Department of Public Safety and Correctional Services

Clinical Services & Inmate Health

Operations Manuals

Administration	Medical Records
Chronic Disease Management	Pharmacy Services
Infection Control	Pregnancy Management
Infirmary Care	Sick Call
Inmate Deaths	Substance Abuse
Medical Evaluations	

By signing this cover page, DPSCS officials responsible for the care and treatment of persons confined to their facilities give approval that the policies and procedures, reviewed and updated as needed annually and found herein, formally establish these processes to be acceptable to DPSCS.

Patricia Goins-Johnson, Executive Director Field Support Services

Sharon L. Baucom, MD Director of Clinical Services

Adaora Odunze, RN, PhD, Director of Nursing

Date Reviewed	1/2013
	11/2014
	1/2015
	2/20/2016

Department of Public Safety and Correctional Services

Clinical Services & Inmate Health

Substance Abuse Manual

Date Reviewed	2/22/2012
	8/2013
	11/2014
	1/2015
	2/20/2016

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

SUBSTANCE ABUSE MEDICAL MANAGEMENT MANUAL

Chapter 1
ALCOHOL WITHDRAWAL

Section A
MEDICAL MANAGEMENT

I. Policy: All DPSCS inmates diagnosed as experiencing ethanol withdrawal will receive evaluation and treatment in accordance with established procedures.

II. Procedure:

A. All inmates with a history of ethanol abuse will be evaluated for current or recent ethanol use during the Initial Medical and Mental Health Screening (IMMS) process followed by evaluation conducted by medical personnel in accordance with established procedures.

B. The initial evaluation will have screening questions and a physical assessment that will include:

1. An Alcohol History that specifically asks about:
    a. Type of alcohol used
    b. Duration of use (in years)
    c. Frequency of use
    d. Amount used daily
    e. Any drugs or medications either prescriptive, over-the-counter, or from non-traditional sources
    f. Complications of ethanol use
    g. Cirrhosis, liver cancer
    h. Esophageal varices
    i. Rehabilitation program(s) history, if applicable
    j. Last consumption: Time/Date/Amount
    k. Any history of seizures and/or delirium tremens.

2. A Physical Examination that looks for all of the following at a minimum:
    a. Is inmate alert and oriented to person, place and time?
    b. Are vital signs abnormal?
    c. Is the odor of alcohol present on the inmate's breath?
    d. Is the sclera icteric?
    e. Is there abdominal distension?
    f. Are there any signs of asterixis, ataxia or nystagmus?
    g. Does the inmate appear to be having hallucinations, acute psychosis, disorientation, or seizure activity?
    h. An assessment of pregnancy for all females under the age of 55.
3. An assessment using the CIWA Scale below that provides a clinically based determination as to whether or not the inmate is experiencing mild or severe ethanol withdrawal based on definitions.

    Clinical Institute Withdrawal Assessment (CIWA) Scale

    - Nausea and Vomiting (0-7)
    - Tremor (0-7)
    - Paroxysmal Sweats (0-7)
    - Anxiety (0-7)
    - Agitation (0-7)
    - Tactile Disturbance (0-7)
    - Auditory Disturbance (0-7)
    - Visual Disturbance (0-7)
    - Headache (0-7)
    - Orientation (0-4)

    CIWA Scoring

    The 10 items listed above are tallied to give a total score with a maximum possible score being 67. A score of:

    - 0-9 is considered absent or minimal withdrawal
    - 10-19 is considered mild to moderate withdrawal
    - >=20 is considered severe withdrawal

C. An Initial Treatment Plan will be developed, implemented, and recorded in the medical record. Alcohol will be added to the Problem List.
    1. Inmates who are assessed as experiencing severe/ life threatening withdrawal will be transferred immediately to a local hospital for inpatient management. Unless contraindicated, all patients will be treated using the treatment modalities outlined in Section 2 of this Chapter (Treatment modalities).
    2. Treatment of mild alcohol withdrawal or impending delirium tremors is aimed at the amelioration of symptoms and does not always require treatment in an inpatient setting. The treatment modality will be determined on a case-by-case basis by the clinician in consultation with the Regional Medical Director or his/her designee.
    3. Pregnant females who have been evaluated and have documentation indicating they are on methadone maintenance but are also experiencing alcohol related withdrawal symptoms should be continued on methadone while receiving interventions for alcohol but this should be evaluated by a medical professional and the determination made on a case-by-case basis. The pregnant inmate will need to be referred to a local hospital emergency room or labor and delivery suite following the assessment by the Addictions Specialist.
    4. There is to be documentation of all findings, recommendations, treatment, and referrals on the appropriate forms to include but not be limited to the IMMS Form, the patient's medical record, and/or all referral forms.

III. References:

A. DPSCSD 130-100 Section: 100-Medical Intake Evaluation
B. Manual of Medical Therapeutics, Little and Brown, 27th Edition
C. Standards for Health Services Correctional Institutions American Public Health Association – APHA Task Force Correctional Health Standards 2003 p. 83-84
D. NCCHC Standard J – G 2014
E. Arrestee Entrance / Refusal PDSD 110-19

IV. Rescissions:130-100-117 all issuances and versions.

V. Date Issued: July 15, 2007
Reviewed: September 19, 2009
November 29, 2010
September 28, 2011
October 29, 2012
July 5, 2013
November 7, 2014
December 2015

Assessment Protocol a. Vitals, Assessment Now. b. If initial score ≥ 8 repeat q1h x 8 hrs, then if stable q2h x 8 hrs, then if stable q4h. c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs, d/c assessment. If score ≥ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer prn medications as ordered and record on MAR and below.	**Date**												
	Time												
	Pulse												
	RR												
	O_2 sat												
	BP												
Assess and rate each of the following (CIWA-Ar Scale):	**Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**												
Nausea/vomiting (0 - 7) 0 - none, 1 - mild nausea ,no vomiting; 4 - intermittent nausea; 7 - constant nausea , frequent dry heaves & vomiting.													
Tremors (0 - 7) 0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended.													
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state													
Agitation (0 - 7) 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about													
Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat													
Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person													
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, ,numbness; 2-mild itch, P&N, burning, numbness, 3 - moderate itch, P&N, burning ,numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations													
Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations													
Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations													
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe													
Total CIWA-Ar score:													
PRN Med: (circle one) Diazepam Lorazepam	**Dose given (mg):**												
	Route:												
Time of PRN medication administration:													
Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)													
RN Initials													

Scale for Scoring:
Total Score =
0 – 9: absent or minimal withdrawal
10 – 19: mild to moderate withdrawal
more than 20: severe withdrawal

Indications for PRN medication:
a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).
b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method)
Consider transfer to ICU for any of the following: Total score above 35, q1h assess. x more than 8hrs required, more than 4 mg/hr lorazepam x 3hr **or** 20 mg/hr diazepam x 3hr required, or resp. distress.

atient Identification (Addressograph)

Signature/ Title	Initials	Signature / Title	Initials

Alcohol W... ...awal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.
0 - No tremor
1 - Not visible, but can be felt fingertip to fingertip
2
3
4 - Moderate, with patient's arms extended
5
6
7 - severe, even w/ arms not extended

Anxiety - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

Paroxysmal Sweats - Rate on Scale 0 - 7.
0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date

2 - disoriented to date by no more than 2 calendar days

3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Auditory Disturbances - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Visual disturbances - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 - not present
1 - very mild sensitivity
2 - mild sensitivity
3 - moderate sensitivity
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Headache - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

ALCOHOL WITHDRAWAL MANUAL

Chapter 1
MEDICAL MANAGEMENT

Section B
PHARMACOLOGICAL TREATMENT MODALITIES

I. Policy: Persons presenting with signs and/or symptoms of alcohol withdrawal will be treated in a humane and effective manner with the goal of therapy being to sedate the patient until calm, understanding that the patient's clinical state will determine the dosage of any medications that will be ordered by a licensed clinician.

II. Procedure:

A. At all times, the achievement and maintenance of fluid and electrolyte balance is essential. Oral or intravenous fluids as appropriate will be administered as ordered after an evaluation by the clinician.

B. Thiamine 100 mg PO or IM daily, multivitamins, and folic acid should be given as a routine for persons with ethanol history.

C. Treatment for Minor Withdrawal

1 Provide Benzodiazepines, either:

a. Diazepam 5 to 20 mg PO every 6 hours or

b. Chlordiazepoxide 25 to 100 mg PO every 6 hours.

2. Increase non-alcoholic fluids by mouth (PO).
3. Schedule the individual for medical follow up within 24-48 hours.
4. Alert the medical custody staff to notify the medical staff if any progression in agitation is seen.
5. Document that observation in the medical record.

D. Treatment for Moderate Withdrawal

1. Observation in an infirmary or off site is required until the individual is stable.
2. Obtain a clinician order for and administer Chlordiazepoxide 100 mg IV (intravenously) or PO every 3 to 6 hours as needed during the first twenty-four hours (NOT TO EXCEED A TOTAL OF 500 mg for that period).
3. An order for IV fluids should be obtained and the fluids administered.
4. A Mental Health status and consult must be obtained.
6. The Addictions Specialist must do an assessment on the individual prior to admission to an infirmary.
7. In the event that symptoms indicate a need, have the person transported to a local hospital.
8. Signs of progression to potential or actual delirium tremors (DTs) will necessitate transportation to a local hospital for care.

E. Treatment for Delirium Tremors

1. Observe for tremulousness, hallucinations, agitation, confusion, disorientation, and autonomic hyperactivity (fever, tachycardia, and diaphoresis typically occur within 72-96 hours after the cessation of alcohol intake).

2. This individual will be treated at the local hospital and not in the infirmary.

III. Rescissions: Attachment A to 130-100-117

IV. Issued: July 17, 2007

Reviewed: September 19, 2009
Reviewed: November 29, 2010
Reviewed: September 28, 2011
Reviewed: October 29, 2012
Reviewed: December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

SUBSTANCE ABUSE MEDICAL MANAGEMENT MANUAL

Chapter 2
MEDICAL MANAGEMENT OF OPIATE WITHDRAWAL

Section A
MEDICAL MANAGEMENT

I. Policy: All DPSCS inmates diagnosed as experiencing opiate withdraw will receive evaluation and treatment in accordance with the DPSCS Methadone Treatment Program including an expedited physical.

II. Procedure:

A. All inmates with a history of opiate abuse will be evaluated for current or recent opiate use at the Receiving/Screening portion of the Intake Process, in accordance with established procedures.

B. The initial evaluation will include:

1. A complete drug history that includes:
    a. Type of opiate used
    b. Duration of use
    c. Frequency of use
    d. Amount used
    e. Last dose Time/Date/Amount
    f. Other drugs used such as alcohol, valium, amphetamines
    g. Complications of drug use that include but are not limited to:
        (i) Bacterial Endocarditis
        (ii) Cellulitis
        (iii) HIV Infection/Hepatitis C
        (iv) MRSA

h. Methadone Program in which the individual is enrolled (if applicable) including the program name and location as well as contact person at that location.

2. A complete physical examination that addresses the following at a minimum:
   a. Documentation of abnormal vital signs.
   b. Are needle tracks present and, if applicable, are they recent or old?
   c. Are there abscesses/ulcers present?
   d. Are there thrombotic veins present?
   e. Is there local edema?
   f. Is there lymphadenopathy?
3. An assessment must be done that includes documentation about whether the patient is experiencing none or mild, moderate or severe withdrawal symptoms based on definitions and the severity scale code assignment using the Clinical Opiate Withdrawal Scale (COWS) as described below:

   Clinical Opiate Withdrawal Scale (COWS)

   - Resting Pulse Rate (0-4)
   - Sweating (0-4)
   - Restlessness (0-5)
   - Pupil Size(0-5)
   - Bone or Joint Aches (0-4)
   - Runny Nose or Tearing (0-4)
   - GI Upset (0-5)
   - Tremor (0-4)
   - Yawning (0-4)
   - Anxiety or Irritability (0-4)
   - Gooseflesh Skin (0-5)

   COWS Scoring

   The 11 items listed above are tallied to give a total score with a Maximum possible score being 48. An inmate with a score of:

   - 5-12 must be considered as being in mild withdrawal
   - 13-24 must be considered as being in moderate withdrawal

- 25-36 must be considered as experiencing moderately severe withdrawal
- >36 must be considered to be in severe withdrawal.

4. Treatment will be initiated upon recognizing that an individual has used opiates
    a. Inmates who are assessed as experiencing severe life threatening withdrawal will be transferred immediately to the infirmary for inpatient management.
    b. If emesis is present, intravenous fluids will be administered until the inmate is able to tolerate a regular diet.
    c. Serum electrolytes and urine output will be monitored closely during this therapy.
    d. If there is no physician on site, the physician assistant or nurse practitioner will contact the on-call physician for admission orders and treatment plan.
    e. Unless contraindicated or the detainee is pregnant and using opiates or the detainee is currently participating in a recognized Methadone Treatment Program, all patients will undergo detoxification utilizing the treatment modalities outlined in Section 2 of this Chapter.
    f. Females, who present with a history of pregnancy or suspected pregnancy, will be placed on low dose Methadone maintenance, (20-25 mg daily) until delivery or the Obstetrics consultant alters the dosage. Those whose serum pregnancy test is negative will subsequently be detoxified utilizing the treatment modalities outlined in Section 2 of this Chapter.
    g. All persons who report they are currently enrolled in a Methadone Treatment Program will be offered continued therapy
        (i) While awaiting verification from the Community Based Opioid Therapy Program (CBOTP) Physician orders will be written for a three day program of Methadone.
        (ii) Further orders regarding the length of treatment will be written and followed for as long as the patient remains in a pretrial facility.

(iii) Once sentenced, patients will be placed on a short-term (12-21days) Methadone detoxification protocol as prescribed by the Addictions Specialist.

h. Detainees will be offered the right to refuse Methadone Therapy, and will be required to sign a refusal form if that is their choice.
   (i) Refusal of therapy will be documented in the detainee's medical record.
   (ii) The signed refusal form will also be placed in that record.

i. Treatment of mild to moderate withdrawal is aimed at the amelioration of symptoms and does not require treatment in an inpatient setting. The treatment modality will be determined on a case by case basis.

C. Documentation of all steps in this procedure will be placed in the electronic record (EMR). In the event that the EMR is non-functional, documentation will be made in the individual's paper medical record and entered into the EMR as soon as it is again working.

III. References:
A. Standards for Health Services in Prisons, National Commission on Correctional Health Care J-51, Intoxication and Withdrawal.
B. CS 130-Clinical Services Substance Abuse Medical Management Manual
C. Hazelden's Treating Opiate Dependency 1993, Smith, Wesson, Tusel.

IV. Rescissions: DPSCS 130-100-118

V. Issued: July 15, 2007
Reviewed: September 14, 2009
December 21, 2010
December 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

SUBSTANCE ABUSE MEDICAL MANAGEMENT MANUAL

Chapter 2
MEDICAL MANAGEMENT OF OPIATE WITHDRAWAL

Section B
PHARMACOLOGICAL TREATMENT OPTIONS

I. Policy: Persons presenting with signs and/or symptoms of Opiate withdrawal will be treated humanely and in an effective manner with the goal of therapy being to offer persons with addictions a chance at getting off drugs with little or none of the pain and potential complication associated with opiate withdrawal, understanding that the patient's clinical state will determine the type and dosage of any medications that will be ordered by a licensed clinician.

II. Procedure:

A. At all times, the achievement and maintenance of fluid and electrolyte balance is essential. Oral or intravenous fluids as appropriate will be administered as ordered after an evaluation by the clinician.

B. The clinician will determine the stage of withdrawal using the Clinical Opiate Withdrawal Scale (COWS) in Section 1 of this chapter.

C. For Severe or Life-Threatening withdrawal scores, the individual will be transported immediately to the local hospital emergency room.

D. For opiate dependent detainees including opiate dependent non- pregnant females, the clinician will have the option to use methadone detoxification by taking the following steps:

1. First make a clear clinical determination the patient is in a state of withdrawal and not a state of overdose by clinically establishing and documenting that patient is not drowsy or obtunded, respiration is not shallow, and pupils are not pinpoint.

2. Make a determination that the patient is in one of the high risk groups listed below who will have a better clinical outcome with methadone detoxification as opposed to symptomatic treatment. High risk groups include:
    a. Patients with COWS Scores of 12 and Above
    b. Patients with Co-Morbid history of severe COPD/Severe Asthma
    c. Patients with Co-Morbid history of Diabetes
    d. Patients with Co-Morbid history of Seizure Disorders
    e. Patients with Co-Morbid history of HIV/AIDS
    f. Patients with Co-Morbid history of CAD/Severe Hypertension, including previous M.I, Cardiac CATH;STENT
    g. Patients with Mental Health history
3. Initiate individualized methadone detoxification using the guidelines below and in consultation with the Addictions Specialist.
4. Ensure that orders are written and implemented for follow-up COWS scoring as well as vital signs monitoring at a minimum of every 6 hours from the time orders are initiated.
5. Have an RN also do rounds (with the physician) on both A and B shifts.
6. Document all actions taken or rationale for choosing an alternate plan of treatment in the progress note.

E. Clinicians will follow the following guideline, using professional judgment in each case, for rapid Methadone detoxification:
    1. Methadone 30 mg stat dose
    2. Methadone 20 mg po Day2
    3. Methadone 10mg po Day 3
    4. Methadone 5mg po Day 4; then discontinue the Methadone.

F. Persons scoring =/< 10 on the COWS, and are not known to have any serious medical and/or mental health co-morbidities will be managed with the following protocol using Clonidine:
    1. Clonidine 0.3 mg three times a day for 2 days
    2. Clonidine 0.2 mg three times a day for 2 days
    3. Clonidine 0.1 mg three times a day for 2 days

4. Clonidine 0.1 mg two times a day for 2 days
5. Clonidine 0.1 mg once a day for 2 days
6. Discontinue Clonidine.
7. Note: Clonidine will NOT be given in the presence of a blood pressure measurement of 90/60 or lower.

G. Pregnant females will be maintained on methadone until delivery and will then be detoxed over 21 days. This will be done in conjunction with OB-GYN consultant and/or Addictions Specialist.

H. Persons who are enrolled in a community drug program, and who are actively taking Methadone prior to incarceration, will be maintained on same dose of verified Methadone prescribed at the community treatment program.

III. References: None

IV. Rescissions: DPSCS 130- 100-118

V. Issued: July 15, 2007
Revised/Reviewed: October 30, 2008
September 14, 2009
December 21, 2010
September 28, 2011
October 29, 2012
December, 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICE/INMATE HEALTH

SUBSTANCE ABUSE MEDICAL MANAGEMENT MANUAL

Chapter 3
METHADONE POLICIES

Section A
ACCESS TO OPIATE THERAPY PROGRAM (OTP) SERVICES

I. Policy: Inmates who arrive at the Baltimore Central Booking and Intake Center (BCBIC) will receive timely and appropriate care by a qualified health care professional as soon as opioid addiction, dependence, or on-going treatment is identified.

II. Procedure:

A. Identification of eligible detainees will occur during the booking process.

1. As part of the initial screening completed during the booking process, detainees are questioned regarding current medication therapy and participation in a Methadone program. Detainees responding affirmatively to Methadone as a medication or as a participant in a Community Based Opioid Therapy Program (CBOTP) are referred to the medical triage team physician prior to completion of the booking process.

2. After obtaining an Authorization to Release Information form (Attachment A) and the medication verification form, the nurse contacts the CBOTP to verify program participation using the established medication verification process.

3. Once verification of CBOTP is received, the nurse will refer the detainee to the addictions specialist and the DPSCS substance abuse counselor.

4. If verification is not received within 24 hours, after consultation with the addictions specialist, the medical triage team physician will write an interim three day order for Methadone while awaiting verification from the CBOTP. This process will occur twenty-four (24) hours per day, seven (7) days per week. Medication administration will be governed by the existing policy titled “Medical Intake Process Part I: The IMMS”

B. Medication Services will be tailored to the needs of the detainee with the addictions specialist’s approval.

1. Methadone will be administered to the detainee only upon the order of the addictions specialist responsible for the pretrial facilities.

2. Pretrial Methadone detainees coming from the community will be placed on the Methadone maintenance dose they were receiving before incarceration, with adjustments as clinically indicated and as approved by the addictions specialist.

3. No Methadone naive detainees will be started on Methadone maintenance therapy during incarceration except for pregnant detainees.

4. Other adjunct medications are prescribed only when clinically indicated and when ordered by the addictions specialist over the pretrial facilities.

5. While other options such as Buprenorphine are used for opioid addiction treatment, only Methadone will

be utilized for pretrial detainees' interim maintenance program.

6. Methadone treatment will be continued as long as the detainee remains in a pretrial custody status and the addictions specialist deems such treatment as clinically necessary. The detainee may refuse to continue participation at any time and will receive appropriate counseling from the addictions specialist and the DPSCS substance abuse counselor.

7. With the exception of pregnant inmates, any detainee receiving Methadone and subsequently sentenced will be placed on a short-term Methadone detoxification protocol between 12-21 days as prescribed by the addictions specialist.

8. With the exception of pregnant inmates, no Methadone treatment of any kind will be continued for sentenced inmates for more than twenty-one (21) days.

C. OTP services will include one or more of the following:

1. Maintenance treatment: daily administration of Methadone only after verification is made that the individual is currently enrolled in a community OTP.

2. Maintenance treatment for those detainees under the age of 18: daily administration of Methadone only after verification is made that the individual is currently enrolled in a community OTP.

3. Maintenance treatment for pregnant inmates

4. Short-term detoxification for Methadone detainees who are prison-bound. The individual will be placed on a detoxification protocol approved by the addictions specialist titrating dosages, reducing those doses incrementally on a daily basis in a humane, medically appropriate manner.

D. OTP staffing needs include:

1. A site addictions specialist certified by the American Society of Addictions Medicine (ASAM) or designee will be the chief medical authority and responsible for program oversight.

2. A full-time day RN who will monitor and oversee nurse involvement with the program. This nurse will have additional responsibilities within the medical services of the medical contractor, but will have prime responsibility for activities occurring in the opioid therapy program.

3. Intake and dispensary staff will be trained regarding the program and cross-trained to provide coverage in areas where OTP services will be provided.

E. Opioid Therapy Program (OTP) special needs include the following:

1. OTP caregivers will be notified by security when detainees or inmates enrolled in the OTP are restrained or placed in seclusion for custody reasons and/or by medical personnel for clinical reasons.

2. OTP detainees that cannot be clinically maintained within the facility will be transferred to an appropriate hospital or alternate care facility.

III. References

IV. Rescissions: None

V. Issued: July 15, 2007

Reviewed: September 16, 2009;
December 22, 2010
October 6, 2011
Reviewed and Revised 10/2012
Reviewed July 2013
Reviewed December 2015

Attachment A

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
REQUEST AND AUTHORIZATION TO RELEASE INFORMATION
AND OTP ENROLLMENT & DOSAGE VERIFICATION SHEET

DATE: _____

TO: _____

_____

I, _____AKA/Alias _____
(Name and DOC#)

Date of Birth:_____ Social Security #:_____

Last known address: _____

Hereby consent to the disclosure to the specific medical information listed:

_____
(Name of Program)

_____ Was medicated at:_____
(Name of Client) (Hospital / Clinic/ Institution)

With Methadone _____mgs on _____
(Dose) (Approximate date and time of treatment)

With Suboxone _____mgs on _____
(Dose) (Date of last script written & quantity dispensed)

Department treated in:_____

Physician Name: _____

****

I, the undersigned, hereby request and authorize any physician, dentist, nurse, psychologist, pharmacist, hospital, clinic, or other health care facility to disclose any and all of the findings and results of their psychological and all other health care examinations and treatment of me to:

_____

_____

(This consent expires in one (1) year unless prior written revocation is given)

_____ _____
SIGNATURE AND DOC # **DATE**

_____ _____
WITNESS **DATE**

PLEASE FAX FORM ASAP TODAY TO: _____

(Name of Facility and Fax #)

DC FORM 130-600aR (Rev. 7/2011)

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

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Section B
PROGRAM SPONSOR

I. Policy: The Medical Contractor will maintain a Medical Director responsible for Opioid Therapy Program (OTP) oversight, preferably certified as a Substance Abuse Specialist who will serve as the Program Sponsor. In any event, there will always be a Substance Abuse Specialist to serve as the designated Program Sponsor as required by SAMHSA.

II. Procedure:

A. The Program Sponsor will ensure appropriate levels of opioid treatment are available and will monitor quality, accessibility, and timeliness of health services for inmates

B. The Program Sponsor's responsibilities will be documented in a written agreement, contract, or job description.

C. The Program Sponsor will be a physician, certified by the American Society of Addiction Medicine (ASAM).

D. The Site Medical Director and Program Sponsor will assume responsibility for administering all addiction treatment services performed under the OTP, and will ensure the OTP is in compliance with applicable local, state, and federal laws and regulations.

E. The Site Medical Director and Program Sponsor will establish

appropriate communication with the facility's other health services so that appropriate and timely coordination of care occurs.

F. The Site Medical Director and Program Sponsor will ensure that the decision to admit or discharge an individual from the OTP is based on accurate clinical information.

III.	References:	Federal regulations for OTPs as set forth in 42FCFR8.12 (Certification of Opioid Treatment Programs, Federal Opioid Treatment Standards).
IV.	Rescissions:	None
V.	Issued:	July 15, 2007
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Section C
ADMINISTRATIVE MEETINGS AND REPORTS

I. Policy: Opioid Therapy Program (OTP) services will be reviewed and discussed at meetings with other components of clinical and administrative services.

II. Procedure:

A. Administrative meetings will be attended by the facility Health Services Administrator (HSA), the Addictions Specialist or their designees, the DPSCS Substance Abuse Counselor, the Day RN responsible for nursing activity related to the Program, a representative from the pharmacy vendor, other general health care professionals as needed, and correctional staff as appropriate. If mental health services operate under a structure separate from health services, the designated mental health clinician or designee will also attend.

B. Administrative meetings will be held quarterly. Minutes or summaries are generated and retained for reference, and copies are distributed to attendees and to DPSCS.

C. Statistical reports of OTP services will be developed and maintained monthly and provided to the HSA, ACOM, DPSCS Chief Medical Officer, Director of Nursing and the medical contractor's Regional Medical Director. At a minimum these reports will include a listing by facility, individual name and SID/DOC number:

1. A monthly list of persons on methadone therapy with a delineation of who is on maintenance and who is on withdrawal therapy.
2. A monthly list of those that have been offered but refused therapy.

3. A monthly list of persons that have been offered and accepted alternative therapies with a description of what is being used for each.
4. A monthly list of those that have been offered and refused alternative therapies. .
5. Statistics will be documented according to facility policy and submitted electronically per contract to the Department of Public Safety and Correctional Services Clinical Services CQI team.

D. The OTP will maintain, at a minimum, the following statistics which will be forwarded to the DPSCS Director of Substance Abuse, Office of Treatment Services, and Reisterstown Road Plaza via fax no less than weekly, and to DPSCS Director of Clinical Services and the State Director of Nursing:
1. The number of possible applicants and the number admitted to OTP services with demographics that include age, race, and gender.
2. The number of inmates receiving OTP services by category of care. (Pregnant opiate users, persons admitted already participating in a recognized methadone therapy program, and opiate users newly placed on methadone or other maintenance or withdrawal programs).
3. All referrals to health services facility staff and/or specialists with information about where the referral was made and if the referral was followed upon.
4. Adverse health events or deaths; and sentential events.
5. Emergency services provided to patients known to be “users” or in methadone programs while detained.
6. The number of treatment verification requests and:
   a. The number verified within 24 hours
   b. The number verified over 48 hours
   c. The number of treatment request by name of community program
7. The number of detoxification interventions discontinued due to inmate’s release.
8. The number of methadone maintenance detoxification individuals initiated because detainee was sentenced to DOC.

III. References

IV. Rescissions: None
V. Issued: July 15, 2007
VI. Reviewed: September 16, 2009
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Section D
AVAILABILITY OF POLICY AND PROCEDURE MANUALS

I. Policy: To ensure that medical contractors and DPSCS staff members are aware and familiar with Opioid Therapy program (OTP) Policy, medical contractors will have a manual of written policies and defined procedures regarding OTP services.

II. Procedure:

A. An OTP Policy and Procedure manual has been developed and will be kept in a place easily accessible to all staff.

B. Staff will be in-serviced on all aspects of the manual prior to commencement of staff services and no less than each calendar year thereafter.

C. Each policy and procedure in the OTP manual will be reviewed at least annually and revised as necessary under the direction of the Program Sponsor.

D. The manual will bear the date of the most recent review or revision and, at a minimum, the signatures of the Program Sponsor and Chief

Medical Officer.

E. Written orders will be developed for nurses and infirmary staff who treat with methadone and will be found in the appropriate sections of this Chapter.

F. The manual or compilation will be placed at the various workstations and accessible to OTP staff.

III. References None

IV. Rescissions: None

V. Issued: July 15, 2007

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Section E
CONTINUOUS QUALITY IMPROVEMENT (CQI)

I. Policy: To continuously identify areas in the opioid treatment delivery system that needs improvement, and to develop and implement strategies for improvement. The Medical contractor will maintain a Continuous Quality Improvement (CQI) process to assess the quality of the Opioid Therapy Program (OTP).

II. Procedure:

A. The OTP will be part of the Pretrial Multidisciplinary Quality Improvement Program. The high risk, high volume and challenging aspects of care will be monitored and reported on an ongoing basis to the CQI Committee.

B. The OTP will have a CQI program that is approved by the Site Medical Director, Program Sponsor and DPSCS – Office of Clinical Services – Inmate Health. The OTP team members will actively participate in monthly reviews that measure effectiveness and efficiency of care and treatment outcomes. Sentinel and adverse outcomes are part of the monitoring and will be brought to the attention of the committee during the monthly reviews.

C. Minutes of OTP meetings will be maintained for review by DPSCS – Office of Clinical Services – Inmate Health. Clinical Services staff may attend meetings or request minutes as needed.

D. Opportunities for improvement will be addressed using a corrective action plan format.

E. Effectiveness of the corrective action plan shall be assessed between 30-60 days of implementation. Documentation of this assessment shall be maintained, presented at the monthly meeting and also recorded in the minutes.

III.	References:	None
IV.	Rescissions:	None
V.	Issued:	July 15, 2007
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Section F
PRIVACY OF CARE

I. Policy: To ensure that health care encounters remain private and that a patient's dignity and confidentiality are protected, all clinical encounters related to the Opioid Therapy Program (OTP) are conducted in a location that maintains patient confidentiality and are carried out in a manner designed to encourage the patient's subsequent use of clinical services.

II. Procedure:

A. Clinical encounters will be conducted in a private location where conversations cannot be overheard and security observation is available only to the extent required to maintain staff safety.

B. Documentation of patient encounters are recorded and maintained providing the same confidentiality afforded to persons in the community receiving similar services.

C. Security personnel will be invited to be present only if the patient possesses a probable risk to the safety of the health care provider or others.

D. Instruction on maintaining confidentiality will be given to security staff as well as to medical staff.

E. Language challenged inmates will have interpreters available, and those interpreters will receive instruction on the necessity of maintaining confidentiality regarding anything they might hear during the process.

III. References: None

IV. Rescissions: None

V. Issued: July 15, 2007

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Section G
ADVERSE HEALTH EVENTS

I. Policy: For all health-related adverse events or death of inmates enrolled in the Opioid Therapy Program (OTP), the program sponsor will determine the appropriateness of clinical care through a clinical review, ascertain whether corrective action in the system's policies, procedures, or practices is warranted; and identify trends that require further study as part of Continuous Quality Improvement (CQI).

II. Procedure:

A. All significant adverse health events including deaths will be reviewed and reported.

B. The Site Medical Director or designee will complete a clinical review for each adverse event, including death, within seventy-two (72) hours per DPSCS policies.

C. The report is shared with treating staff, including representatives of the facility's medical and mental health staffs, as appropriate.

D. The DPSCS Chief Medical Officer/Medical Director, the appropriate Agency Contract Operations Manager (ACOM), and the State Medical Examiner will be notified immediately of any death per DPSCS policy.

E. Corrective action will be taken (and documented) when necessary and a copy of the Corrective Action Plan (CAP) will be submitted for review to the appropriate ACOM and the facility's CQI committee.

F. Critical incident debriefing will occur in the event of an adverse health event.

III.	References:	None
IV.	Rescissions:	None
V.	Issued:	July 15, 2007
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Section H
CREDENTIALING

I. Policy: To ensure that the facility's health care professionals are licensed and legally qualified personnel, providing services to detainees in the Opioid Therapy Program (OTP), are appropriately trained in opioid treatment and credentialed according to the licensure, certification, and registration requirements of the State of Maryland. Training programs will be approved by DPSCS.

II. Procedure:

A. A credentialing process will verify current licensure, certification, or registration for new hires and should include the following:

1. Identification of person responsible for conducting verification process;
2. Articulation of the actions that person should take in the confirmation process and which agencies should be contacted.

B. Inquiries will be made regarding sanctions or disciplinary actions that state boards, other employers, and the National Practitioner Date Bank (NPDB) have taken, and procedures will be established for periodic reconfirmation of the information.

C. An in-service OTP will be given to every new hire. Documentation and a copy will be provided to the Agency Contract Operations Manager (ACOM).

D. The Site Administrator is responsible for maintaining verification of current credentials for all qualified health care professionals at a readily accessible on-site location.

E. Medical contractors will ensure that those authorized to prescribe controlled substances have a current individual Drug Enforcement Administration (DEA) license and Controlled Drug Substance (CDS) certification. This information will be updated annually and a copy will be provided to the ACOM.

F. Medical contractors will ensure that absolutely no physician with restricted medical licenses provides services with the OTP.

G. All personnel providing services to detainees will be given an in-service on how to recognize abstinence syndrome in opioid-dependent detainees.

III. References: None

IV. Rescissions: None

V. Issued: July 15, 2007
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Section I
MEDICATION ADMINISTRATION TRAINING

I. Policy: To ensure that medications given through the Opioid Therapy Program (OTP) are properly administered and that appropriate security measures are implemented and maintained, training in medication administration and security considerations related to medication administration will be given to all staff involved with the OTP prior to working in the program and at least annually thereafter.

II. Procedure:

A. The OTP's Program Sponsor and Site Medical Director will approve the training program. Education components for training to be provided to all persons working in OTP will include at a minimum:

1.) The process for administering methadone or other controlled substances,

2.) The importance of accurate medication counts,

3.) The responsibility of holding the keys to controlled medications,

4.) Dangers associated with the hoarding of medications,

5.) Potential for drug trafficking and the potential for overdose, and

6.) Managing adherence to therapy regimes.

B. Training and in-service will include issues such as how staff can identify and minimize:
   1.) Hoarding of medications
   2) Selling of drugs
   3.) Overdoses
   4.) Dispensing errors
   5.) Count discrepancies.
   6.) Issues of adherence.

C. Opioid agonist treatment medications will be administered or dispensed only by a practitioner licensed and registered under appropriate State and Federal laws. The agent must be a pharmacist, registered nurse, licensed practical nurse, or other professional authorized by Federal and State law to administer or dispense opioid drugs.

D. Documentation of completed training and testing of staff that administer or deliver medications will be kept on file in each employee's personnel record and shall be available for review by DPSCS assigned employees upon request.

III. References: None

IV. Rescissions: None

V. Issued: July 15, 2007

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Section J
PHARMACEUTICAL OPERATIONS

I. Policy: To ensure that the Opioid Therapy Program (OTP) of pharmaceutical services is legally and properly operated, OTP will use only those opioid agonist treatment medications that are approved by the DPSCS Chief Medical Officer for use in the treatment of opioid addiction.

II. Procedure:

A. The Opioid Therapy Program will comply with all applicable state and federal regulations regarding prescribing, dispensing, administering, disposal and procuring pharmaceuticals.

B. The State's pharmacy vendor and medical contractor will adhere to a strict accountability system regarding pharmaceutical security and utilization.

C. Secure opioid safes that meet federal and statutory regulations, having double locks with different manual key access and/or electronic passwords will be utilized for pharmaceutical storage.

D. Access to safe entry devices (i.e. key and/or password) will be limited to management. The charge nurse will maintain narcotics keys; Addictions Specialist and/or designee will keep the pass code. In any event, two (2) individuals must be present to open the safe.

E. Counting of the medication will occur daily at the beginning and end of each shift by the nurse leaving and the nurse coming on duty; this must be documented as correct or appropriate action must be taken to notify the site medical director. No

persons may leave until any error has been tracked and recorded as resolved/unresolved.

F. All medication will be stored under proper conditions according to manufacturer specifications regarding sanitation, temperature, light, moisture, ventilation and segregation. Antiseptics, disinfectants, and other medications for external use are stored separately from internal and injectable medications.

G. An adequate and proper supply of antidotes and other emergency medications along with related information (including posting of the poison control telephone number in areas where overdoses or toxicological emergencies are likely), will be made readily available to the staff.

H. Narcan will be kept as a stock medication for use in the event of an adverse condition requiring immediate detoxification of a narcotic agent. It will be used only if ordered by the attending physician.

III. References:
A. Food and Drug Administration Section 505 of the Federal Drug and Cosmetic Act (21 U.S.C. 355)
B. Wexford Employee Manual

IV. Rescission: None

V. Issued: July 15, 2007

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Section K
MAINTENANCE MEDICATION ADMINISTRATION

I. Policy: Each opioid agonist treatment medication is administered and dispensed in accordance with its approved product labeling and at the direction of the Addiction Specialist or designee.

II. Procedure:

A. Prescription medications will be administered or delivered to the patient only upon the order of the Site Addictions Specialist or designee.

B. Treatment with methadone for a patient in a pretrial status will be ordered only for those confirmed as already participating in an approved community Opioid Therapy Program (OTP).

C. All detainees would have to go through the established verification procedure as being an active participant in an approved Community Based Opioid Therapy Program (CBOTP) before a methadone maintenance process is re-instituted after incarceration.

D. A verification form will be faxed to the CBOTP, where it is completed by that agency and faxed back to the correctional facility on behalf of the patient.

E. Other adjunct medications are prescribed only when clinically indicated and only by an individual appropriately licensed to prescribe such medications.

F. While there are other options such as buprenorphine for opioid treatment, the OTP will only use methadone for a pretrial inmate's interim maintenance program, unless otherwise approved by the Department of Public Safety and Correctional Services' Chief Medical Officer.

G. All detainees previously on buprenorphine will be converted to methadone after consultation with the prescribing outside community agency.
H. Opioid medication will be continued as long as the patient's custody status remains as pretrial.
I. Once sentenced, persons using methadone will be placed on short-term methadone detoxification protocol lasting 12-21 days.
J. No methadone treatment of any kind (maintenance or withdrawal) will be continued for sentenced inmates for more than 21 days after the sentence begins with the exception being pregnant women.
K. All methadone will be given under direct observation therapy (DOT) with documentation in the medication administration record (MAR) at the time of medication administration.
    1. Methadone shall be crushed and dissolved in water before administering to a patient with a Methadone Maintenance order.
    2. A second cup of water in the original cup containing the medication shall be provided by the nurse to the patient to assure that all particles of the medication are consumed.
    3. The nurse shall assure that all medication is swallowed before allowing the patient to leave the administration area.
L. Documentation of methadone maintenance will be placed on the Problem List/EMR.
M. Inmates who are not considered candidates for maintenance will have the reasons documented in the progress notes by the provider.

III. References: None

IV. Rescissions: None

V. Issued: July 15, 2007
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Section L
DETOXIFICATION

I. Policy: To ensure that detainees who are intoxicated or undergoing withdraw from opiate, alcohol or any other mood-altering drugs are managed in a humane manner with appropriate considerations for patient safety and privacy. All Opioid Therapy Program (OTP) detainees undergoing withdrawal from any mood-altering drug of dependence will be appropriately evaluated and placed under consideration for Methadone or other detoxification medications. Documentation by the provider regarding consideration for Methadone use will be made in the progress notes of the medical record/EMR when alternative detoxification medication is used. Any refusals of withdrawal treatment by the patient will be documented in the medical record. If able, the patient must sign a formal refusal form.

II. Procedure:

   A. Established protocols described in the DPSCS Clinical Services Manual will be followed for the treatment and observation of individuals manifesting symptoms of intoxication and withdrawal; appropriate protocols will be followed for detoxification that will include the potential use of Methadone as a detoxification agent. The OTP will ensure that copies are available in hard copy or electronic format for use at the facility. Copies will be readily accessible to all medical personnel.

   B. Protocols used will be those approved by the addictions specialist or program sponsor, and DPSCS. They shall be reviewed annually and remain consistent with nationally accepted guidelines.

C. Withdrawal and detoxification will be done only under physician supervision in accordance with local, state, and federal laws.
D. The program sponsor or addictions specialist will determine opioid medication dosages for detoxification.
E. No new maintenance doses will be initiated during incarceration, i.e., after sentencing.
F. Procedures ensure that detainees admitted to short-term detoxification treatment by the OTP physician are appropriate for such treatment.
G. Because inmates enrolled in the OTP may have been taken into custody recently and are frequently users of other drugs (including alcohol), intoxication and withdrawal remain a concern.
H. Inmates experiencing severe, life-threatening intoxication, overdose, or withdrawal will be transferred immediately to a DPSCS approved licensed acute care facility.
I. Individuals at risk for progression to more severe levels of intoxication or withdrawal will be admitted to an infirmary under constant observation by qualified health care professionals, and will have medications, which may include Methadone, administered to prevent severe withdrawal symptoms when clinically indicated. Whenever severe withdrawal symptoms are observed, the addictions specialist or another designated physician will be consulted promptly for intervention and direction. If not available, persons exhibiting life threatening symptoms will be transferred to off site hospitals.

III. References:
A. The American Society of Addiction Medicine
B. The American Academy of Addiction
C. Book 5, Section 2 of Chapters 1 and 2 of the inmate Health Services manual

IV. Rescissions: None

V. Date Issued:July 15, 2007
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December 2011,
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Section M
CARE OF THE PREGNANT INMATE

I. Policy: Pregnant inmates needing or already on methadone receive appropriate Opioid Therapy Program (OTP) services that take into account their special needs. Prenatal care and other gender-specific health services are provided by the OTP through a referral to an OB/GYN specialist.

II. Procedure:

A. Prenatal care includes:

1. Medical examinations on a schedule that matches the community standard.
2. Laboratory and diagnostic tests (including HIV testing, STI, hepatitis etc.).
3. Appropriate therapy for laboratory findings as indicated.
4. Advice on appropriate levels of activity, nutritional guidance, counseling on safety precautions, exercise, fetal well-being, and labor education.

B. Appropriate protocols as described in Chapter 2; Section 2 of the DPSCS: OCS/IH Substance Abuse Medical Management Manual are followed when Opioid agonist medication is prescribed for pregnant detainees.

C. Because of multiple risk factors, pregnant women on methadone will be referred to the high risk OB/GYN clinic for follow-up.

D. Pending review by the specialist, initial methadone maintenance for females who are identified as drug users will be made consistent with protocols approved by DPSCS.

E. Documentation of the patient's prenatal history and other relevant medical information should accompany the patient when referred to an offsite hospital or specialist for medical care.

F. Medical and Mental Health staff will work together to assess the potential effects of psychotropic medications on the developing fetus versus the mother's need for continuing psychotropic medication through consultation between medical vendor physicians and mental health vendor psychiatrists.

III. References: DPSCS: OCS/IH Substance Abuse Management Manual Chapter 2; Section 2.

IV. Rescissions: None

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Section N
RECORD FORMAT AND CONTENT

I. Policy: To ensure that a health record is properly created and maintained for all Opioid Therapy Program (OTP) inmates in the Electronic Medical Record (EMR) or, at a minimum, the paper health record in the event the EMR is unavailable, the medical contractor will follow the DPSCS medical record policy. Findings of all clinical encounters in the OTP are recorded in the health record as well as the Master Problem List.

II. Procedure:

A. There will be documentation that the OTP has verified that a detainee is enrolled in an approved community based OTP (CBOTP) agency prior to his or her incarceration. Copies of medical records from the CBOTP will be solicited via release of information signed by the detainee.

B. At a minimum, the OTP record should contain these elements:

1. Identifying information (e.g., inmate name, identification number, date of birth, sex, race);
2. A problem list containing medical and mental health diagnoses and treatments as well as known allergies;
3. Initial OTP and other health assessment forms;
4. Progress notes of all significant findings, diagnoses, treatments, and dispositions;

5. Provider orders for prescribed medication and medication administration records (MAR); reports to OTP treatment; consent and refusal forms; release of information forms;
6. Opioid treatment plan including but not limited to place, date, and time of each clinical encounter; and signature and title of each professional adding an entry.
7. Progress notes reflecting consideration for methadone with information that was considered in making the inmate ineligible for OTP if applicable.

C. Integration of electronic and paper health information will be completed according to established procedures.
   1. At a minimum, a list of current problems and medications is common to all mental health, medical and OTP records and will be available in the EMR.
   2. All changes in medication dosages will be documented in the medical record.

D. Basic medical and OTP health information must be shared among health team members to ensure continuity of care and avoid adverse outcomes because of lack of coordination.

E. Identification of record entries may be by written signature, initials, rubber-stamped signature (that is initialed) or electronic signature as long a master record of the origin of those formats with printed name, title and signature is readily available in each medical record.

F. The problem-oriented health record structure is to be used. The problem list will remain active until the patient is removed from the OTP program.

G. Transfer of detainees within the pretrial system should reflect patient enrollment in OTP program to ensure continuity of care. A copy of the Medication Administration Record (MAR) must be included with the medical record that will accompany the individual being transferred.

H. Electronic health record systems should protect access and provide security of the record by the use of passwords. Procedures for “down time” and regular back-ups will be in place

III. References: None
IV. Rescissions: None
V. Date Issued: July 15, 2007

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Section O
CONFIDENTIALITY OF INFORMATION

I. Policy: To ensure that confidentiality of a patient's oral, written or electronic Opioid treatment record information is maintained in a confidential manner and shared only with those persons directly involved in the care of detainees, evidence will be kept that indicates the Opioid Therapy Program (OTP) staff receives instruction in maintaining patient confidentiality.

II. Procedure:
   A. OTP records not part of the EMR, but stored in the facility, will be maintained under secure conditions separate from other security or correctional records.
   B. Depending on the physical organization of health services at a facility, a hard-copy of OTP records may be kept separately or together with medical and mental health records.
   C. Access to OTP records and health information will be controlled by the Site Medical Director and Program Sponsor with OTP staff designated as appropriate.
   D. If records are transported by non-health staff, the records shall be kept in a sealed envelope or wrapper.
   E. Non-health care staff that observe or overhear clinical encounters shall be instructed that they are also required to maintain confidentiality.

III. References: None

IV. Rescissions: None

V. Date Issued: July 15, 2007
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Section P
INFORMED CONSENT

I. Policy: Participation in the Opioid Therapy Program (OTP) is governed by informed consent practices applicable in the State of Maryland. Inmates are encouraged to use their right to make informed decisions regarding health care and they are made aware that their participation in the OTP is voluntary. Informed consent of next of kin, guardian, or legal custodian is obtained when required by law.

II. Procedure:

A. Policy and procedure requires written documentation of informed consent for participation in OTP.

B. All relevant facts regarding the use of and treatment for opioid drugs will be explained to the detainee before the consent is obtained and before any treatment is instigated.

C. Informational materials that will be provided to detainees include a contract or agreement that outlines the rights and responsibilities of inmates participating in OTP. This document spells out, in detail, any reports that will be forwarded to the courts, correction officials, parole authorities, or DPSCS.

D. Inmates must consent in writing to sharing any confidential health information.

E. In facilities where an inmate is required to give “blanket” consent before treatment by the health services staff, written consent is still required for participation in the OTP.

III. References: None

IV. Rescissions: None

V. Date Issued: July 15, 2007
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Section Q
RIGHT OF REFUSAL

I. Policy: An inmate may refuse Opioid Therapy Program (OTP) evaluation and treatment or withdraw voluntarily at any time from participation. A patient's refusal of care is to be an informed decision, with all consequences explained to the individual. Inmates may not be punished for exercising the right of refusing treatment.

II. Procedure:

A. Any health evaluation and treatment refusal will be documented, follow DPSCS policy, and must include the following:

1. description of the nature of the service being refused,
2. evidence that the inmate has been informed of potential consequences to his or her health as a result of the refusal,
3. the signature of the patient; and,
4. the signature of a health services staff witness

B. In the event the patient does not sign the refusal form, it will be noted on the form by the health services staff and a witness to the refusal will be asked to sign:

1. If the health of the inmate is in jeopardy, housing for medical reasons cannot be refused, and the inmate should be monitored in the infirmary.
2. A multidisciplinary team approach to the medical management of the individual should be conducted. Included on that team should be mental health, substance abuse, social work professionals, and the physician at a minimum.

3. In situations where the refusal may seriously jeopardize the patient's health, the individual should be brought to the medical clinic, and both benefits and risks of the proposed treatment explained. The health professional (nurse, mid-level provider, or physician) will answer any questions the patient may have. If the patient wishes to decline treatment, he or she should be counseled about the possible medical consequences of that refusal; and,
4. If the patient refuses and the condition is not life threatening, he or she should be allowed to refuse treatment and decline in writing.
    a. If there are no dire consequences to the refusal (such as a missed appointment or a missed medication), the health professional may simply note in the record that the person was a no-show for sick call or refused medication.
    b. Documentation of missed doses of medication related to OTP should be brought to the attention of the provider immediately and documented on the MAR.
    c. Progress notes must reflect any referral to a provider.

C. Health professionals should counsel inmates who repeatedly do not keep clinic appointments. Detainees who have refused a particular treatment repeatedly when the health professional believes it to be in the patient's best interest should also be counseled. All counseling must be recorded in the patient's medical record.

D. Some refusals may result from system disincentives (e.g., holding sick call at a time that conflicts with other important programming) and should be addressed by exploring possible alternatives so that the conflicts are lessened or eliminated.

E. When the patient asks to withdraw from participation, the OTP will use a protocol that allows the withdrawal to take place in a therapeutic manner. If the inmate refuses to accept that protocol, placement in the infirmary for observation monitoring for withdrawal and potential intervention should be made.

III. References: None

IV. Rescissions: None

V. Date Issued: July 15, 2007

Reviewed: December 29, 2010
October 28, 2011
October 3, 2012
November 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

SUBSTANCE ABUSE MEDICAL MANAGEMENT MANUAL

Chapter 3
METHADONE POLICIES

Section R
CLINICAL PICTURE/CRITERIA FOR HOSPITALIZATION/CIWA SCALE

I. Policy: Clinicians dealing with persons who may be intoxicated or otherwise under the influence of controlled or illegal substances will have the tools to accurately assess opiate intoxication, opiate withdrawal, opiate overdose as well as other forms of intoxication or withdrawal.

II. Procedure:

A. The clinician will observe a picture of opiate intoxication that includes:
   1. consciousness;
   2. sedation;
   3. dizziness;
   4. drowsiness;
   5. somnolence;
   6. obtundancy;
   7. “nodding”;
   8. normal /to euphoric mood; and,
   9. an intake drug history that will be consistent with history of opiate use or other sedatives or hypnotics

B. The clinician will observe a picture of acute overdose that includes:
   1. unconsciousness;
   2. pin-point pupils; and
   3. slow and shallow respiration.

C. The clinician will observe a picture of opiate withdrawal that includes:
   1. anxiety,

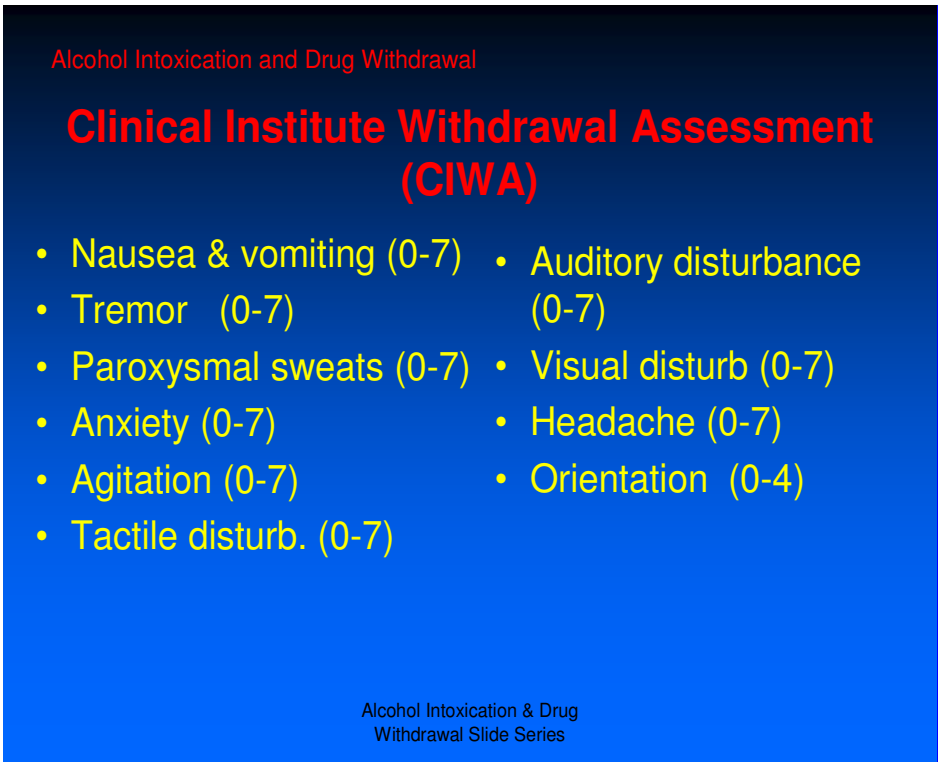
2. restlessness,
3. yawning,
4. nausea,
5. sweating,
6. nasal stuffiness,
7. stomach cramps,
8. drug-seeking behavior,
9. vomiting,
10. diarrhea,
11. muscle spasms,
12. muscle pain,
13. increased blood pressure,
14. tachycardia,
15. fever,
16. chills,
17. rhinorrhea,
18. lacrimation and,
19. dilated pupil

D. Based on clinical findings, the criterion for infirmary admission includes:
1. severe tremulousness,
2. fever,
3. mild hallucinosis,
4. mild confusion,
5. mild decrease in mental alertness,
6. mild hemodynamic instability if the staffing in the level of care is of such a nature that vital signs cannot be monitored frequently, round the clock; and,
7. complicated polysubstance that is causing altered sensorium or mild hemodynamic instability.

E. Based on clinical findings, the criteria for hospitalization include:
1. severe dehydration/severe hemodynamic instability,
2. signs of overdose as outlined above,

3. patient is unconscious ,
4. pupils are pin-point,
5. respiration is slow and shallow,
6. co-morbidities that by themselves require hospital treatment,
7. co-morbidities that are associated with polysubstance abuse, intoxication or overdose (such as aspiration pneumonia, status epilepticus, severe altered mental status, gastrointestinal bleeding, unexplained and serious head trauma),
8. co-morbidities that would complicate detoxification (example-poorly controlled diabetes, hypertension, seizure disorder),
9. co-morbid mental illness that would complicate detoxification-example suicidal ideations, gestures, attempts, acutely decompensating mental illness; and,
10. complicated polysubstance abuse that is causing severe altered sensorium or moderate to severe hemodynamic instability.

F. CIWA Scale



III. References: None

IV. Rescissions: None

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