Provincial Health Services Authority

Correctional Health Services - Update

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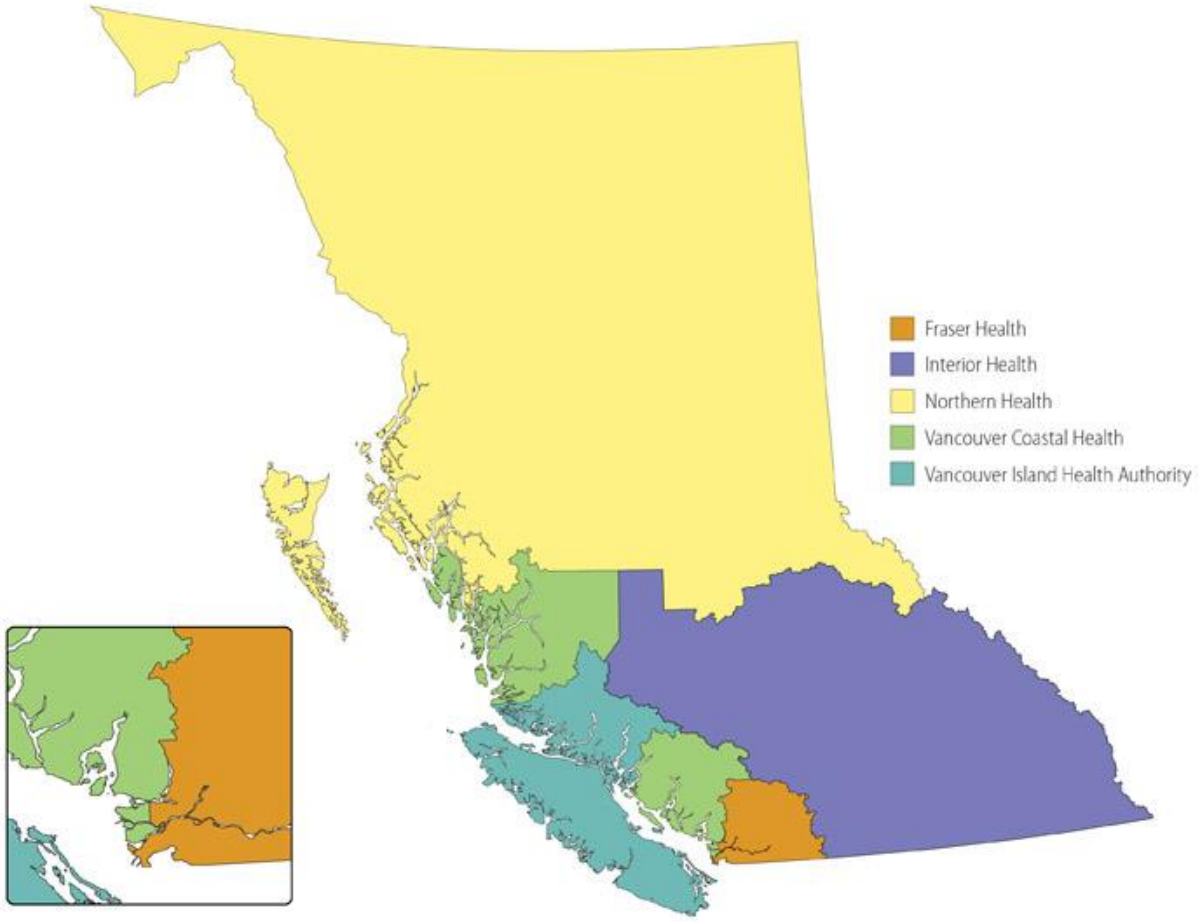
Andrew MacFarlane

April 11/2018

BC MENTAL HEALTH
& SUBSTANCE USE SERVICES
An agency of the Provincial Health Services Authority

Similar to FNHA, PHSA covers the entire province of BC



Correctional Health Services

Reason for the Change – October 1st, 2017

Health Services are previously delivered at 10 Correctional Centres by a for profit service provider.

- Poor health status of the inmate population
- Reviews, audits, reports calling for change
  - WHO report (2013)
  - BC Coroner's Report (2014)
  - BC Auditor General Report (2015)

Provincial Health Service Authority

- BC Cancer Agency
- BC Centre for Disease Control
- BC Women's and Children's Hospital
- BC Emergency Health Services
- BC Renal Agency
- BC Transplant
- BC Mental Health and Substance Use Services (including Correctional Health Services).

BC Mental Health & Substance Use Services

An Agency of the Provincial Health Services Authority

Burnaby Centre for Mental Health & Addictions

Heartwood Centre for Women

Forensic Psychiatric Services

Correctional Health Services

Provincial Specialized Programs
(commissioned)

Continuum

Research & Knowledge Translation & Exchange

Provincial Planning & Strategic Networking

Academic Teaching/Training

MHSU Literacy (BC Partners)

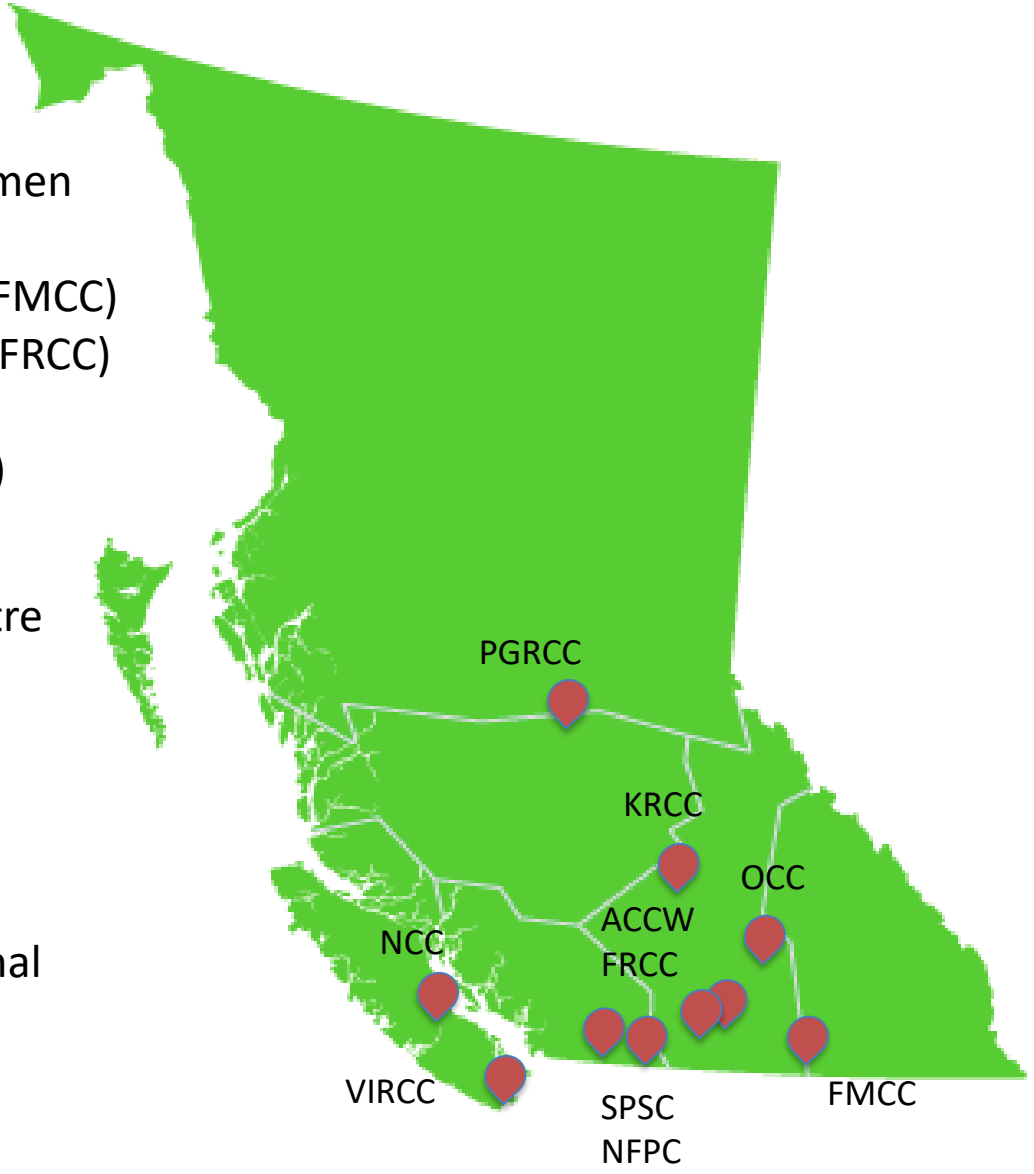
Provincial Correctional Centres

Lower Mainland

- Alouette Correctional Centre for Women (ACCW)
- Ford Mountain Correctional Centre (FMCC)
- Fraser Regional Correctional Centre (FRCC)
- North Fraser Pretrial Centre (NFPC)
- Surrey Pretrial Services Centre (SPSC)

Vancouver Island, Interior, Northern

- Kamloops Regional Correctional Centre (KRCC)
- Nanaimo Correctional Centre (NCC)
- Okanagan Correctional Centre (OCC)
- Prince George Regional Correctional Centres (PGRCC)
- Vancouver Island Regional Correctional Centre (VIRCC)

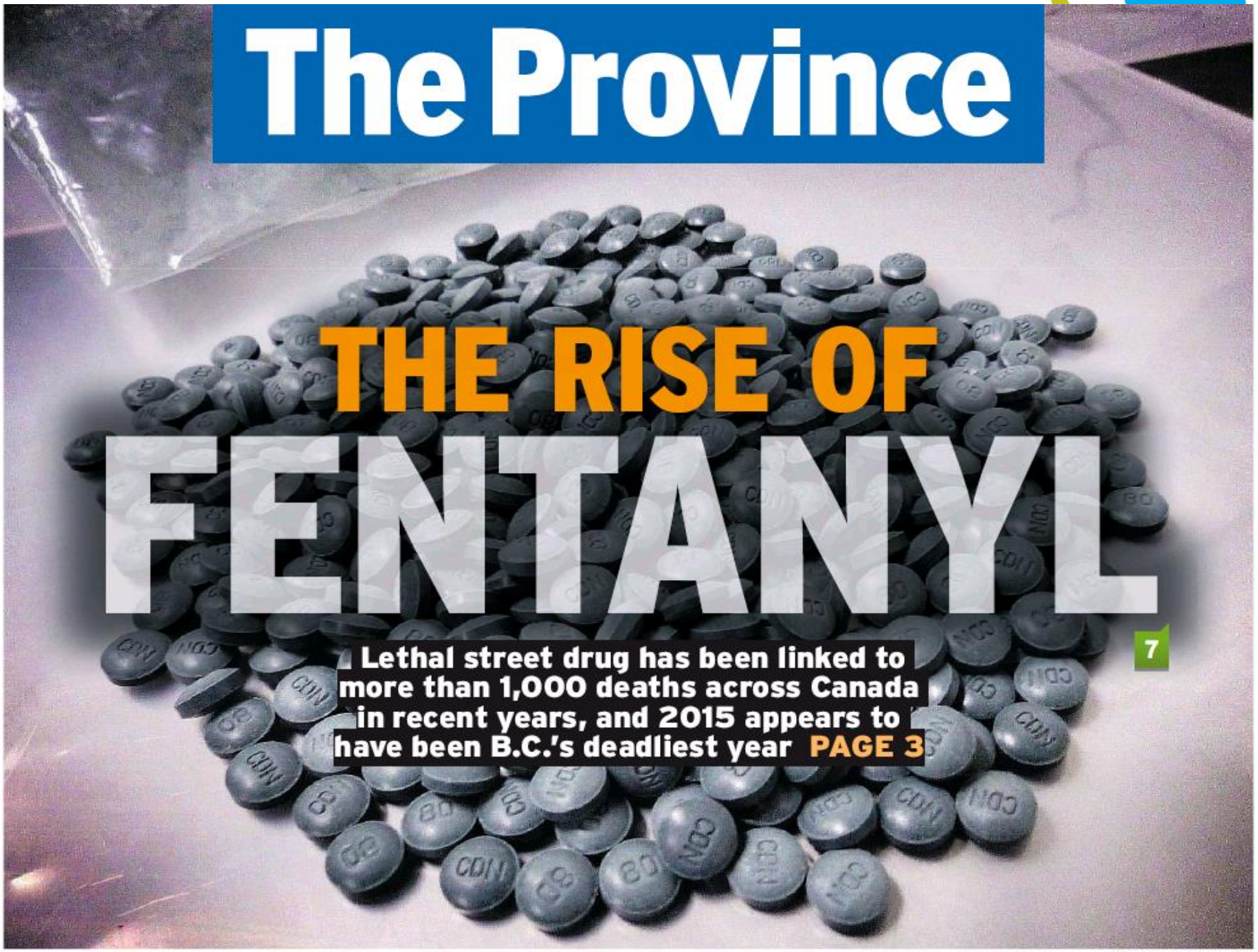


CHS Strategic Direction:

improve the quality of health care in provincial correctional centres

- Eliminate barriers to accessing health care for inmates
- Implement evidence-based clinical guidelines, standards and practices in Correctional Health
- Improve the continuity of care by improving transitions between correctional facilities and RHAs, primary care and community services
- Enhance the skills and clinical competencies of all correctional health disciplines
- Improve reporting and accountability by developing and tracking performance indicators
- Prepare and implement Accreditation in 2021
- Develop strong partnerships with BC Corrections and Ministry of Public Safety & Solicitor General, RHAs, community providers and other stakeholders

The Province



THE RISE OF FENTANYL

Lethal street drug has been linked to more than 1,000 deaths across Canada in recent years, and 2015 appears to have been B.C.'s deadliest year PAGE 3

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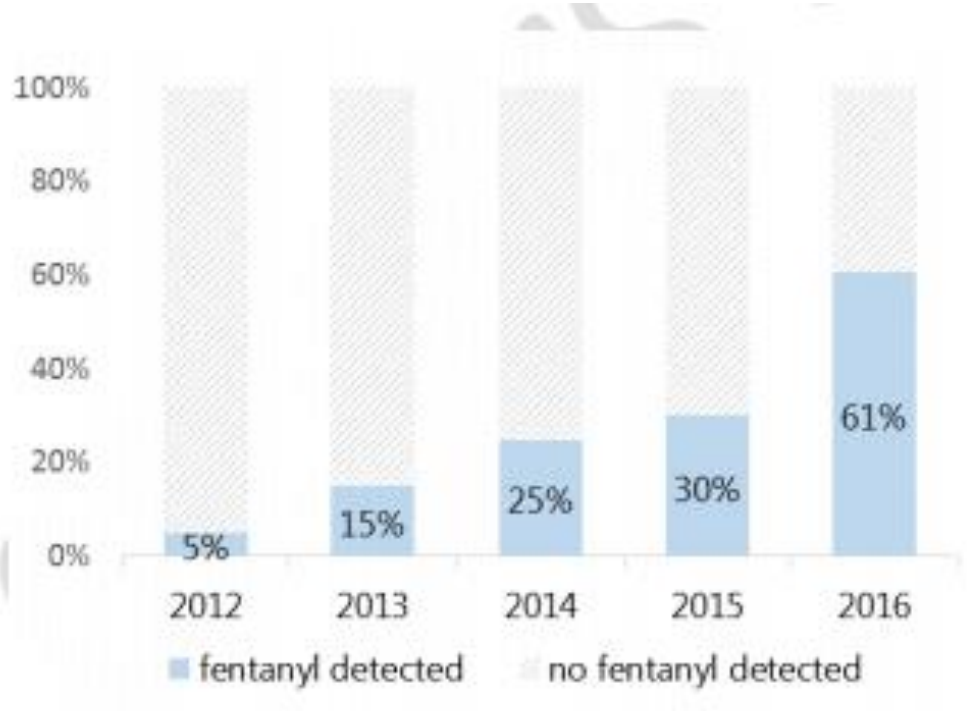
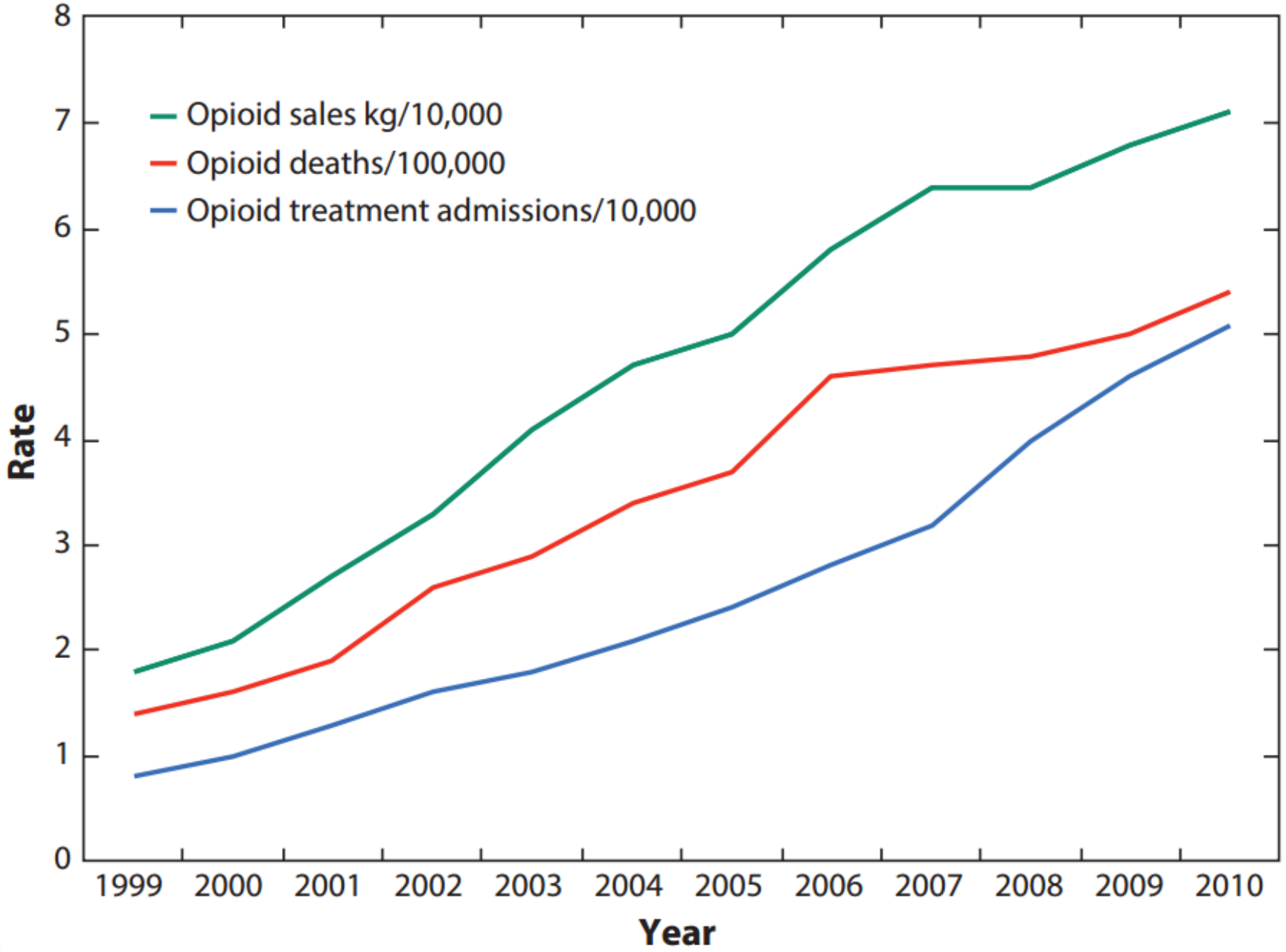
— THE CANADIAN PRESS FILES



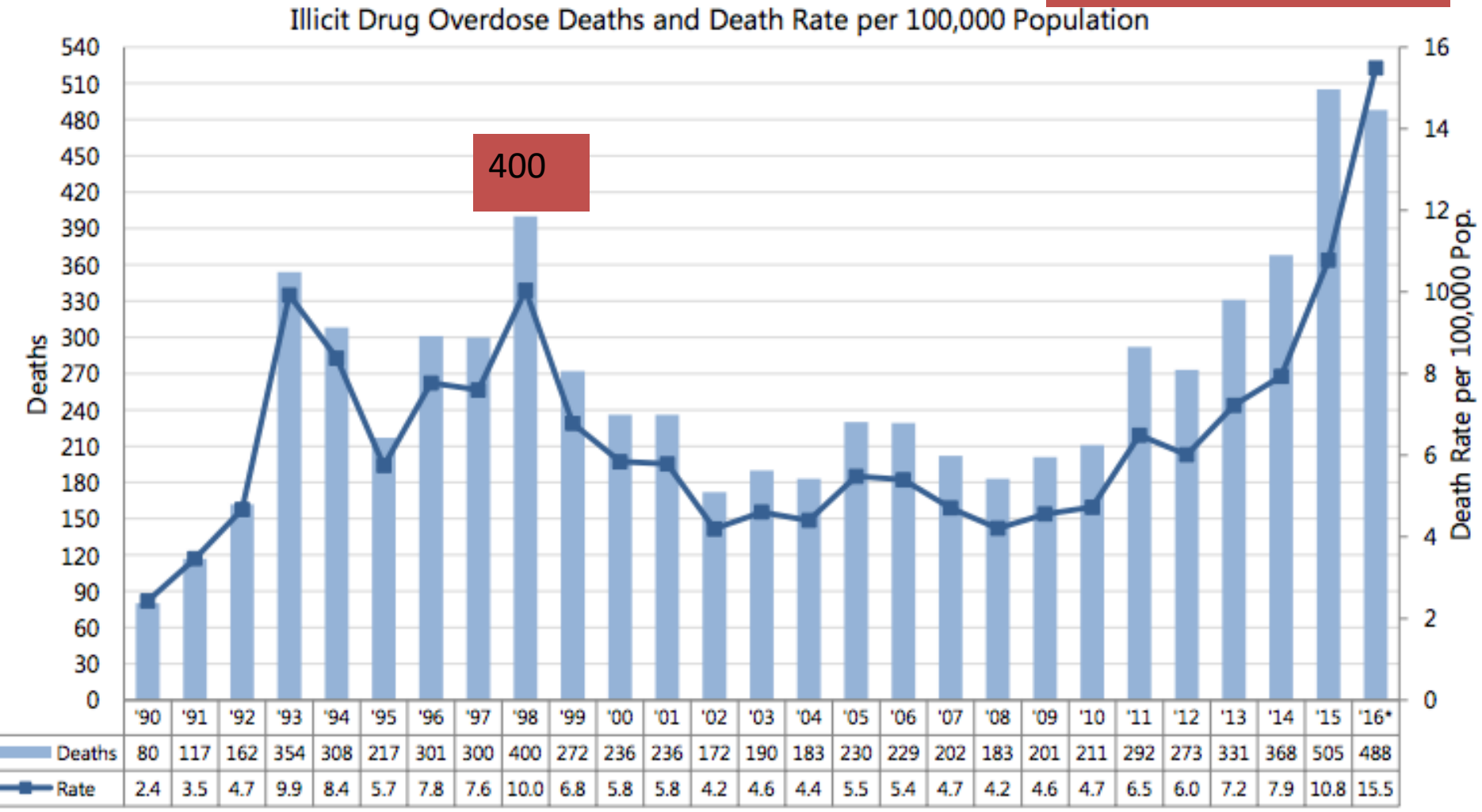
Illicit Drug Overdose Deaths With Fentanyl Detected, 2012-2016[2]



Source: Annual Review of Public Health

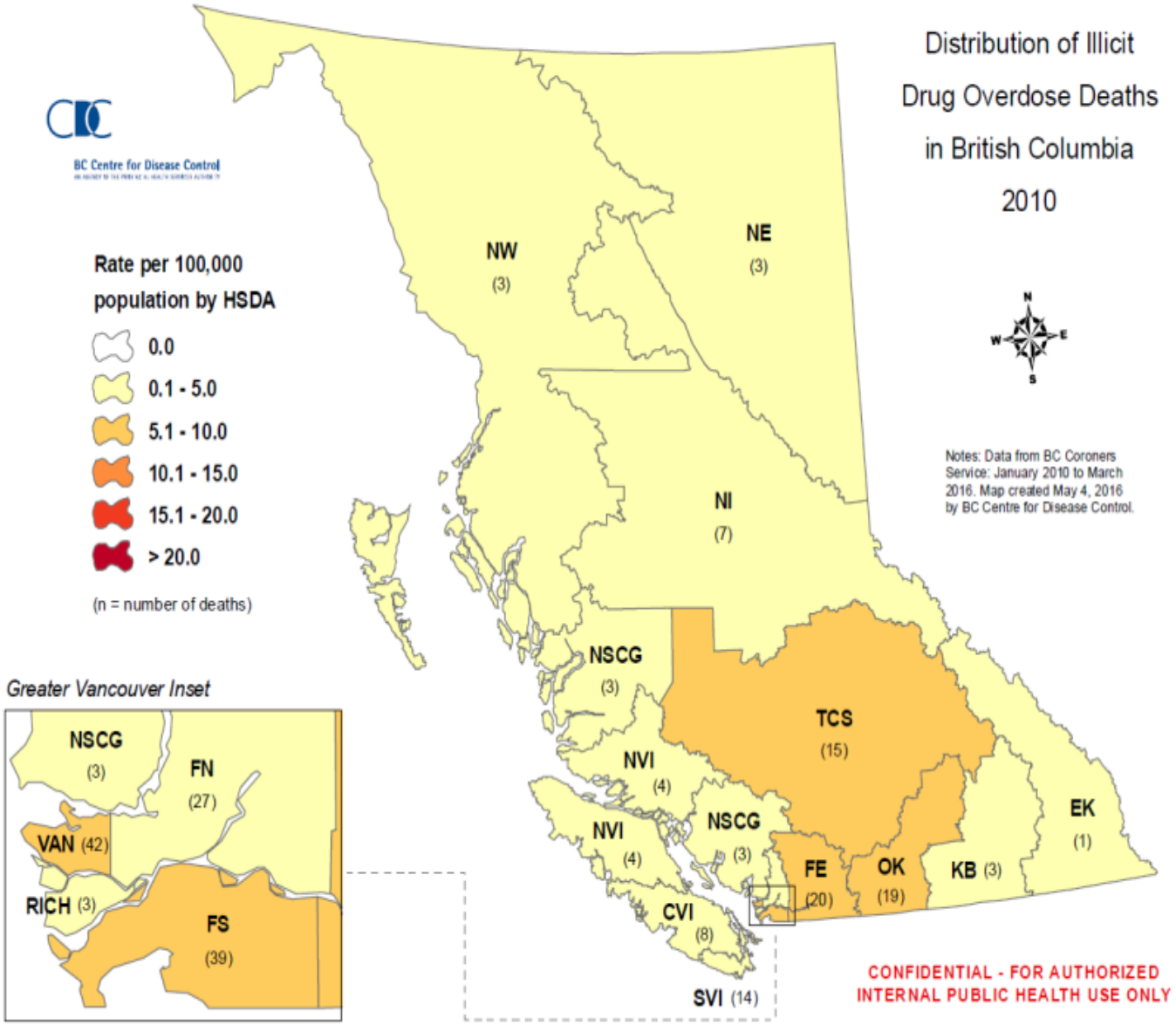

ILLICIT DRUG OVERDOSE DEATHS IN BRIT

Oct 2016
662 deaths



http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

2010


BC Centre for Disease Control
Distribution of Illicit
Drug Overdose Deaths
in British Columbia
2010
Rate per 100,000
population by HSDA
0.0
0.1 - 5.0
5.1 - 10.0
10.1 - 15.0
15.1 - 20.0
> 20.0
(n = number of deaths)
Notes: Data from BC Coroners Service: January 2010 to March 2016. Map created May 4, 2016 by BC Centre for Disease Control.
N
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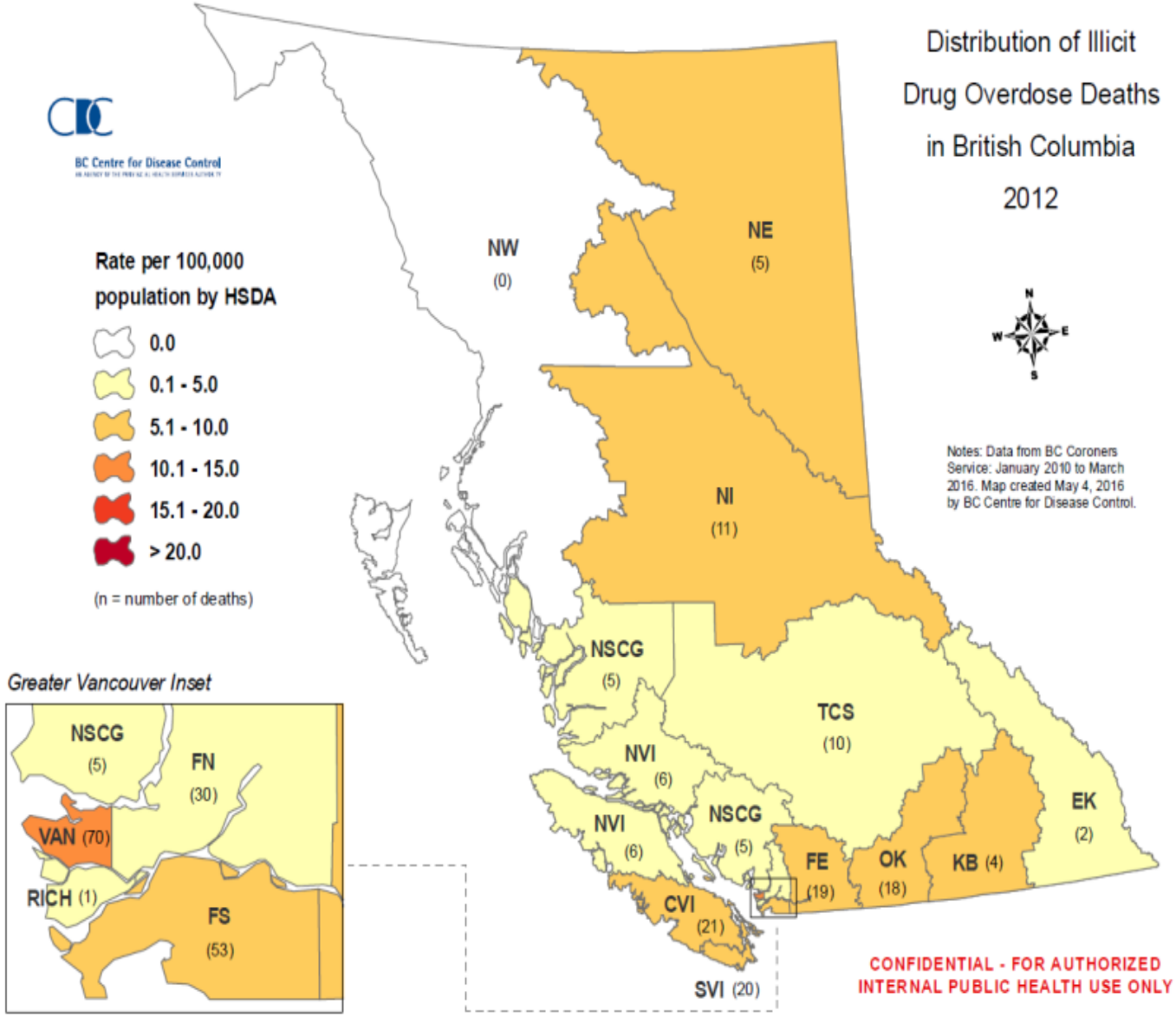
NW
(3)
NE
(3)
NI
(7)
NSCG
(3)
TCS
(15)
NVI
(4)
NVI
(4)
NSCG
(3)
EK
(1)
FE
(20)
OK
(19)
KB (3)
CVI
(8)
SVI (14)
Greater Vancouver Inset
NSCG
(3)
FN
(27)
VAN (42)
RICH (3)
FS
(39)
CONFIDENTIAL - FOR AUTHORIZED
INTERNAL PUBLIC HEALTH USE ONLY

2012


Distribution of Illicit Drug Overdose Deaths in British Columbia 2012
BC Centre for Disease Control
Rate per 100,000 population by HSDA
0.0
0.1 - 5.0
5.1 - 10.0
10.1 - 15.0
15.1 - 20.0
> 20.0
(n = number of deaths)
Notes: Data from BC Coroners Service: January 2010 to March 2016. Map created May 4, 2016 by BC Centre for Disease Control.
NW (0)
NE (5)
NI (11)
NSCG (5)
TCS (10)
NVI (6)
NVI (6)
NSCG (5)
CVI (21)
SVI (20)
FE (19)
OK (18)
KB (4)
EK (2)
Greater Vancouver Inset
NSCG (5)
FN (30)
VAN (70)
RICH (1)
FS (53)
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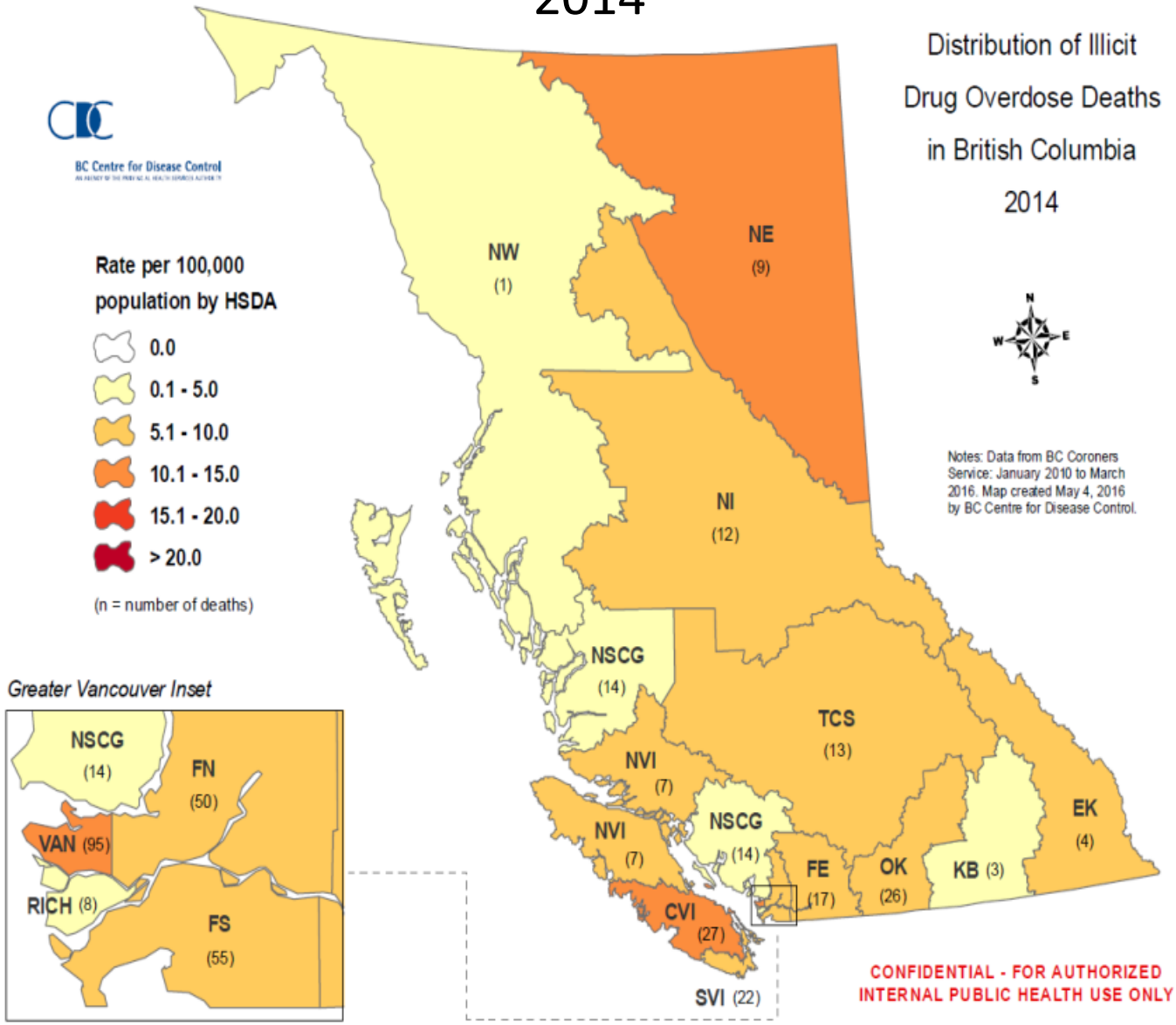
2014


BC Centre for Disease Control
Distribution of Illicit Drug Overdose Deaths in British Columbia 2014
Rate per 100,000 population by HSDA
0.0
0.1 - 5.0
5.1 - 10.0
10.1 - 15.0
15.1 - 20.0
> 20.0
(n = number of deaths)
Notes: Data from BC Coroners Service: January 2010 to March 2016. Map created May 4, 2016 by BC Centre for Disease Control.
NW (1)
NE (9)
NI (12)
NSCG (14)
TCS (13)
NVI (7)
NVI (7)
NSCG (14)
FE (17)
OK (26)
KB (3)
EK (4)
CVI (27)
SVI (22)
Greater Vancouver Inset
NSCG (14)
FN (50)
VAN (95)
RICH (8)
FS (55)
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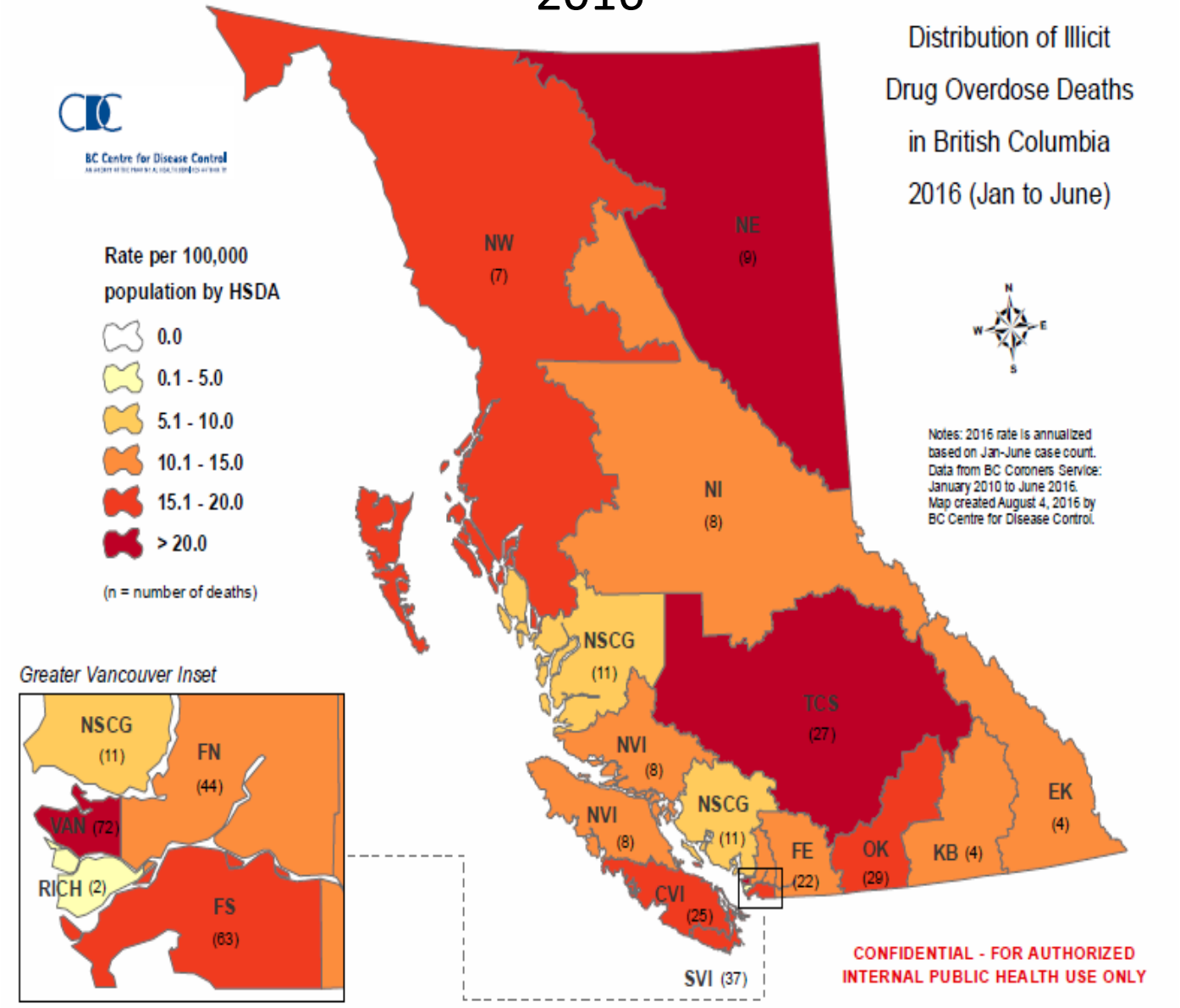
2016


BC Centre for Disease Control
Distribution of Illicit Drug Overdose Deaths in British Columbia 2016 (Jan to June)
Rate per 100,000 population by HSDA
0.0
0.1 - 5.0
5.1 - 10.0
10.1 - 15.0
15.1 - 20.0
> 20.0
(n = number of deaths)
Notes: 2016 rate is annualized based on Jan-June case count. Data from BC Coroners Service: January 2010 to June 2016. Map created August 4, 2016 by BC Centre for Disease Control.
N
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NW (7)
NE (9)
NI (8)
NSCG (11)
TCS (27)
NVI (8)
NVI (8)
NSCG (11)
FE (22)
OK (29)
KB (4)
EK (4)
CVI (25)
SVI (37)
Greater Vancouver Inset
NSCG (11)
FN (44)
VAN (72)
RICH (2)
FS (63)
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BC Coroners Service Death Review Panel: A Review of Illicit Drug Overdoses, March 28, 2018

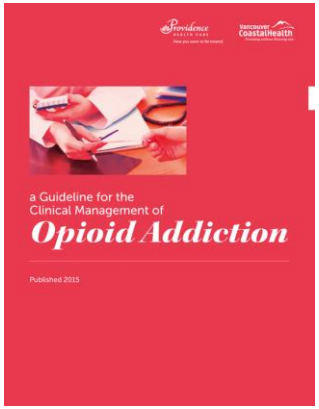
- OD Deaths Jan 1-Dec 31, 2016
  - Northern, 52 deaths
  - Death rate per 100,000 = 18.5
- OD Deaths Jan 1-July 31, 2017
  - Northern, 31 deaths
  - Death rate per 100,000 = 18.0
- Indigenous persons represent 10% of overdose deaths
- PGRCC 60-80% indigenous population
- Sixty-six percent had involvement with BC Corrections
  - 10% died within 30 days of release
  - [OD risk 6-8 times higher than general population 1 week post release]

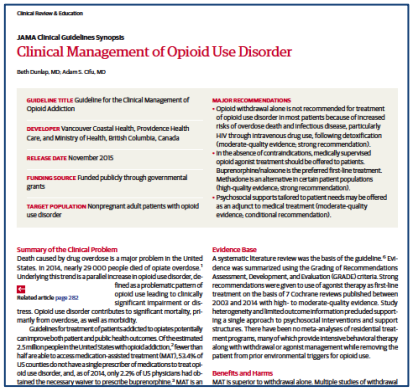
BC Coroners Service Death Review Panel: A Review of Illicit Drug Overdoses, March 28, 2018

- Recommendations for Correctional Population on Release
  - Take Home Naloxone
  - Access to drug checking services
  - Linkage to addiction services including opioid agonist treatment

Current State of Correctional Health Services Response to Opioid Overdose Epidemic

- Current State at Correctional Health Services
  - Take Home Naloxone
  - Access and Transition Nurses
  - OAT Nurse
  - MHSU Nurse
  - Expanded OAT clinics
    - Currently 30-35% of population on OAT
    - Reduction in wait list to to zero
  - Matrix and Smart Recovery





Clinical Review & Education

JAMA Clinical Guidelines Synopsis

Clinical Management of Opioid Use Disorder

Beth Dunlap, MD; Adam S. Cifu, MD

GUIDELINE TITLE Guideline for the Clinical Management of Opioid Addiction

DEVELOPER Vancouver Coastal Health, Providence Health Care, and Ministry of Health, British Columbia, Canada

RELEASE DATE November 2015

FUNDING SOURCE Funded publicly through governmental grants

TARGET POPULATION Nonpregnant adult patients with opioid use disorder

MAJOR RECOMMENDATIONS

- Opioid withdrawal alone is not recommended for treatment of opioid use disorder in most patients because of increased risks of overdose death and infectious disease, particularly HIV through intravenous drug use, following detoxification (moderate-quality evidence, strong recommendation).
- In the absence of contraindications, medically supervised opioid agonist treatment should be offered to patients. Buprenorphine/naloxone is the preferred first-line treatment. Methadone is an alternative in certain patient populations (high-quality evidence, strong recommendation).
- Psychosocial supports tailored to patient needs may be offered as an adjunct to medical treatment (moderate-quality evidence, conditional recommendation).

Summary of the Clinical Problem

Death caused by drug overdose is a major problem in the United States. In 2014, nearly 29 000 people died of opiate overdose.[1] Underlying this trend is a parallel increase in opioid use disorder, defined as a problematic pattern of opioid use leading to clinically significant impairment or distress. Opioid use disorder contributes to significant mortality, primarily from overdose, as well as morbidity.

Related article page 282

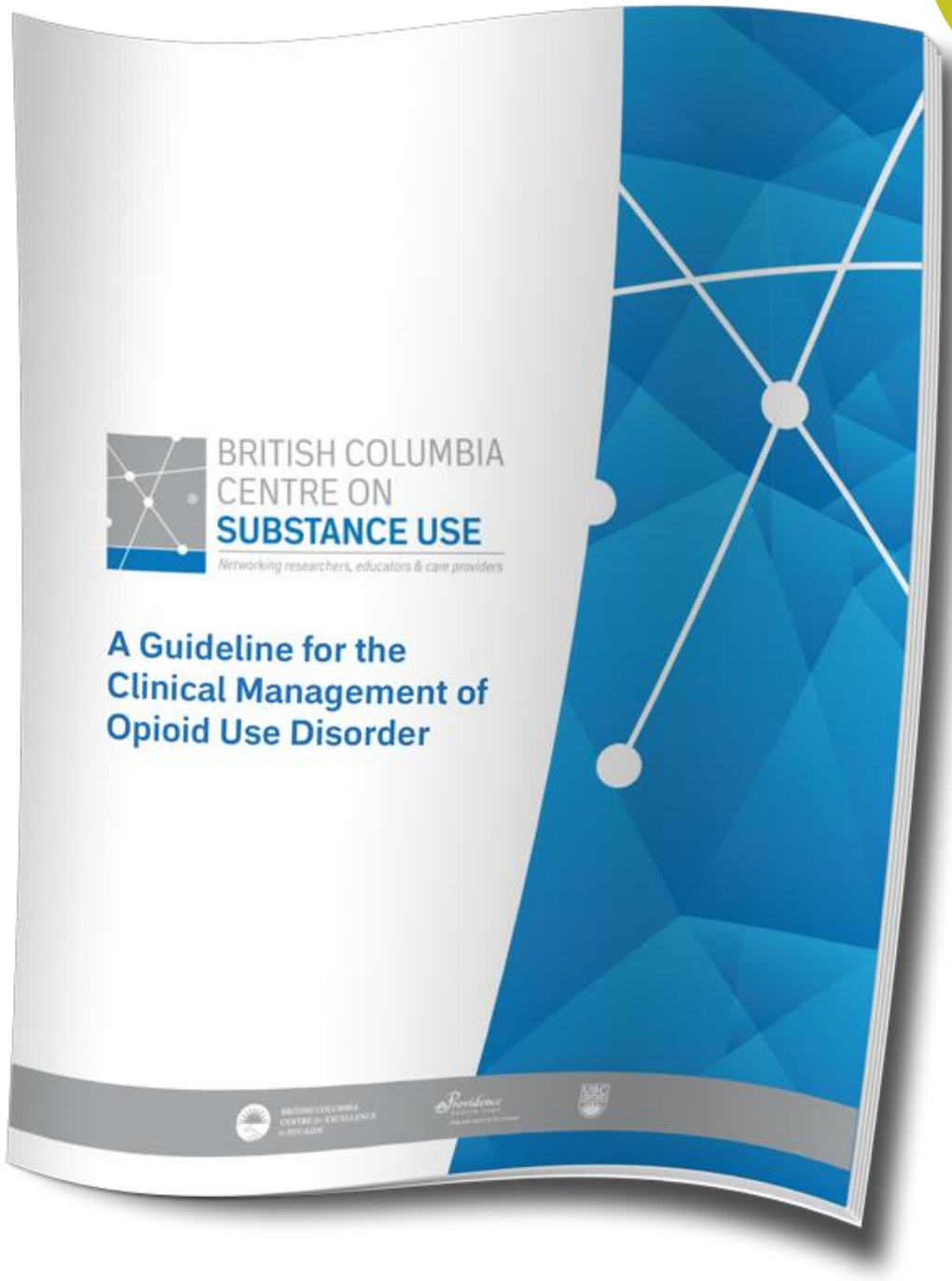
Guidelines for treatment of patients addicted to opiates potentially can improve both patient and public health outcomes. Of the estimated 2.5 million people in the United States with opioid addiction,[1] fewer than half are able to access medication-assisted treatment (MAT). 53.4% of US counties do not have a single prescriber of medications to treat opioid use disorder, and, as of 2014, only 2.2% of US physicians had obtained the necessary waiver to prescribe buprenorphine.[2] MAT is an

Evidence Base

A systematic literature review was the basis of the guideline.[3] Evidence was summarized using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria. Strong recommendations were given to use of agonist therapy as first-line treatment on the basis of 7 Cochrane reviews published between 2003 and 2014 with high- to moderate-quality evidence. Study heterogeneity and limited outcome information precluded supporting a single approach to psychosocial interventions and support structures. There have been no meta-analyses of residential treatment programs, many of which provide intensive behavioral therapy along with withdrawal or agonist management while removing the patient from prior environmental triggers for opioid use.

Benefits and Harms

MAT is superior to withdrawal alone. Multiple studies of withdrawal



Release date
January 2017

What does work for opioid addiction:
Opioid Agonist Therapy

Methadone

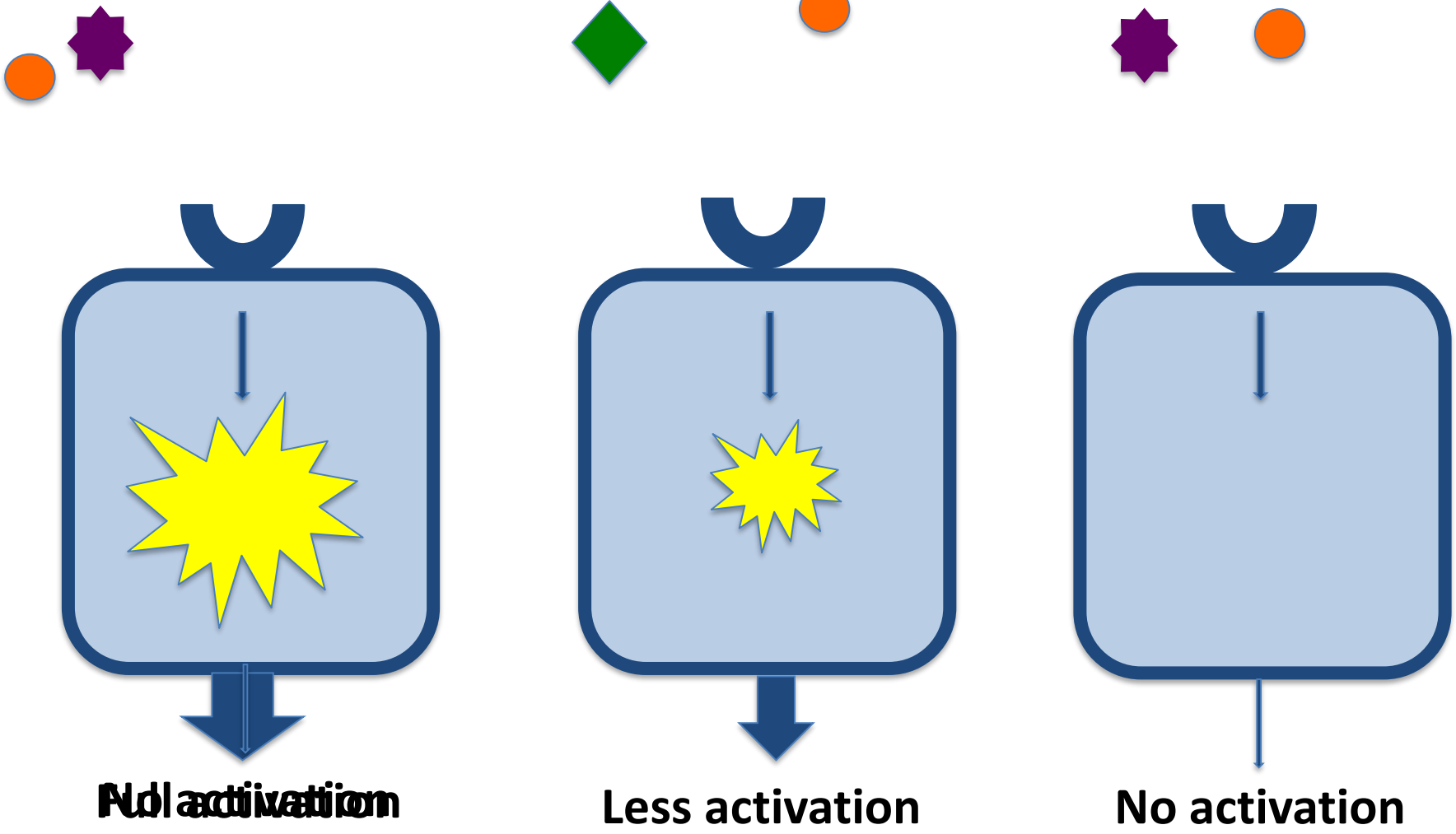
Buprenorphine/naloxone (Suboxone®)

Treatment duration: usually at least 12 months and then a slow taper

Full Agonist
(i.e. heroin, methadone, morphine)

Partial Agonist
(i.e. buprenorphine)

Antagonist
(i.e. naloxone, naltrexone)



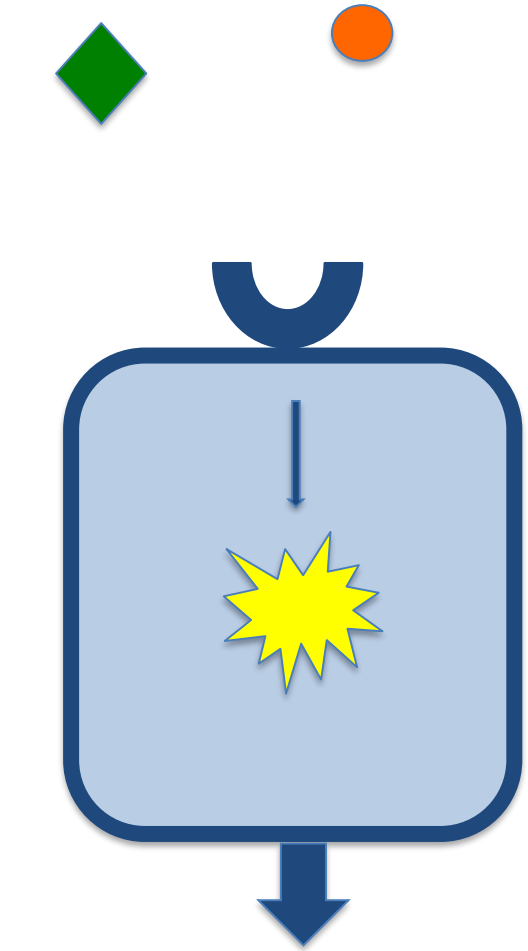
Full activation

Less activation

No activation

Partial Agonist

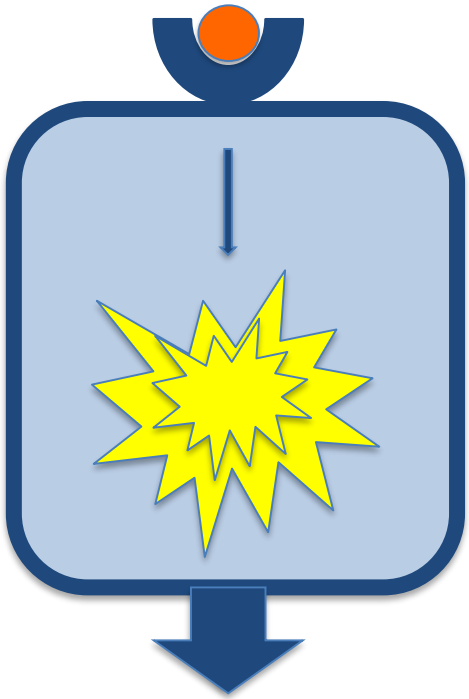
(i.e. buprenorphine/naloxone - Suboxone)



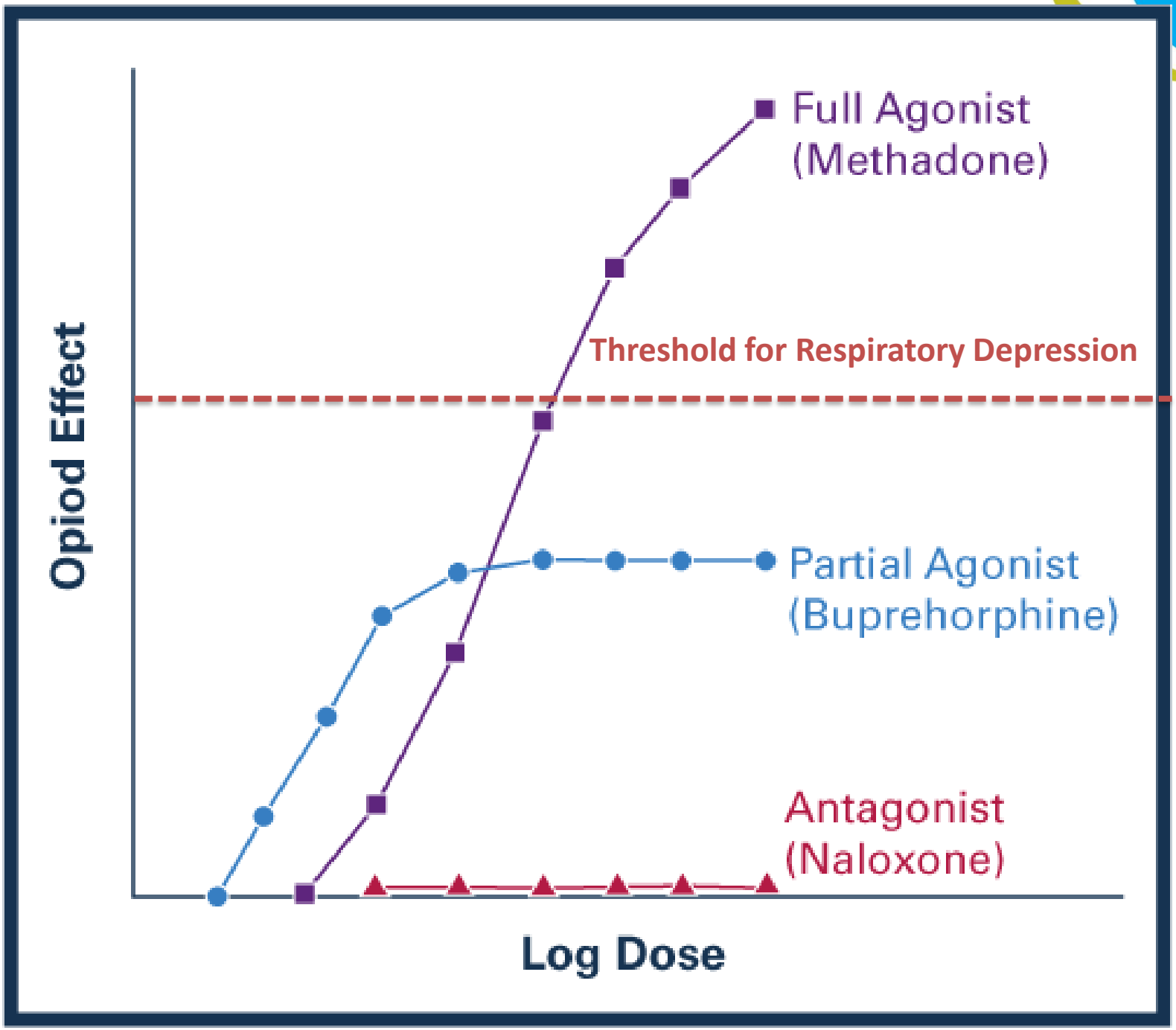
Partial activation

Full Agonist
(i.e. heroin, methadone, morphine)

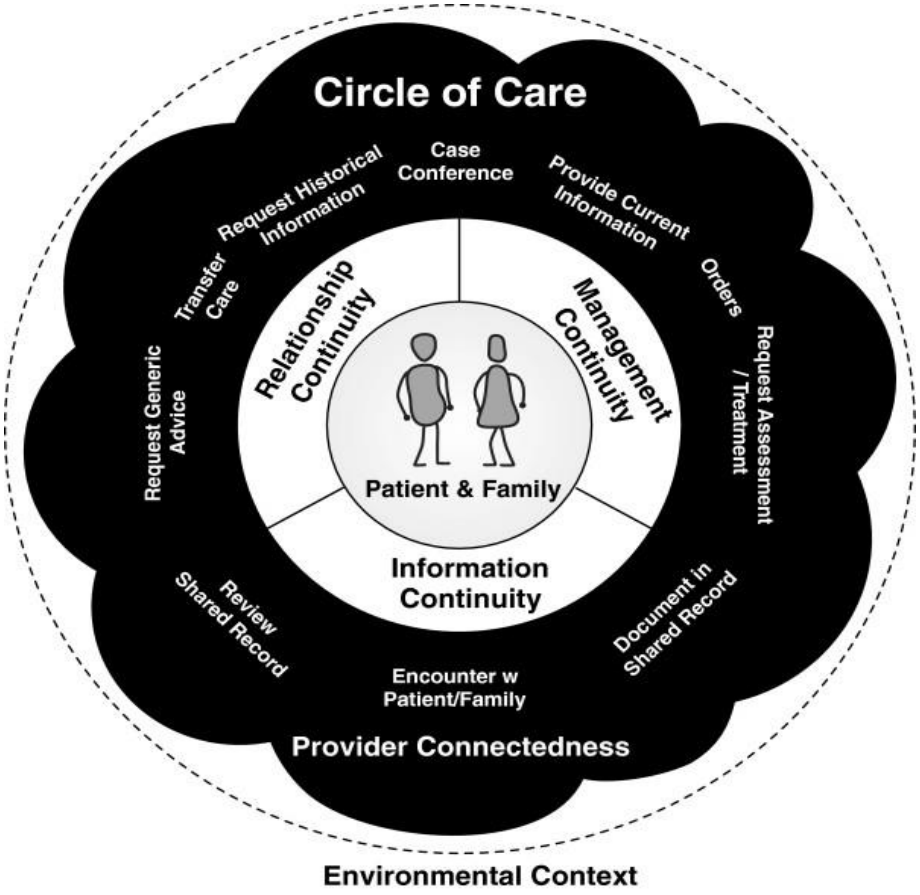
Partial Agonist
(i.e. buprenorphine)



This relative difference between full activation of the receptor and partial activation of the receptor is called **'PRECIPITATED WITHDRAWAL'**


Full Agonist
(Methadone)
Threshold for Respiratory Depression
Partial Agonist
(Buprehorphine)
Antagonist
(Naloxone)
Opiod Effect
Log Dose

Increase focus on transitions/ continuity of care



Our Vision
Where we want to go with CHS

- Engage clients and internal and external supports in the health care system to increase the quality of primary, mental health, and substance use care in custody and enhance the continuity of care upon release.
- We want to be able to have established discharge plans so that we can do the “warm hand-off” and insure that our clients make it to their community physician, their pharmacy to pick up their medications, their mental health team, or treatment centre.

Questions