

# Guidance on Contingency Planning for People who use Drugs and COVID-19

Version 2.0

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Updated May 2020



## Who is this guidance for?

This guidance has been developed to support those planning and designing services as well as those managing and delivering services for people who use drugs (PWUD), in particular those people on opioid substitution therapy (OST) and people who inject drugs.

The aim is to ensure that essential treatment and harm reduction services for this vulnerable group of people can adapt to ensure high standard service delivery in the challenging circumstances of the pandemic.

The guidance is designed to help services

- Maintain services that support and treat people who are affected by problem drug use
- Ensure that people using their service and others are supported to comply with Government guidance on social distancing, self-isolating and shielding.

To achieve this the guidance lays out examples of issues people planning and delivering services may face or are actually facing; suggestions for how these issues may be addressed with good practice examples from Scotland where these exist and some of the evidence base for suggested practice changes.

## Who compiled this guidance?

This guidance was drafted by Scottish Drugs Forum in collaboration with the Sexual Health and Blood Borne Virus Prevention Leads Network, co-ordinated by the Scottish Health Protection Network. The Drug Death Task Force MAT group have also reviewed the guidance. There has been wider consultation on draft versions of this guidance.

## Acknowledgements

The process of developing this guidance and the guidance itself has been informed and enhanced by colleagues and professionals across the drugs field in Scotland, and beyond, who have shared their insights and experiences and offered practical support including in sharing evidence base for practice changes and service protocols – including those appended to this version of the Guidelines.

SDF thanks all the people who have been able to take the time and make the effort to support this work in what for many of us are very challenging times, personally and professionally.

## Disclaimer

COVID-19 is a rapidly evolving pandemic with national advice and guidance updated regularly. This document is accurate at the point of publication and will be reviewed regularly and updates issued as and when required.

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## Introduction

The initial response to the COVID19 pandemic made by those planning and delivering local services has meant that a diversity of approaches and issues now exists across Scotland. While there have been interesting and even very positive innovations, some initial developments have raised significant concerns both in terms of maintaining treatment and harm reduction service provision and in protecting people from possible coronavirus infection by supporting them to social distance, self-isolate or be shielded as appropriate. Concern was such that a letter was sent to Alcohol and Drug Partnerships (ADPs), Health and Social Care Partnerships (HSCPs) and Integration Joint Boards (IJBs) by the Minister For Public Health and the Interim Chief Medical Officer<sup>1</sup> expressing concern and reaffirming that substance use services are to be regarded and managed as essential services that are to be prioritised and maintained.

This Guidance supports ADPs, HSCPs and IJBs in understanding issues that have arisen or may be envisaged and supporting the development of essential service provision.

The following are some of key issues that have been identified, either as additional issues or an expansion of the issues raised in Version 1.0 of this guidance published in March:

- **The moves to OST ‘take home’ doses and the clinical management and support of the most vulnerable people using services**
- **Clinical management and support of those using street benzodiazepines**
- **Identification and swift access to OST for those people with an opioid dependence who are not in treatment**
- **Support of people with a substance problem who are homeless**
- **Clinical management and continuity of care of those released from prison**
- **Clinical management and support of people who have a stimulant-based substance use problem**
- **Issues raised by the need for self-isolation and shielding by PWUD**
- **Changes to the delivery of IEP and naloxone services including through postal services**
- **BBV testing and treatment capacity**
- **Maintaining compliance with and supporting social distancing and other COVID-related advice**
- **Ensuring adequate deployment of key substance use staff including hospital liaison nurses**

## Background

Interruption to the existing provision of OST and associated clinical care can put people at increased risk of overdose and, in turn, drug-related death. It is also likely to result in people sourcing illicit drugs as an alternative and thus putting themselves at further increased risk from harm including overdose, blood-borne viruses, related infections and, potentially, increasing the risk of COVID-19 exposure or transmission.

**It is essential to ensure that people are engaged and maintained in treatment and that adequate OST services are continued.**

Due to control measures in response to COVID-19, pharmacies and other services have reduced their frontline, patient-facing services. Among the consequences of this is that many people on OST have been moved from daily or frequent supervised dispensing to 'take home doses', many for the first time in their treatment histories.

In Scotland, there are around 300 sites offering injecting equipment provision (IEP), with around 300,000 attendances and over four million needles and syringes distributed per annum. Since the pandemic began, this essential harm reduction service has been constrained by a reduction in the number of IEP sites; a reduction of opening hours of IEP sites including pharmacies and decreased accessibility with service-users sometimes needing to join lengthy queues.

Reduced access to sterile injecting equipment will increase the risk of equipment re-use and the sharing of injecting equipment which, in turn, increases the risk of skin and soft tissue infections, spore-forming bacterial and blood-borne virus infections in a population with existing high prevalence of viral hepatitis and HIV.

**It is essential to ensure that adequate IEP is maintained.**

Potential strategies to address this include providing people with larger supplies at each presentation and the development of postal IEP provision to maintain, if not increase, national coverage.

Reports suggest that the supply of illicit drugs have been disrupted during the lockdown across the country, with some limited exceptions. There are also expected issues for people using drugs in meeting their usual suppliers and purchasing drugs due to social distancing and restrictions on travel. Variations in drug availability results in people diverging from substances they are used to, consuming unfamiliar substances of variable strengths and in different ways. Poly-substance use is likely to become more common. In order to sustain the effect of their limited supply of drugs, individuals may start using more harmful ways of consumption for example, injecting.

**All of these changes increase the risk of overdose and drug-related deaths.**

In response to this disrupted drug supply chain, some areas are already reporting that more people are seeking access to treatment and support. This includes more vulnerable stimulant users who may not have been previously visible to services.

**It is essential that services are accessible to new clients and patients, particularly with regards to OST and naloxone.**

Access to treatment is vital to ensure that the most vulnerable PWUD are able to self-isolate even if not classified as requiring shielding.

## 1 Emerging issues and challenges

### 1.1 Increasing the rate of 'take home' supply of OST

There have been very significant changes to the dispensing arrangements for OST across Scotland since 'lockdown' began with a high proportion of people now receiving 'take home' doses of their medication. In some areas, this has been a radical shift from the previous practice of the majority people being on daily supervised dispensing. There are clearly risks in this for the more vulnerable among people using services. For example, OST patients affected by homelessness may not have a safe storage option for their take home doses; others may become targets for exploitation due to their prescriptions; and others may struggle to take their medications as prescribed. Most areas have developed an individualised process whereby there is a discussion with the person regarding receiving a take home supply. Alternative options developed for some patients include daily delivery of OST or the collection of OST daily by someone else collecting on behalf of the patient. These options support self-isolation and shielding. For those patients who, after discussion of options, feel that a take home supply is unsuitable the continuation of the daily pick up regime may be appropriate.

Home delivery will be essential for those who are self-isolating, have been identified as person requiring shielding or have locally been identified as person who, because of underlying health conditions, is particularly vulnerable to COVID-19. A variety of ways of providing home delivery have been developed through drug and alcohol staff, volunteers and redeployed employees undertaking the delivery of medication. It has also been possible to allow pick up of medication to be undertaken by someone on behalf of the patient.

### 1.2 Benzodiazepine use and prescribing options

A rise in the availability of street benzodiazepines, including drugs such as etizolam and alprazolam, and the associated increased risk of overdose and death requires a nuanced and pragmatic approach to risks of benzodiazepine use in Scotland. Reducing the harms associated with the problematic use of benzodiazepines for those with a co-dependence on opioids is a current consideration of the Drug Death Taskforce Medication Assisted Treatment Subgroup.

As such, the particular pattern of benzodiazepines use among many people who use drugs in Scotland, the serious potentially dangerous withdrawals many can suffer (including rebound anxiety), and the added relative risks they may take in order to source an illicit supply, cannot be ignored in the current context. This forms part of a clinical decision to prescribe and meets the key public health objectives of the COVID 19 response to identify groups of particular concern for whom additional measures are required. Similar to the rationale of providing and supporting access to OST, benzodiazepine prescribing is a means to enable PWUD to comply with social distancing and self-isolation advice, and so protect them effectively from COVID-19.

It is important to acknowledge the absence of peer reviewed and established evidence-based guidance on benzodiazepine prescribing. Nevertheless, experienced prescribers working in a person-centred way with clients should weigh providing a safe supply of pharmaceutical benzodiazepines against the risk of harm from illicit use

Points to consider:

Due to illicit production, it is not possible to estimate tolerance based on patient reports.

As an anxiolytic, etizolam is considered to be 5–10 times more potent than diazepam; 1 mg of etizolam is considered approximately equivalent to 5 mg of diazepam.<sup>2</sup>

When negotiating the prescribing of benzodiazepines, a risk assessment taking into consideration concurrent alcohol and/or illicit drug use should be carried out, and a low initial dose commenced and titrate as needed.

For patients at risk of benzodiazepine withdrawal, enquire which benzodiazepine the patient is using and aim to prescribe according to current use. A tapered protocol should be offered if an individual wishes to stop or a temporary maintenance protocol can be considered if an individual feels they cannot stop during self-isolation.<sup>3</sup>

Daily dispensing would negate the benefits of a safe supply as it means people cannot comply with self-isolation and it may also affect compliance with social distancing rules. Dispensing should be in alignment with OST arrangements.

### **1.3 Ensuring rapid access to OST for those not in service**

People with drug problems, have a high prevalence of multiple co-morbidities that include respiratory and cardiovascular disease, and so are at increased risk of morbidity and mortality from COVID19. We know from the evidence that the health of individuals with opioid dependence is safeguarded while in substitution treatment.<sup>4</sup> In addition, changes in the illicit drug market are likely to push more people into seeking OST. This is partly due to a reduction in heroin supply and quality. Therefore, although under pressure, services need to be able to prioritise OST provision, ideally on the day of patient presentation, in line with the draft Medication Assisted Treatment Standards from the Drug Deaths Task Force. Rapid access to OST is crucially important at this time to keep people safe and assist them to comply with social distancing and self-isolation advice. To facilitate this, some services have developed and operationalised doorstep titrations using existing protocols.

Maintaining stability is an issue for many people who use drugs and is particularly important at this time with wider welfare and safeguarding implications within households in relation to uncertainty or changes in income, intimate partner violence and child protection. People affected by homelessness with problematic substance use are particularly vulnerable and may not be able to take up provided accommodation without OST and are more likely to drift back onto the street.

A decision on whether methadone or buprenorphine is preferable given the patient's specific circumstances and the limitations of the current context is important. Titration onto methadone in particular is often safer when the medication can be provided on a daily supervised dispensing regime from a pharmacy, at least until a stable dose is achieved. Where this not possible because of reductions in pharmacy provision or in relation to the need for a person be shielded or self-isolate some areas have introduced 'door step' titrations to an appropriate dose followed by daily delivery of methadone.

Naloxone kits should routinely be provided to people commencing OST.

## 1.4 Homelessness and PWUDs

There is a significant crossover between people with substance problems and the homeless population.

Guidance from Pathway has addressed the homeless population.<sup>5</sup> The Guidance has been developed in a UK / English legal context but is of use to those planning and delivering service in Scotland. This was most recently updated on 5<sup>th</sup> May 2020 and may be subject to further updates

Health Protection Scotland provide wider guidance for non-healthcare settings<sup>6</sup> including homelessness settings. These guidelines are now available in version 4 which may be subject to further revision

The delivery of this plan, for people with an opioid-based substance use problem, are entirely dependent on the effective delivery of OST medication.

The key components of the plan are:-

- I. Establish centralised coordination for the homeless sector and efficient deployment of resources
- II. Mobilise the staffing, accommodation, infrastructure and services needed to implement the Test, Triage, Cohort, Care Protocol. This requires cross-sector co-operation between all organisations providing homeless services for example hostels, temporary emergency accommodation, third sector and statutory homeless support services and the NHS.
  - Identify and transfer all symptomatic homeless people/suspected cases (with new or worsening cough, SOB or fever (>37.5 degrees centigrade) to an assessment area RT PCR Testing.
  - Identify and offer transfer to COVID Hostel/Hotel centre all asymptomatic people (with No new or worsening cough, SOB or fever) who meet the criteria for 12-week isolation.
  - Educate and advise all remaining asymptomatic untested and negative cases - as per public health advice.
- III. Establish COVID-care facilities
  - High specification hostels (own rooms and bathrooms), unused hotels or NHS /private sector clinical spec facilities.
  - Providing a quarantined assessment area for COVID-19 testing and awaiting results.
  - Providing clinical support to symptomatic patients and rapid identification and transfer to NHS facilities for patients who need respiratory/life support.
- IV. Establish COVID-protect facilities
  - These facilities aim to cohort ASYMPTOMATIC cases who are at very high risk of serious disease and death if infected during the period of intense community COVID-19 transmission.

- COVID-PROTECT facilities must initially quarantine residents in their own rooms and maintain high vigilance and regular (at least daily) symptom screening in order to ensure that cases admitted who were initially asymptomatic BUT infected can be rapidly identified, isolated and transferred to COVID-CARE facilities.
- Following a 14-day quarantine period, residents are offered free movement and socialisation provided they remain within the facility.
- Continue outreaching test and triage protocols across the sector for the entire duration of the pandemic.

### **1.5 Treatment in prison and early releases in response to COVID-19**

Approximately 25% of people in prison receive a daily supervised OST, which is difficult to sustain under COVID due to attempts to comply with social distancing and elevated rates of staff absence; it also raises issues that prisoners are exposed to close contact with others during escorted journeys around the prison to receive medication. In order to ensure continuity of OST, support social isolation and restricted movement within prisons and to support staff during the current pandemic, Scottish Ministers have agreed to a transition to wide-scale prescribing of Buvidal, the long acting buprenorphine depot injection, the main OST drug in prison for people serving six months or longer. As part of this transition, it will be important that choice of OST remains, this will particularly important for those who have an adverse reaction to Buvidal or have significant underlying mental illness that would make such a switch traumatic particularly in the prison environment. It will be crucially important that all areas have added Buvidal to their local formulary/prescribing guidance. However, in the immediate future those to be liberated from prisons = (see below) will not be on Buvidal.

It is essential that those leaving prison who are at risk of overdose are provided with naloxone on release. In addition to the existing intramuscular product already provided, work is underway to pilot the provision of intranasal naloxone to increase the numbers of people with naloxone in their possession on release.

On 22 April 2020, The Cabinet Secretary for Justice wrote to concerned parties to notify them that he had informed the Scottish Parliament on 21 April of his intention to use powers under the Coronavirus (Scotland) Act 2020 and that regulations are to be laid before Parliament so that a limited number of short-term sentenced individuals can be released early.<sup>7</sup> The scheme will be limited to those sentenced to 18 months or less and who on 30 April have 90 days (three months) or less left of their time in custody.

There are likely to be 350-400 people released under the scheme from prison before the end of May. Many will be PWUDs and a significant proportion will be homeless at the time of release. Ensuring continuity of care is essential to keeping people safe on release. Good co-ordination and planning between Scottish Prison Service (SPS), prison healthcare services and community-based drug services and pharmacy is more important than ever, particularly with regard to continuation of OST and the provision of accommodation.

The Scottish Prison Service (SPS) currently provide lists to local authorities which set out all those individuals who are due to return to their area within the next 12 weeks. The criteria above will help identify those who may be affected by early release and SPS will endeavour to provide that information to local authorities as soon as it is known.

Local authorities and SPS already have processes in place to accommodate individuals upon liberation, the broad principles of which are set out in Sustainable Housing Upon Release for Everyone (SHORE) guidance.<sup>8</sup>

Revised SHORE guidance, reflecting on COVID-19 and how local authorities and SPS should work together was issued to prisons and local authorities on 1 April 2020.

This re-emphasised the importance of prisons and local authorities effectively working together to ensure individuals are liberated directly into accommodation upon their release. It recognises that local authorities as well as SPS will have been impacted by COVID-19 and the traditional processes and ways of working between both services will no longer be feasible and as such require reviewing. It also stresses the importance of continued multi-agency working; partnership working across the full range of public services remains vitally crucial to facilitate as seamless an approach to liberation as possible, and to support individuals with their physical, emotional and financial well-being for their transition into the community.

‘Continuity of care is a key consideration: Local authorities, health boards and integration joint boards will all continue to play a key role in ensuring that people released are able to access local services (general practice, mental health, alcohol and drug treatment, community pharmacy and social care) quickly to make certain that they remain safe on release.’ This clearly includes drug treatment services.

A small number of prisoners are currently self-isolating as a precaution and work is underway to consider the medical care and supervision of any prisoners involved in this process who have COVID-19 symptoms or other medical conditions, to ensure they are managed appropriately. It will be important thought is given for any COVID-19 specific arrangements that need to be put in place dependent on the release destination. Close communication between prisons and community partners will be needed to ensure a continuity of care across all the areas we know can present challenges on release including accessing benefits, GP registration and continuity of prescriptions and substance use.

## **1.6 Stimulant users**

Historically, addiction and substance use treatment services have not had much uptake from people seeking help with stimulant use. Anecdotal reports suggest that more of these individuals are coming into contact with services as their ability to source their drug of choice diminishes or that changes to daily routine enforced by lockdown have led to the realisation that their substance use is problematic to them and other people. In a lockdown situation, the effects of drug use (including withdrawals) may become more apparent to other members of the family. These withdrawals are significant and can include depression, anxiety, lethargy, paranoia, mood swings, restlessness, agitation, vivid, unpleasant dreams and muscle aches and pains. The physical and psychological symptoms of withdrawal vary depending on individual factors, such as the user’s tolerance, metabolism, length of addiction, severity of addiction, and the presence of underlying mental health conditions or other addictions.

The ‘Orange Book’<sup>9</sup> identifies psychosocial interventions as the mainstay of treatment for problematic stimulant use. Some countries like Canada have taken a pragmatic harm reduction approach and used therapeutic drugs such as dexamphetamine or methylphenidate off licence to

substitute illicit stimulants. There is some published support for this<sup>10</sup>, but little local clinical experience. While there have been licensed pharmaceutical treatments in the pipeline for some time, none are as yet available. This absence of licensed substitute treatments and a lack of understanding of the relationship of stimulant dependence and withdrawal in a polysubstance use setting is problematic in trying to support people who use drugs in maintaining social distancing, lockdown and shielding advice.

Currently, individuals with significant and objective withdrawal symptoms are often managed in acute inpatient settings with benzodiazepines and antipsychotics.

Psychosocial treatment for crack/cocaine use is recommended despite limited evidence, primarily as there is currently no legitimate alternative. In addition, the psychosocial interventions used, such as cognitive behavioural therapy, motivational interviewing and brief interventions, and contingency management have tended to have short term value only in helping people trying to stop or reduce crack and cocaine use.<sup>11</sup>

### **1.7 Blood Borne Virus testing**

Pragmatic considerations due to changes in access to services and staff need to be considered when assessing how to maintain testing and what should be prioritised. In assessing a hierarchy of current short-term risk HIV testing appears to carry greater priority than hepatitis C (HCV) testing.

Only through continued early identification and access to anti-retroviral treatment (ART) can reductions in HIV incidence and mortality be achieved and HIV outbreaks amongst PWID avoided. Point of care (POCT) testing (finger prick or saliva) can provide rapid screening results or can be carried out at home if the person has access to a test. Assessment of testing interventions should consider rapid and sustainable access to treatment pathways for those given a positive diagnosis.

Different ways of distributing tests and/or providing should be explored, such as including with IEP supplies. Staff should understand and be able to communicate to service users the positives and negatives of each form of test. Some NHS Boards have also further trained staff members to be able to undertake testing using venepuncture, however this is reliant on people still being able to access services and staff and the provision of suitable PPE. Assessment of risk management and PPE needs of staff are also key considerations of the method of testing that is employed.

When considering other BBV testing, all delayed BBV results from dry blood spot tests must be proactively followed up in a timely manner once COVID-19 related restrictions allow. NHS Clinical Governance related to lab testing and staff protocols for POCT has been developed in at least two board areas. It may be more timely to assess the ability of third sector services currently delivering POCT to assist.

### **1.8 Hospital liaison nurses**

Hospital liaison are an essential component of an effective alcohol and drug treatment and recovery system of care. It is important to note that experienced drug and alcohol liaison nurses are an invaluable resource during critical inpatient hospital capacity management scenarios, as they are able to provide specialist advice on treatment and care while people are in hospital and safely negotiate discharge of PWUD in co-operation with community services. This should help reduce

hospital readmission and protect the NHS during the pandemic. As with all alcohol and drug services, these services should not be redeployed. Any redeployed staff should be returned to these roles as soon as practicable.

### **1.9 Isolation, loneliness and mental health challenges**

There is a growing realisation and concern that one of the significant health impacts of the pandemic is on mental health for the general population, this may be a particular concern for people with a substance use problem. People may use drugs more frequently or in larger quantities to help manage poor mental health. Substance use can make existing conditions worse or have interactions with prescribed medication. It is important to ensure service users have uninterrupted supply to any medications prescribed for their mental health and have the ability to have their medication reviewed if they require, in order to help manage any changes in their mental health during this time. Increased access to emotional support and counselling is also crucial. Many mental health services are providing phone and online support rather than face-to-face services. Service users may not be in current contact with mental health services but may require additional support during this time.

There have been a variety of resources expanded to help individuals including online and telephone supports -

For urgent help, you can call the Samaritans 24 hours a day, 7 days a week, on [116 123](tel:116123) / [www.samaritans.org](http://www.samaritans.org) [jo@samaritans.org](mailto:jo@samaritans.org)

Breathing Space - [0800 83 85 87](tel:0800838587) / [www.breathingspace.scot](http://www.breathingspace.scot)

The service is open: · Monday to Thursday - 6pm to 2am · Friday 6pm to Monday 6am

#### **Shout**

24/7 crises text service, free on all major mobile networks, for anyone in crisis anytime, anywhere. You can access by texting 85258 website [www.giveusashout.org/](http://www.giveusashout.org/)

For non-crisis mental health advice and signposting to local services:

#### **Scottish Association for Mental Health (SAMH)**

Call [0344 800 0550](tel:03448000550)

Or email: [info@samh.org.uk](mailto:info@samh.org.uk).

There is also information on mental health support during the pandemic available at: <https://www.samh.org.uk/about-mental-health/self-help-and-wellbeing/coronavirus-information-hub>

The service is open from 9am to 6pm, Monday to Friday, except on Bank Holidays.

There is access to free cognitive behaviour therapy online support at living life to the full: <https://littf.com/corona/>

For people with a substance use problem isolation and loneliness can be significant issues.

There is a variety of self-help tips for people staying home during the pandemic from the mental health foundation available here: <https://www.mentalhealth.org.uk/coronavirus/staying-at-home>

For those seeking the support of peers through fellowship and mutual aid, e-support is available although face to face group meetings and recovery cafes have had to be moved online.

Narcotics Anonymous - <https://online.ukna.org/>

Cocaine Anonymous - <https://www.cascotland.org.uk/covid19>

SMART Recovery - <https://smartrecovery.org.uk/online-meetings/>

Alcoholics anonymous - [08009177650](tel:08009177650) / <https://www.alcoholics-anonymous.org.uk/Home/help@aamail.org>

## 2 Medication shortage

Medication supplies may be disrupted for a variety of reasons. This document provides guidance on potential steps to follow should OST supplies be disrupted.

Anyone in receipt of OST should be informed about the potential for a disruption in medication supply as a result of COVID-19 and of plans to mitigate against this to ensure support for any measures which become necessary.

Any individual in receipt of OST and in contact with treatment providers should be offered and encouraged to take a supply of naloxone - **even if they have previously received a supply** - and should be provided with overdose awareness advice and training. Naloxone should also be offered to their family or household members, and others who may potentially witness an overdose. If people request more than one kit at a time this request should normally be accepted.

### **Stock Shortages of Opioid Substitution Medication**

In the event of a stock shortage, consider the following steps:

#### **Movement of existing supplies within the community pharmacy network**

Pharmacy businesses should be encouraged to include in their business continuity plans options to move stock, as permitted within the relevant legal framework, to meet patient need.

#### **Alternative Opioid Substitution Therapy options**

In the event of severe disruption to medication supplies consideration may be given to substituting alternative opioid agonist formulations or medications. Consideration should be given to ensure no contraindications exist, such as injecting risk or known allergies to ingredients, prior to recommending the switch.

It is also important that Controlled Drug regulations are adhered to when writing and dispensing prescriptions. Changes require that amended or new prescriptions are provided. New prescriptions are required to supply alternative formulations.

It is anticipated that emergency legislation will be enacted to allow development of Serious Shortage Protocols (SSP) for Controlled Drugs for a limited period as part of the pandemic response. If the legislation becomes activated by a secretary of state announcement the alternative opioid substitution therapy options detailed below can be considered for inclusion in the preparation of SSPs by NHS Scotland.

##### **A. Generic Formulations**

Pharmacists are able to supply branded products against a generic prescription. Generic medications should be used in the first instance with branded medications used as required if generic products become unavailable.

This will not require replacement prescriptions but may raise issues of cost and remuneration processes within the pharmacies.

## B. Sugar Containing and Sugar-Free Preparations

Using all stocks of methadone oral solution may require patients receive sugar-containing methadone or sugar-free preparations according to availability.

There are few absolute indications which necessitate one formulation over the other except allergy or intolerance. Diabetic patients may receive sugar containing medication as per other sugar sources in their diet. The sugar content of most preparations is approximately half that of typical soft drinks.

## C. Different Preparation Strengths

A small amount of alternative methadone oral solution formulations are available and this may provide some additional capacity. This includes 10mg/ml oral concentrate solution.

Care must be taken to clearly communicate the differences between this formulation and a typical 1mg/ml. **Dilution of concentrate to lower final strength is required.**

## D. Methadone tablets

Methadone tablets are not licensed for treating opioid dependence and are not normally recommended in local prescribing guidelines but may be considered if methadone oral solution is not available. Doses are equivalent to oral solution but tablets are only available in multiples of 5mg so the patient may be required to take a large quantity of tablets.

The usual procedure for prescribing an unlicensed medication should be followed and individuals specifically warned about the risk of injecting tablets as a precaution.

## E. Conversion to alternative opioids

There are various formulations of buprenorphine available and all options should be considered according to need:

- Buprenorphine sublingual tablets (including generics and Subutex)
- Note - Temgesic is unlicensed for Opioid Dependence treatment
- Buprenorphine supralingual oral lyophilisate tablets (Espranor)
- Buprenorphine and naloxone combination alternative opioids

Buprenorphine is licenced as an OST medicine. It is likely that similar issues will affect the availability of buprenorphine as they will with methadone in the event of significant breakdowns in the supply or delivery chain. Where this medication is available, it may provide an alternative to methadone treatment in suitable patients.

- Conversion from methadone or other opioid agonists may risk precipitated withdrawal and caution is required. Conversion from buprenorphine to other opioid agonists is similarly complex and specialist support is recommended. There is substantial international experience (Germany, Switzerland, Canada) and some local experience (Lanarkshire, Lothian, Tayside) of micro-dosing which enables a more gentle if slower transition from another opiate to buprenorphine. Protocols are available for micro-dosing on request.

- Depot injectable buprenorphine (Buvidal) may be considered where available. This requires additional titration steps and may be of particular use in secure settings. (Local protocols are available)
- Buprenorphine transdermal patches may be necessary to consider where no other alternatives exist (unlicensed use).

Dihydrocodeine may be considered as an alternative to methadone if the options above are unavailable. Dihydrocodeine is regularly used in custodial settings or in situations where acute management of opioid dependence is necessary quickly.

DHC Continus is a modified-release (12 hour) preparation which will reduce the peaks and troughs in plasma concentration that occur with immediate release preparations. This is preferred over immediate release preparations in the management of opioid dependence.

Dihydrocodeine is not licensed for the treatment of opioid dependence and, as above, the procedure for prescribing unlicensed medication should be followed.

Due to variations in tolerance and metabolism for methadone it is not possible to provide dose equivalence. Patients should be monitored regularly during titration onto treatment. The patient should be made aware at the outset that dihydrocodeine will only be prescribed in the absence of other, licensed, options.

Morphine Sulfate is often used in some countries, for example, Austria, Switzerland and Canada.

### **Other opioid agonists**

Other opioid agonists, such as codeine, do exist in modified release formulations however these are uncommon and unlikely to be sufficiently available to provide a useful alternative. Immediate release codeine may be an option to consider.

#### **F. Symptomatic Withdrawal Management**

If there is a complete breakdown of the supply chain and OST supplies are exhausted, then “symptomatic relief packs” should be provided for enforced withdrawal. These would consist of a small quantity of opioid agonist with guidance on a reducing regimen (over a few days) along with symptomatic relief treatments to manage withdrawal symptoms e.g. Loperamide, and analgesics.

Prescribing and dispensing of OST and alternative options should be in line with the 2017 National guidance on clinical management of drug misuse and dependence.<sup>12</sup>

## 3 Disruption to community pharmacy dispensing

### 3.1 Access to pharmacy

Community pharmacy closures or restricted opening hours have already occurred during the COVID-19 pandemic and continued disruption is likely. In the event of closures, this will lead to disruption in the dispensing of OST and in the provision of injecting equipment.

#### **The Scottish Government has identified that that OST and IEP are essential services to be maintained by pharmacies**

The Public Health Minister and the Interim Chief Medical Officer have expressed their concern that this status has not led to the preservation and maintenance of resources and service provision most recently in a letter to ADP, HSCP and Joint Boards on 17 April 2020.<sup>13</sup>

Pharmacies are independent contractors who are responsible for their own Business Continuity Plans (BCP). It will be possible for pharmacy businesses (e.g. multiples and chains) to internally share stock in the event of closures. This should be covered in the pharmacy BCP.

Pharmacy businesses should liaise with health boards, local drug treatment services and their Accountable Officer and CD Governance team throughout the pandemic. When pharmacy sites are closed, staff should ensure that the information contained in Controlled Drug registers and on active prescriptions on dosage and when last consumed or supplied is made available to allow confirmation and safe continuity of prescribing of new prescriptions at alternative locations.

In the event of pharmacy closures, consider the following steps:

- Replacement prescriptions provided to another pharmacy
- Exploring alternative models of dispensing and delivery, supported by statutory or third sector specialist services.

Widespread closure of pharmacies has the potential to be hugely challenging and clearly it will be important not to create situations where large number of vulnerable people with drug problems are put in close proximity to each other or exposed to unnecessary infection risk from wider public contact. Drug services should work closely with pharmacies to minimise the impact of increased demand and to maintain services for OST dispensing within any limited capacity.

### 3.2 Home delivery of medication

As highlighted the need for home delivery of medication has increased during the pandemic to date. Arrangements have been put in place in local areas to support this including drug and alcohol service staff, volunteers and people redeployed from non-essential services. Areas have developed protocols for Collection and Delivery of OST by Nominated Persons. Edinburgh is included as annex 1.

### **3.3 Collection of medication by others**

Nominated representatives (such as family members, friends etc) can collect dispensed medication, including Controlled Drugs, with the patient's consent. The patient can authorise someone to collect on their behalf. No amendment is required to the prescription.

Further details of the requirements for collection of Controlled Drugs by a representative are contained in the Medicines Ethics and Practice guide (MEP) published by the Royal Pharmaceutical Society (RPS). This resource has been made available by the RPS to all pharmacists during the COVID-19 pandemic.

<https://www.rpharms.com/publications/the-mep>

Pharmacists are advised to get written authorisation from the patient to collect on their behalf. However it is acceptable to accept a phone call from the patient in exceptional circumstances (as Covid-19 may present). The person collecting is acting as the "patient's representative" and it is this authorisation that allows them to legally possess a Controlled Drug that has not been prescribed to them.

Collection by a nominated representative extends to health and social care staff, Police and volunteers.

### **3.4 Staff shortages**

Staff shortages may occur due to illness, self-isolation, or carer and childcare responsibilities. As per the express instruction of the Minister for Public Health and the Interim Chief Medical Officer, staff should not be redeployed elsewhere to care for patients with COVID-19 within the NHS as this will impact on the ability of services to operate a full-service model and prioritisation of activities will be required.

If the situation deteriorates to the extent that there are severe restrictions on treatment services and pharmacy staffing, then it may be necessary to seek temporary local exemptions or national UK amendments to the legal requirements to ensure continuity of prescribing and dispensing.

### **3.5 Potential temporary measures to maintain supply of Controlled Drugs.**

On the 1<sup>st</sup> April 2020, the Home Secretary wrote to the Chair of the Advisory Council on the Misuse of Drugs (ACMD) proposing a set of temporary measures to enable the supply of controlled drugs. The ACMD responded on the 7<sup>th</sup> April providing advice and recommendations associated to the measures proposed. Full details of the three temporary measures proposed for supply of Controlled Drugs can be found within the correspondence. In summary the proposed amendments include:

1. Emergency supply of controlled drugs to patients receiving these as part of on-going treatment without a prescription.
2. Extension of serious shortage protocols to include controlled drugs (excluding schedule 1).
3. Enabling variation to the frequency of instalment prescriptions.

<https://www.gov.uk/government/publications/letter-to-the-acmd-on-emergency-legislation-to-enable-the-supply-of-controlled-drugs>

<https://www.gov.uk/government/publications/acmd-advice-on-covid-19-emergency-legislation-to-enable-supply-of-controlled-drugs>

Governance of the proposed changes will be through health services and local advice and guidance will be provided. It should be noted that these changes are enabling and cannot be acted upon immediately. They can only be actioned after the Secretary of State specifies:

1. when the change comes into effect
2. how long the change is effective for,
3. the geographical area the change is effective in. This could be national, regional or specific to a local are.

## 4 Disruption to injecting equipment provision (IEP)

Community pharmacy plays an important role in IEP in many areas and communities. Currently this has been disrupted along with other forms of IEP. NHS Boards are instigating alternative methods of provision such as vehicle, foot outreach, peer or postal delivery. These types of services may require the collection of pertinent personal information (i.e. name and address) to allow them to operate, the client should be aware of this and reassured this will only be used for IEP services. An urgent audit of methods of communicating to service users if supplies are interrupted/closures foreseen should also be undertaken.

Naloxone should be offered and/or promoted with every IEP transaction, excepting IPED-related transactions. Information should also be in the packs regarding safer injecting practice and wound care, SDF has produced related [information materials](#).<sup>14 15 16</sup>

Clients attending IEP services should be encouraged to take away enough injecting equipment to last 14 days and return at similar intervals thereafter. This may not be realistic for many and the provision of enough new needles to meet the number of planned injections should be paramount. Large sharps containers should be provided to facilitate safe home disposals. There should be urgent discussion with local police regarding their interactions with clients carrying extra IEP equipment. All clients should be aware of how to clean injecting equipment should the need arise. COVID-19 avoidance strategies should be routinely promoted to clients through all IEPs. Staff should also communicate the increased risk of transmission if sharing smoking/inhalation equipment.

There are challenges in recording transactions and data on the use of IEP services as IEP quickly adapts to the pandemic's unique circumstances. Attempts should always be made to ensure these data are recorded using the usual NEO system if at all possible. Where this is not possible an alternative should be found. This data will be crucial in further development IEP provision and other related matters.

## 5 Patient illness / quarantine / attendance in community pharmacy / shielding

Individual consideration of OST (e.g. methadone or buprenorphine) supervision and instalment dispensing relaxation should be reviewed for each patient. Consideration should be given to relaxing dispensing arrangements for patients such that pharmacy visits are reduced. This will reduce the risks of exposure to the wider public in the pharmacy and help to reduce the impact on pharmacy services. There will be higher and not insignificant overdose risk in some patients as a result of these relaxations – it is essential to have ensured naloxone is offered - even if supplied previously - and that risk assessment, safe storage, children at home, etc. is performed and documented for each patient. Regular telehealth follow-up and welfare outreach support is advised.

For patients instructed to self-isolate for a number of days (government advice, and not simply self-imposed), an immediate relaxation of drug supervision arrangements will need to be considered. Supervision is not a legal requirement and pharmacists can exercise professional judgment when relaxing supervision. This should be done in consultation with the prescriber and patient. Although supervision may be relaxed the instalment frequency and collection from the pharmacy on the specified dates is not affected by reduction in levels of supervision.

Patients may need a full 14 days of take-home medications to comply with self-isolation dependent on symptoms. This supply may need to be collected by family members or a designated other. Ideally the pharmacist should receive and retain a signed letter from the patient authorising someone to collect on their behalf. However, if there is an identified infection risk, verbal consent is acceptable.

There are also likely to be issues regarding people having the familial or social capability to self-isolate/quarantine and arrange collection of medication by a trusted individual. This is part of a wider plan by Scottish Government however these situations should be anticipated and planned for.

For those PWUDs who fall into the shielding category there is a range of support available including deliveries of food and medications. Areas should identify people who would not necessarily fall into the shielding group, this should include all those categorised by the addiction service as vulnerable, so that they have access to all necessary resources that other vulnerable people are getting access to i.e. Welfare Rights, Access to Money, heat, food etc. .

## 6 Other measures

### 6.1 Communication with pharmacy services

Regular and clear communication with pharmacy contractors giving details of the current situation and measures in place within the health board is essential to ensure that community pharmacy is able to continue operating and to provide support to OST patients and PWUD. This should utilise clinical mailboxes which require to be regularly checked by pharmacy staff.

### 6.2 Communication with other IEP services

The NEO360 system, which is used to collect information on those obtaining injecting equipment and paraphernalia, can also be used to quickly transmit urgent alerts and messages to pharmacy and other IEP service staff. This can be used to remind staff to promote supply of naloxone, to encourage individuals to take at least two weeks supply of injecting equipment for themselves and to encourage people to collect equipment for others. NEO360 can also be used to distribute information materials on COVID-19 and the best practice required to self-clean equipment should that be necessary.

Professional guidance on COVID-19 is available at: <https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/>

## 7 Communication with people who use drugs re COVID-19

Resources containing information specific to people who use drugs and COVID-19 have been produced by a number of organisations and these can be found at <http://www.sdf.org.uk/covid-19>

General public information on COVID-19 is available at <https://www.nhsinform.scot/coronavirus>

Information of services for PWUD can be found here:

<http://www.scottishdrugservices.com/>

<http://www.needleexchange.scot/>

Or people can phone the Know the Score Helpline:

<https://knowthescore.info/help-and-support/drugs-helpline/>

## 8 Carers and Family of people Who Use Drugs

Carers and family members must also be recognised and planned for as part of the response. Carers UK have made these specific points:

- If carers become ill themselves with COVID-19, they may not be able to provide care.
- If the carer lives with the person being cared for, robust plans to support the person with care needs must be developed. It is essential that services are not withdrawn without clear risk planning. This equally applies to a clear process for providing emergency support for those carers who provide care with no support from formal social care.
- Carers may not always live with the person being cared for. 76% of those providing less than 20 hours of care per week do not live with the person they care for.
- In the event that carers are not able to support the person needing care e.g. travel or are looking after children unable to attend school, then it is essential that the local health and care services have a clear picture of the person needing support.
- Carers may have long term conditions or disabilities themselves that increase their vulnerability, which must be factored into planning.
- Carers and family members should be offered and supplied with naloxone.

More information is available on the Carers UK website: <https://www.carersuk.org/help-and-advice/health/looking-after-your-health/coronavirus-covid-19>

Help and advice is also available by phoning the Scottish Families Affected by Drugs and Alcohol helpline:

<https://www.sfad.org.uk/support-services/helpline>

## Appendix 1 Edinburgh Health and Social Care Partnership

### Protocol for Collection and Delivery of OST by Nominated Persons

For patients self isolating and unable to collect a methadone prescription from the prescriber and/or dispensed methadone at a community pharmacy. A pool of alternative “nominated persons” should be used on a stepwise basis as below, to collect & deliver to a patient on their behalf if no alternative. To be co-ordinated individually by each hub, an assigned daily rota clinical co-ordinator in each hub.

- **Step One** Ask for a patient’s own nominated person as a first step (trusted friend or family member or hostel staff).
- **Step Two** try to use current hub clinical staff members as nominated persons.
- **Step Three** Use the hubs own currently allocated outreach workers (both NHS & 3<sup>rd</sup> Sector) as a priority - redirection of their work stream
- **Step Four** Engage with 3<sup>rd</sup> Sector organisations ie CGL & Turning Point staff as nominated persons from all hubs to see if anyone can support from other hubs (list will be provided)
- **Step Five** Look to a wider pool of volunteers ie other charity agencies, later year medical/nursing student volunteers or redeployed/previous NHS staff to act as nominated persons. (Better if PVG cleared or police disclosure cleared) (list will be provided and circulated and updated)

### Procedure

- Each hub takes their own responsibility to co-ordinate nominated persons and deliveries.
- Each hub should have a nominated daily co-ordinator for delivery
- Patients identified for delivery should be highlighted to co-ordinator for delivery the following am
- Morning deliveries better as takes account of possible queues, delays, returns etc
- Each hub will be cascaded information of available alternative “nominated persons”
- When needed the hub work stepwise through steps 1-5 as above to find help for the next morning
- Need to work in teams of two and carry a mobile phone
- Try and buddy up less experienced volunteers with more experienced 3<sup>rd</sup> sector/staff
- Each hub should have simple paperwork keeping a record of “nominated persons” deliveries and note these in individual patients’ clinical notes as well
- Each hub should supply the nominated persons simple paperwork with vital information & vital contact numbers
- Any deliveries should be recorded on patients’ clinical records.

### Present to Hub

- Clinical co-ordinator calls the patient and gets consent & to advise of delivery the next day to ensure patient will be at home
- Clinical co-ordinator calls from pool of “nominated persons” stepwise as above that they will be needed the next morning for delivery & calls the pharmacy to notify of persons coming to collect

- Nominated persons present in the morning at the hub/practice
- Receive from the co-ordinator paperwork of patient name, address, dob, dispensing pharmacy address and any other helpful information (eg patient phone number/door colour/ identification helpers) with naloxone and IEP if needed
- Protective face masks and gloves provided
- Normal practice is that signed consent note is given to person collecting on a patients behalf consider infection risk in this.
- Hubs may want to consider getting patient on their caseloads to pre-sign consent of collection of behalf of forms incase the patient self isolates- this should be discussed with the patient. Example sheet attached.

### **Travel to Pharmacy**

- The nominated persons then travel to the pharmacy to collect the medication
- The nominated persons will be asked to show ID / hand consent form/ give name as legal recipient
- The medication will be handed over from the pharmacy in a sealed bag with a label attached
- This label has the patients name and address on it
- This bag must not be opened or tampered with and the label remain intact
- The nominated persons must both check the patient details on the label match with those on the paperwork before leaving the shop

### **Travel to Patient House/Hostel & Handover**

- The nominated persons then drive to the patients address
- They may want to call the patient ahead to ensure they are at home and advise they are coming
- In the car, the nominated persons retrieve the patients pharmacy bag
- TWO PERSON CHECK on correct patient name and address on label, place in discrete bag for delivery.
- Once at the correct door, TWO PERSON CHECK on correct house number & any identifiers given.
- The nominated persons ring the doorbell, leave the bag on the ground & stand back 2 metre distance
- When patient opens the door ask for verbal confirmation of Name & DOB & show ID if available (ie bus pass)
- The nominated persons witness the patient open the bag and check medication
- Ask the patient to verbally count the medication
- Any queries must be re-directed by the patient to the pharmacy
- No medication to be returned to pharmacy on patients behalf to fix errors as these will need to be destroyed - only returned if patient not in
- NEVER leave medication without physical handover to the patient. NEVER to be left in any "safe places"
- A Welfare check, IEP, Naloxone, food parcels etc could be delivered on this visit as well

### **After Delivery**

- Call the clinical co-ordinator to check in and advise of successful delivery
- If the patient is not at home, the medication has to be returned to spittal street and this will need to be destroyed
- Pharmacy cannot accept patient returns for re-use or for storage on patients behalf

### **Nominated Persons Must:**

- Report into the hub co-ordinator before and after
- Work in teams of two (use the vans if available for social distancing)
- Carry a mobile phone- charged with important contact numbers saved in this
- Carry ID badges but have these hidden when out on active delivery
- Travel in an unmarked vehicle if possible
- If possible have sat nav available /google maps
- Must not visibly carry marked pharmacy carrier bags- place in backpacks/other non identifiable bags
- Be mindful and careful of their surroundings
- Avoid bulk, multiple deliveries to avoid carrying high volumes of controlled drugs and to avoid errors in delivery
- Must not keep medication on themselves overnight- if the patient is not in, they must return this to Spittal Street for destruction on the same day- be mindful of times.

### **Points to note:**

- Deliveries should be in the morning- there will likely be delays in the pharmacy and a need to keep the afternoon free in case of a need to return medication to the pharmacy or spittal street.
- Be aware of opening and closing times of pharmacy and spittal street.
- **Under no circumstances have the nominated persons to keep medication in their possession**
- **Understand we cannot hold storage of patient named controlled drugs within the hubs- if the patient is not at home need to return to spittal street & will need to be destroyed**
- All usual remote and outreach working procedures to be followed
- All current protective procedures, social distancing to be followed eg sitting front and back seat of car & with wearing of gloves and face masks and use of alcohol hand sanitizers
- Hands washed before and after delivery
- Remember the medication is legally the patients property after leaving pharmacy premises



Date:

I (patient name) \_\_\_\_\_ (DOB: / / ) confirm that in extenuating circumstances,

If I am unable to attend my nominated pharmacy which is

\_\_\_\_\_

I give permission to \_\_\_\_\_(relationship)\_\_\_\_\_

to collect my prescription(s) which is currently prescribed by Substance Misuse Service in

\_\_\_\_\_

Client Signature \_\_\_\_\_ Client Name \_\_\_\_\_

Staff Signature \_\_\_\_\_ Staff Name \_\_\_\_\_

Substance Misuse Service, HUB ADDRESS  
HUB ADDRESS  
Tel No: CONTACT NUMBER

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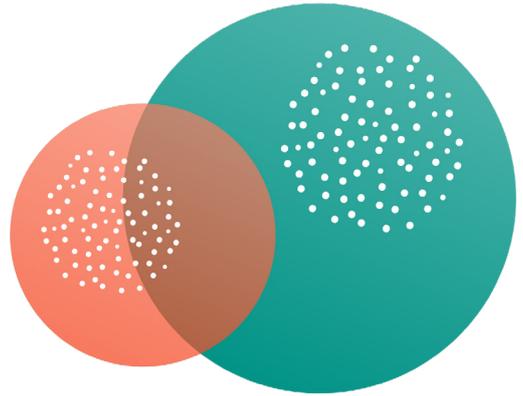
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- [facebook.com/scottishdrugsforum](https://facebook.com/scottishdrugsforum)
- [youtube.com/user/scottishdrugsforum](https://youtube.com/user/scottishdrugsforum)

### SDF's COVID-19 Information Hub

[www.sdf.org.uk/covid-19](http://www.sdf.org.uk/covid-19)

### Find a drug service in your area

[www.scottishdrugservices.com](http://www.scottishdrugservices.com)

### Find a needle exchange in your area

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