damage to any of the major organs or systems of the body and those side effects that do occur are considerably less harmful than the risks of tobacco, alcohol and unsanctioned opiate use. The major hazard associated with methadone is the risk of overdose. This risk is particularly high at the time of induction to methadone maintenance treatment, and when methadone is used in combination with other sedative drugs. The relatively slow onset of action and long half-life mean that methadone overdose can be deceptive and toxic effects may become life threatening many hours after ingestion (Humeniuk, Ali, White, Hall, & Farrell, 2000). Because methadone levels rise progressively with successive doses during induction into treatment, most deaths in this period have occurred on the third or fourth day of treatment.

**Buprenorphine** (From the *National Guidelines*<sup>6</sup> (Gowing et al., 2014, pp. 81–82).

Unlike methadone, the effect of buprenorphine on respiratory depression reaches a ceiling, with higher doses not increasing respiratory depression to a significant degree. This action appears to make buprenorphine safer than methadone in overdose. However, even low doses of buprenorphine can be toxic when combined with sedatives such as benzodiazepines and alcohol (Faroqui, Cole, & Curran, 1983; Forrest, 1983; Papworth, 1983; Sekar & Mimpriss, 1987). Dose response studies show that high doses of buprenorphine (16mg daily or more) do not result in substantially greater peak opioid effects than lower doses (8 or 12mg) (Walsh, Preston, Bigelow, & Stitzer, 1995). Doses many times greater than normal therapeutic doses appear to be well-tolerated in most individuals, and rarely result in clinically-significant respiratory depression, except in individuals who are not opioid tolerant.

Precaution should be exercised when buprenorphine is administered concomitantly with CYP3A4 inhibitors (e.g. protease inhibitors, some drugs in the class ofazole antimycotics such as ketoconazole, calcium channel antagonists such as nifedipine, and some antiviral medications such as Atazanavir) as this may lead to increased plasma concentrations of buprenorphine. The side effects of buprenorphine are similar to those of other opioids (Lofwall, Stitzer, Bigelow, & Strain, 2005), the most common being constipation, disturbed sleep, drowsiness, sweating, headaches, nausea and reduced libido.

Many patients report less sedation on buprenorphine than on methadone. Users describe buprenorphine, as compared to methadone, as facilitating “more normal” levels of daily activity, leaving them more clear-headed and able to make decisions (Fischer et al., 1999; Holt, Treloar, McMillan, Schultz, & Bath, 2007). However, this may not be acceptable to all patients, some of whom may benefit from the sedative and anxiolytic effect of methadone (e.g. those experiencing the symptoms of post-traumatic stress disorders).

Research evidence suggests that buprenorphine has minimal effect on psychomotor performance (Lenne, Dietze, Rumbold, Redman, & Triggs, 2003; Mintzer, Correia, & Strain, 2004), and less effect than methadone (Soyka et al., 2005) or slow release oral morphine (Giacomuzzi, Haaser, Pilsz, & Riemer, 2005). Any effect is likely to be greatest during the early stages of treatment or following dose increases. At such times patients should be advised to exercise caution in driving or operating machinery.

There have been some reports of acute hepatitis following buprenorphine use (Herve et al., 2004; Saxon et al., 2013). However, a recent randomised controlled trial comparing buprenorphine/naloxone with methadone for treatment of opioid dependence found no evidence of liver damage during the initial six months of treatment with either medication (Saxon et al., 2013). Baseline infection with hepatitis C or B was the only significant predictor of moving from low to elevated transaminase levels.

5 References are as per the *National Guidelines*.

6 References are as per the *National Guidelines*.

## 7.6 Appendix 6: Features of Opioid Intoxication, Opioid Withdrawal and Overdose

### Features of Opioid Intoxication

*From the National Guidelines (Gowing et al., 2014)*

Signs of opioid intoxication:

- constriction of pupils
- itching and scratching
- sedation and somnolence
- lowered blood pressure
- slowed pulse
- hypoventilation

### Features of Opioid Withdrawal and Overdose

*From the National Guidelines (Gowing et al., 2014)*

Signs and symptoms of opioid withdrawal:

- dilation of pupils
- anxiety
- muscle and bone ache
- muscle cramps
- sleep disturbance
- sweating
- hot and cold flushes
- piloerection
- yawning
- lacrimation
- rhinorrhoea
- abdominal cramps
- nausea
- vomiting
- diarrhoea
- palpitations
- rapid pulse
- raised blood pressure

Signs of opioid overdose:

- pinpoint pupils
- loss of consciousness
- respiratory depression
- hypotension
- bradycardia
- pulmonary oedema

# OPIOID SUBSTITUTION TREATMENT MONITORING FORM

## 7.7 Appendix 7: OST Monitoring form (example)

PRISONER NAME										PRISON LOCATION									
CRN	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY
Observations	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY
Pupil size (mm)																			
Blood Pressure (mmHg)																			
Pulse rate (b/min)																			
Respiratory rate (b/min)																			
Level of Consciousness																			
Speech																			
Gait																			
Staff Initials																			

Do not dispense medication and notify medical staff if any of following:  
Pupils  $\leq 2$  mm   PR  $> 100$    RR  $< 12$    BP  $< 90/60$  mmHg  
Speech = 1 or 2   Gait = 1   Level of consciousness = 1 or 2

Pupil size   1mm •   2mm •   3mm •   4mm •   5mm •   6mm

Gait  
0 = normal  
1 = impaired

Speech  
0 = normal  
1 = slurred  
2 = pressured

Level of Consciousness  
0 = alert (normal)  
1 = drowsy, but responds (alert) to stimuli  
2 = drowsy, no response to verbal stimuli  
3 = agitated

## 7.8 Appendix 8: OSTP Referral to Community Program form

Available via JCare

### OSTP REFERRAL TO COMMUNITY

<b>Date:</b>	«Letter.Letter.Date»		
<b>Name:</b>	«Letter.Patient.LastName», «Letter.Patient.FirstNames»		
<b>CRN:</b>	«Letter.Patient.RegistryKey("CRN").Value»	<b>MNI:</b>	«Letter.Patient.FileNumber»
<b>Date of Birth:</b>	«Letter.Patient.DateOfBirth»	<b>Gender:</b>	«Letter.Patient.Macro.GENDER»
<b>ATSI:</b>	«Letter.Patient.Macro.ATSI»		
<b>Interpreter:</b>	«Letter.Patient.InterpreterRequired»	<b>Language:</b>	«Letter.Patient.PreferredLanguage»
<b>Prison:</b>	«Letter.Patient.Organisation.UnitName»		

**Day and Date of Release/Court:** [Insert Text]

<b>Refer to Dr:</b>	«Letter.Recipient.FullName»		
<b>Address:</b>	«Letter.Recipient.AddressStreet1», «Letter.Recipient.AddressStreet2», «Letter.Recipient.AddressStreetState», «Letter.Recipient.AddressPostCode»		
<b>Phone:</b>	«Letter.Recipient.Phone1» «Letter.Recipient.Phone2»	<b>Fax:</b>	«Letter.Recipient.Fax»
		<b>Faxed:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Date and time of appointment:</b>	[Insert Text]		

Your Doctor will need: Medicare Card, Healthcare Card & 2 x passport size photos. Some Doctors may have a "start up" fee.

<b>Refer to Pharmacist:</b>	[Insert Text]		
<b>Address:</b>	[Insert Text]		
<b>Phone:</b>	[Insert Text]	<b>Fax:</b>	[Insert Text]
		<b>Faxed:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cost for Pharmacy is approximately \$35 per week.			

<b>Drug:</b>	[Insert Text]
<b>Dose:</b>	[Insert Text]
<b>Last Dose:</b>	[Insert Date]
<b>Prescribed by:</b>	Dr [Insert Text] «Letter.LoggedOnPOS.FullName»

#### Comments

[Insert Text]

**IMPORTANT PLEASE NOTE:** You must see your Doctor first for a consultation and to arrange your permit. When the permit has been approved the Doctor will then write a script for your medication. Take the script and a photo the Doctor has signed to your pharmacy for dispensing of your medication. Please allow sufficient time for all this to occur. Good luck.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name:** «Letter.LoggedOnUser.FullName» **Designation:** «Letter.LoggedOnUser.JobTitle»

## 7.9 Appendix 9: Notification of Release from Prison of a Patient Treated with Methadone or Buprenorphine for Opioid Dependence form

### Notification of release from prison of a patient treated with methadone or buprenorphine for opioid dependence

(Please print legibly in block letters and provide all information)



NOTIFIER DETAILS	
SURNAME (FAMILY NAME)	FIRST NAME
PRISON NAME	
SUBURB/TOWN	POSTCODE
QUALIFICATIONS	TELEPHONE
FAX	
EMAIL ADDRESS	
I notify that the following patient has been treated with methadone or buprenorphine for opioid dependence and has now been released from prison.	
Signature: .....	
Date: .....	

PATIENT DETAILS	
SURNAME (FAMILY NAME)	FIRST NAME
POST-RELEASE ADDRESS (IF KNOWN)	
SUBURB/TOWN	POSTCODE
DATE OF BIRTH (DAY/MONTH/YEAR)	SEX
	MALE <input type="radio"/>
	FEMALE <input type="radio"/>
DPR NUMBER (IF KNOWN)	

TREATMENT HISTORY WHILE IN PRISON	
WHERE WAS THE LAST DOSE ADMINISTERED (IF DIFFERENT TO ABOVE)?	TELEPHONE
WHAT DRUG WAS LAST ADMINISTERED?	WHAT WAS THE LAST DOSE (mg)?
METHADONE <input type="radio"/>	
BUPRENORPHINE <input type="radio"/>	
DATE OF LAST DOSE ADMINISTERED:	

POST-RELEASE ARRANGEMENTS	
HAVE ARRANGEMENTS BEEN MADE FOR TREATMENT POST-RELEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, NAME OF PRACTITIONER:	
SUBURB/TOWN	TELEPHONE
NAME OF COMMUNITY PHARMACY:	
SUBURB/TOWN	TELEPHONE
IF A PRESCRIPTION HAS BEEN WRITTEN FOR THE PATIENT FOR METHADONE OR BUPRENORPHINE BY A PRISON MEDICAL OFFICER TO TREAT FOR A PERIOD POST-RELEASE, PLEASE PROVIDE DETAILS OF THAT PRESCRIPTION.	
WHAT WAS THE DRUG PRESCRIBED?	DOSE PRESCRIBED (mg)?
METHADONE <input type="radio"/>	
BUPRENORPHINE <input type="radio"/>	
NO. OF DAYS TREATMENT PROVIDED (PLEASE CIRCLE):	
1 2 3 4 5 6 7	
NOTE: A PRISON MEDICAL OFFICER IS AUTHORISED TO PRESCRIBE UP TO 7 DAYS TREATMENT WITHOUT THE NEED TO OBTAIN A PERMIT. A PERMIT MUST BE OBTAINED IF THE TREATMENT IS TO EXCEED 7 DAYS.	

**DRUGS AND POISONS REGULATION**  
tel: 1300 364 545 fax: 1300 360 830 email: [dpcs@health.vic.gov.au](mailto:dpcs@health.vic.gov.au)



## IMPORTANT NOTICE ABOUT PRIVACY

The information set out in this form is provided to the Department of Health to facilitate with statutory notification requirements and the issue of permits as required under the *Drugs, Poisons and Controlled Substances Act 1981*. The collection, use and disclosure of the information provided will be in accordance with the law, including the provisions of the *Health Records Act 2001*. The information collected may be disclosed to health practitioners practising in the following health professions: medical, nursing and midwifery and pharmacy, when necessary to facilitate coordination of the patient's drug treatment and safe prescribing of drugs. For example, it may be necessary to disclose this information when another health practitioner applies for a permit or is considering prescribing a drug of dependence. The notification may not be processed if all information requested on the form is not completed.

Further information about privacy or about Victorian drugs and poisons legislation may be obtained by calling Drugs and Poisons Regulation (DPR) on 1300 364 545 or visiting the DPR website at: <http://www.health.vic.gov.au/dpcs>.

## 7.10 Appendix 10: Resources

### General

#### **Drugs and Poisons Regulation, Department of Health and Human Services**

GPO Box 4057  
Melbourne 3001  
Tel: 1300 364 545  
Fax: 1300 360 831  
Email: [dpcs@health.vic.gov.au](mailto:dpcs@health.vic.gov.au)  
Web: <http://www.health.vic.gov.au/dpcs>

### DirectLine

DirectLine provides counselling, information and referral, including:

- Pharmacotherapy contact details
- Details of needle and syringe programs and bin locations
- Details of drug and alcohol agencies and drug withdrawal beds
- HIV/AIDS information and referral
- Drink driving education and assessment referral

Tel: 1800 888 236 (24 hour service)

#### **Drug and Alcohol Clinical Advisory Service (DACAS)**

Provides advice and information on the clinical management of patients with drug and/or alcohol problems, including:

- Advice on recognising and managing withdrawal symptoms
- Information about drug use complications
- Drug information
- Prescribing information
- Assistance with cases of acute intoxication

Tel: 1800 812 804 (24 hour service)

Web: <http://www.dacas.org.au>

#### **Pharmacotherapy Advocacy, Mediation and Support (PAMS)**

Provides confidential telephone-based information, support, advocacy and referral for any pharmacotherapy client related issue in Victoria.

Tel: 1800 443 844 (Monday – Friday, 10am – 6pm)

Web: <http://hrvic.org.au/pharmacotherapy>

### Specialist Pharmacotherapy Services

These services provide a consultative service to pharmacotherapy prescribers seeking expert opinion about the management of patients with psychiatric, social, medical or treatment problems.

#### **Eastern Health Alcohol and Drug Services**

Ground Floor, 43 Carrington Road  
Box Hill 3128  
Tel: (03) 9843 1288  
Fax: (03) 9843 1266  
Web: <http://www.easternhealth.org.au>

#### **Austin Health**

Studley Road  
Heidelberg 3084  
Administration line: (03) 9496 5000  
Pharmacy line: (03) 9496 5999  
Fax: (03) 9459 5999  
Web: <http://www.austin.org.au>

#### **Southcity Clinic**

Level 1, 61–69 Brighton Road  
Elwood 3184  
Tel: (03) 9525 7369  
Fax: (03) 9525 7369  
Web: <http://www.southcityclinic.com.au>

#### **Western Health Drug Health Services**

3–7 Eleanor St  
Footscray 3011  
Tel: (03) 8345 6682  
Fax: (03) 8345 6027  
Web: <http://www.wh.org.au>

## 7.11 Appendix 11: Process of Producing the Current Manual

In 2014, Justice Health commissioned Turning Point, Eastern Health to review and update the *Victorian Prison Opioid Substitution Therapy Program Clinical and Operational Policy and Procedures Manual* (Office of the Correctional Services Commissioner, 2003) in line with state and national guidelines and contemporary evidence and practice.

The review was undertaken between September 2014 and March 2015 and comprised three key stages:

- A review of contemporary evidence and practice (Phase 1).
- A review of the 2003 manual against current operational and clinical practice within Victorian prisons (Phase 2).
- A review of the revised guidelines against current operational and clinical practice within Victorian prisons (Phase 3).

After each phase, the manual was reviewed and revised to incorporate contemporary evidence and practice. The revision and implementation process was informed and guided by the Project Steering Committee, and the Turning Point Expert Advisory Group.

### Phase 1 – Review contemporary evidence & practice

A literature review incorporating grey and published literature was conducted. This component focused on identifying evidence based practice (EBP) regarding pharmacotherapy in the prison setting, clinical outcomes, procedures and practices, policies, assessment (initial and monitoring), dosing, consent, roles and responsibilities, special populations (e.g., Aboriginal and Torres Strait Islanders (ATSI), persons from culturally and linguistically diverse (CALD) backgrounds, illiterate, persons with acquired brain injury (ABI), withdrawal and withdrawal management (as it relates to long term planning), co-occurring conditions, and discharge planning.

Ten semi-structured interviews were conducted between November 2014 and January 2015 with key stakeholders to supplement the literature review, particularly topics where literature was sparse (e.g., strategies implemented within prisons to minimise diversion of OST doses). Interviews served a number

of purposes: contextualisation of the manual within the current system, policy and general procedural shifts; current implementation of OST programs in prisons in Victoria and interstate, and provision of OST more broadly (e.g., current trends, issues and risks).

### Phase 2 – Review 2003 manual against current practise

A workshop was convened in October 2014 with 13 representatives from Victorian prison key stakeholder groups (i.e., correctional health service providers contracted to provide OST within prisons; prison general managers; Justice Health policy advisors; Corrections Victoria policy advisors; and community-based AOD treatment providers). Representatives were identified by Justice Health.

The workshop involved a series of group activities, whereby representatives reviewed sections of the manual that applied directly to their role within the Victorian prison OST program. The workshop discussions provided clear guidance on the useability of the manual, the relevance and accuracy of current content and the nature of the changes required to update the manual.

Information provided in the workshop was incorporated during the drafting process.

### Phase 3 – Critique of revised guidelines

A second and final workshop was convened in February 2015 with eight representatives from Victorian prison key stakeholder groups (i.e., correctional health service providers contracted to provide OST within prisons; Justice Health policy advisors; and community-based AOD treatment providers). Six of the eight representatives also attended the first workshop.

The workshop reviewed the structure and content of the revised guidelines with the purpose of seeking agreement on changes made and identifying sections which required further work. Information provided was incorporated during the drafting process.

## **Project governance**

### ***Project Steering Committee***

The Steering Committee was convened by Justice Health and the Committee met six times over the duration of the project. The members of the Steering Committee who guided the project:

- Julie Bond (Correct Care Australasia)
- Scott Drummond (Justice Health)
- Christine Fuller (Correct Care Australasia)
- Fiona Grinwald (chair) (Justice Health)
- Kathy Ha (Department of Health and Human Services)
- Dr Cameron Loy (Correct Care Australasia)
- Jan Te Maru (Correct Care Australasia)
- Dr Bruce McLaren (St Vincent's Health)
- Kristine Mihaly (St Vincent's Health)
- Jacinta Pollard (Caraniche)
- Jenny Roberts (Corrections Victoria)
- Dr Charles Roth (St Vincent's Health)
- Meredith Williamson (Justice Health)

### ***Turning Point Expert Advisory Group***

The Turning Point Expert Advisory Group comprised Eastern Health/Turning Point Addiction Medicine and Psychiatric Specialists. This group provided advice and support to the project team on questions of best practice and clinical procedure. The members of the Expert Advisory group were:

- Dr Keri Alexander
- Dr Shalini Arunogiri
- Dr Matthew Frei
- Professor Daniel Lubman

### ***Project Team***

The Turning Point project team comprised three members: Dr Barbara Hunter, Mollie Flood and Janette Mugavin.

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