CORRECTIONAL SERVICE CANADA

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Interim Guidance on Opioid Use Disorder Program: Medication

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Correctional Service Canada | Service correctionnel Canada

Canada

Contents

Medication

Choice of medication

CSC is committed to delivering evidence-based, patient-centred care, which includes ensuring access to appropriate and effective medications. As part of this commitment, CSC maintains a National Formulary that supports the consistent and equitable provision of opioid agonist treatment (OAT) across institutions.

The following OAT medications are currently included on CSC's National Formulary:

- Buprenorphine extended-release injection (Sublocade)
  - First line OAT treatment at CSC
- Methadone
  - Considered in cases where Sublocade is deemed not clinically appropriate

The following medications are *not* listed on CSC's National Formulary and are therefore not routinely available for ongoing treatment:

- Buprenorphine-naloxone film/tablet (Suboxone)
  - No longer listed as open benefit
  - Used *only* for induction prior to initiating Sublocade
- Slow-Release Oral Morphine (SROM)
  - *Not* a recommended treatment for OAT at CSC
  - Necessitates an Addiction Medicine Consultation if required.

Dosing Recommendations

The current British Columbia Centre for Substance Use (BCCSU) guidelines serve as the reference standards for CSC. Sample dosing protocols from BCCSU are provided in Appendix I. All dosing titrations must be based on a clinical assessment of the individual's opioid tolerance to ensure safe and effective treatment delivery.

Medication administration process

The preparation and administration of OAT medication is a clinical function to be carried out only by health care professionals. Clinical and product guidelines evolve continuously in response to emerging evidence and regulatory update. Healthcare professionals are responsible for remaining current and informed on best practice for OAT administration.

1. Administration process for **buprenorphine extended-release injection (Sublocade)**:

   Important: Sublocade is for subcutaneous injection in the abdomen ONLY.

   a) Remove Sublocade from refrigerator at least 15 minutes prior to administration to reach room temperature. Discard Sublocade if left at room temperature for longer than 12 weeks.

   b) Apply ice to the site 10 minutes prior to injection to ease pain.

   c) As universal precaution, always wear gloves to avoid accidental exposure.

d) Remove the safety needle and the syringe from the carton, check the liquid clarity (ranges from colourless to yellow to amber), and attach the safety needle.

e) Prepare the injection site. Sites should be rotated between doses to avoid irritation.

f) Remove excess air from the syringe.

g) Pinch the injection area to lift the adipose tissue from the underlying muscle to prevent accidental intramuscular injection.

h) Inject the medication by inserting the needle fully into the subcutaneous tissue, using a slow and steady push. The angle of injection will depend on the amount of subcutaneous tissue.

i) Withdraw the needle at the same angle used for insertion and release the pinched skin. Gently wipe any small amount of blood/fluid with a gauze before applying a bandage.

j) Instruct patients not to rub or massage the injection site and that they may have a lump for several weeks that will decrease in size over time.

2. Administration process for **methadone** under directly observed therapy (DOT). To ensure safe and verified ingestion of methadone, the nurse must adhere to the following procedures:

a) Administer methadone to ONE patient at a time to ensure that privacy is respected.

b) Verify patients' identity using two identifiers such as their picture ID and FPS number.

c) Medication must not be poured.

d) Provide patients with a full cup of water or instruct them to pour several ounces of water directly into the methadone bottle to facilitate complete ingestion.

e) Observe patients as they drink the water, then engage with them in conversation or have them open their mouth for inspection to verify oral ingestion. Please see High Alert Medication (Appendix F of the CSC National Formulary) and Medication Distribution and Administration Guidelines).

f) Ensure that the patient returns the empty methadone bottle immediately following administration.

3. Administration process for **buprenorphine/naloxone films** *during Sublocade induction*. To ensure proper administration and ingestion of buprenorphine/naloxone films, the nurse must:

a) Ensure buprenorphine/naloxone films are administered whole, as they should not be cut, chewed, or swallowed.

b) Instruct patients to drink a glass of warm water immediately prior to administration to humidify the oral cavity and facilitate absorption.

c) Hand the film package to the patients and observe them tear it along the designated dotted line. Monitor placement of the film onto one side of the buccal mucosa.

d) Ensure patients press and hold the film firmly in place for a minimum of 5 seconds to promote adherence to the mucosal surface.

e) Confirm that no two films are overlapping during administration.

f) If multiple films are prescribed, the additional film must be placed on the opposite side of the buccal mucosa. If a third film is necessary, repeat the process once the first two films have dissolved.

Please note that buprenorphine/naloxone films are not administered sublingually, except for the initial dose when starting OAT.

Post-administration security observation

Following the administration of methadone or buprenorphine-naloxone by a health care professional, mandatory observation by operations staff (e.g. Correctional Officers) is required to prevent medication diversion. This post-administration monitoring is a security measure carried out under the authority and direction of the Institutional Head or delegate.

The recommended observation period is:

- **20 minutes** following methadone administration
- **5 minutes** following buprenorphine/naloxone film administration

Transition between OAT Medications

As transitions between OAT medications require careful clinical oversight due to the potential for precipitated withdrawal and dosage titrations challenges, prescribers are strongly encouraged to consult with an addiction medicine expert or with the national substance use services medical advisor. These consultations ensure that transitions are managed in alignment with best practices and tailored to patients' clinical needs.

All individuals admitted to CSC from provincial/territorial correctional facilities, or directly from the community, who are receiving intravenous opioid agonist treatment (iOAT) or slow-release oral morphine (SROM) as part of OAT, should be reviewed in consultation with the MRP overseeing their care, preferably prior to transfer to CSC.

A structured transition plan from iOAT to methadone will be developed in collaboration with a qualified addiction medicine specialist to ensure clinical oversight and continuity of care.

For individuals on SROM, comprehensive collateral documentation detailing their OAT history must be obtained to support clinical decision-making. Transition from SROM to methadone or buprenorphine/naloxone extended-release injection will be determined on a case-by-case basis, based

on a thorough assessment of clinical risks and benefits.

For additional clinical guidance, refer to the BCCSU publication: A Guideline for the Clinical Management of Opioid Use Disorder (2023 Update).

Appendix I: Dosing Recommendations

Extended-Release Buprenorphine

General initiation and dosing information:

- Individuals should generally be initiated and stabilized on sublingual buprenorphine/naloxone (8–24mg/day) for a minimum of 7 days prior to receiving extended-release buprenorphine.
- If needed, more rapid transition to extended-release buprenorphine may be feasible and may facilitate treatment retention.
- Individuals starting extended-release buprenorphine should be prescribed 300mg for the first two months, followed by a maintenance dose of 100mg/month from the 3rd month.
- *Note:* People who have been stable on 8mg/2mg–18mg/4.5mg of sublingual buprenorphine/naloxone may begin to receive their maintenance dose of 100mg/month once a month after a single induction dose of 300mg.
- Prescribers may consider providing supplemental sublingual buprenorphine/naloxone for individuals who continue to experience opioid withdrawal and cravings during induction.
- At the discretion of the MRP, the maintenance dose may be increased to 300mg/ month if the person experiences ongoing opioid cravings or ongoing unregulated opioid use while on a 100mg/month maintenance dose.
- Extended-release buprenorphine doses must be administered monthly.
- A minimum length of 26 days is required between doses.

BCCSU – Extended-release Buprenorphine Guidance

Methadone

INITIATION

- During initiation, prescribers should see individuals in person or virtually at least weekly
- Clinical assessment is necessary before adjusting methadone doses

Determining the starting dose

Table 2. Starting doses for methadone based on individual's opioid tolerance

Level of tolerance	Suggested starting dose
No/low tolerance | opioid-naïve High risk of toxicity Includes people who have completed withdrawal management, those not currently using opioids but at risk of return to use, individuals with heavy use of other sedating agents, and people with severe comorbidities that affect toxicity risks	5–10mg/day
Unknown/moderate tolerance Moderate risk of toxicity Includes people who use benzodiazepines or other sedatives (prescribed or unprescribed), people with alcohol use disorder	10–20mg/day
Known high tolerance Lower risk of toxicity Includes people actively using opioids	20–30mg/day
Known very high tolerance Very low risk of toxicity Characterized specifically by previous methadone experience and current fentanyl use	30–40mg/day*

* Higher doses may be considered with caution on a case-by-case assessment of risks and benefits; rationale for higher doses should be documented and person's informed consent should be obtained. Close monitoring should also be arranged for individuals receiving higher starting doses.

Stabilization

The optimal therapeutic dose varies widely among individuals

- Historically ranged from 60mg-120mg.
- However, this is based on evidence collected before the emergence of fentanyl in the unregulated drug supply/
- Doses of 150mg or higher may be required in some individuals to meet therapeutic goals.

BCCSU – Methadone Guidance