Health Research Board

Impact of COVID-19 on drug services in four countries.

An evidence brief

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Abbreviations

AA	Alcoholics Anonymous
ALDP	Ana Liffey Drug Project
BC	British Columbia
BCCSU	BC Centre on Substance Use
BNX	Buprenorphine-naloxone
CA	Cocaine Anonymous
CBOs	community-based organisations
CDC	Centre for Disease Control
CES	Community Employment Scheme
CTL	Central Treatment List
COVID-19	corona virus disease
DEA	Drug Enforcement Administration
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
HSE	Health Service Executive
GP	general practitioner
MQI	Merchants Quay Ireland
NA	Narcotics Anonymous
NGO	non-governmental organisation
NHS	National Health Service
NSW	New South Wales
NSP	needle and syringe programme
OASAS	Office of Addiction Services and Supports
OAT	opiate agonist therapy
OCG	organised criminal groups
OST	opioid substitution treatment
OTP	opiate treatment programs
OUD	opiate use disorder
PPE	personal protective equipment
RDATF	Regional Drug and Alcohol Task Force
SAMHSA	Substance Abuse and Mental Health Services Administration
SHAAP	Scottish Health Action on Alcohol Problems
SOP	standard operating procedures
SSA	Society for the Study of Addiction
SSRN	Social Science Research Network

SRO	single room occupancy
SROM	sustained release oral morphine
TAD	take away doses
US	United States
UNODC	United Nations Office on Drugs and Crime
VCH	Vancouver Coastal Health
WHO	World Health Organization

Executive summary

This evidence brief examined the impact of the COVID-19 pandemic on drug services in New South Wales, Scotland, New York State and British Columbia. These jurisdictions were chosen because they are developed economies, have been disrupted by the COVID-19 epidemic, and official documentation is available in English. They also have patterns of problem drug use similar to Ireland and provide a comparable range of treatment and harm reduction responses. The evidence brief also presents a summary of information available in Ireland and in other countries in the European Union to provide a context beside which findings from the four research countries can be read.

Question 1: How has COVID-19 impacted on people who use drugs?

At the time this research was being done there was very little evidence available regarding the impact of the COVID-19 pandemic. In early March 2020 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) began an investigative rapid assessment to monitor the impact of COVID-19 on the drugs situation in Europe and the responses to it. This assessment included a mini web survey of people who use drugs but might not be accessing services. The first report from the EMCDDA study was published in May 2020 and some of the findings from that report, and from an EMCDDA report on drug markets, are presented in this report. Information on the situation in the four research countries was mainly anecdotal, apart from one survey undertaken in Scotland.

Irish and European context

Data from the EMCDDA's mini-web survey indicate that respondents in Ireland who used cannabis or cocaine more frequently (daily or almost daily) in the 30 days prior to introduction of restrictions were much more likely to use drugs more frequently or to use greater amounts in one session than they had before. In answer to the question 'In general, would you say you have used more or less illicit drugs, since the start of the COVID-19 epidemic in your country?' 209 (33%) respondents replied less, 142 (22%) replied more, and 90 (14%) replied the same amount.

An EMCDDA study on drug markets found that disruptions to the supply chain were most evident at the distribution level, resulting in increased violence in some countries. Bulk movement of drugs through shipping has not been interrupted. Domestic production of cannabis has been disrupted and prices have increased. Alternative means of both acquisition, for instance through online sources, and distribution, through the postal service and drops, have been reported.

New York

Drug Enforcement Administration reports that the price of street drugs is more costly as distribution costs have risen. Since March, cannabis prices increased by 55%, cocaine prices by 12%, and heroin prices by 7%.

Scotland

The Scottish Drug Death Taskforce has received feedback from services and communities which suggests that service-level provision of harm reduction services is being scaled back in some areas. Responses to the CREW survey in April suggest that there have been product shortages, less variety, poorer quality and some price increases. Some respondents report an increase in unintended withdrawal symptoms as a result of reduced availability.

Question 2: How has COVID-19 impacted on the demand for drug and alcohol services?

There was little concrete information available to answer this question. The European context is described below with information from one of the research countries.

Irish and European context

Many EU countries saw an initial decline in treatment demand attributed to restrictions on movements, reduced capacity in treatment services and fewer referrals from the criminal justice

system. Harm reduction services have reported an increase in demand for social support and increases in alcohol and benzodiazepine use as a result of higher levels of anxiety among service users. Generally, much of the increased demand for treatment services has come as a result of people's inability to access heroin.

Scotland

There is anecdotal evidence that more stimulant users are coming into contact with services due to a reduced ability to source these drugs or due to changes to daily routine enforced by lockdown leading to the realisation that their substance use is problematic. This includes more vulnerable stimulant users who may not have been previously visible to services.

Question 3: What guidelines and supports have been provided for drug and alcohol services in light of COVID-19?

This was the research question for which there was most evidence available. All of the health services in the areas covered responded very quickly to the situation with clear recommendations and generally a high degree of flexibility. The need to maintain access to opiate substitution treatment (OST) or opiate agonist therapy (OAT) for existing clients is a common theme and ensuring this has required a great deal of coordination and the development of innovative service and policy approaches. Variations in responses are somewhat determined by historical factors, the degree of autonomy accorded to local administrators of health services and the degree to which a harm reduction ethos has been embedded. For instance, New York followed guidelines issued by the DEA, a federal body, and the degree of independence, or willingness to innovate, at the state and city level seems to be less than in Vancouver or British Columbia. Separate but compatible guidelines for OAT have been published by Vancouver Coastal Health, a regional health authority, and the BC Centre for Substance Abuse, a networked organisation providing support for evidence-based approaches to substance use and addiction. Health Canada provides the overarching direction for policy and health service delivery at the federal level.

Irish and European context

In Ireland, guidelines on contingency planning recommend a number of actions, in particular for people who are unable to access services either through their own isolation or because services are not currently available. The process by which a clinical review for OST clients can be undertaken remotely (with video link or smartphone) is spelled out in detail in guidance documents. A number of options are available for a person in treatment who is isolating at home including provision of sufficient doses for the duration of the self-isolation, provision of medication to family members or a driver or key worker. The guidelines provide advice regarding securing the stored doses, general safety, medicines management policy, remote consultation and record keeping.

OST treatment services have continued. The use of eConsultation software and the delivery of medication have ensured people in isolation can continue their treatment. Clinics have implemented social distancing measures and provided people with letters stating the date and time of their appointment to ensure permission to travel during the period of restricted movement. Recovery groups are now provided online in a number of areas.

The wait for methadone treatment has been reduced from 12 weeks to 3 days. Benzodiazepine prescriptions have increased to enable easier stabilisation of drug use during isolation. Resources have been provided to support cocooning and isolation of vulnerable homeless people. Outreach services have been active in providing information on COVID-19 to clients when delivering needle and syringe exchange services

Temporary amendments to the medicinal products and misuse of drugs legislation are designed to ensure that patients can continue to access their ongoing treatment and 'regular' medicines during the ongoing emergency and to assist in easing the additional burdens on prescribers and pharmacists arising from the pandemic. The amendments allow for the electronic transfer of prescriptions between doctors and pharmacies and remove the need for a paper equivalent. The legislation also extends the validity of prescriptions from six to nine months and enables pharmacists to make

additional supplies of prescription-only medicines to patients from an existing prescription. This additional authority to pharmacists must only be used where, in the pharmacist's professional judgement, continued treatment is required and it is safe and appropriate to make an additional supply.

Several international organisations have produced guidelines for drug services and these have been adapted or added to by services in many countries. Most guidelines include advice on take-home doses, moving from supervised consumption of substitution medication, prescription delivery, remote counselling and initiation of treatment. German guidelines point out that an OST patient must be visited by a doctor when a prescription for self-administration is being delivered.

While these guidelines are welcome, many countries have reported challenges in starting treatment for new clients. Detoxification has been discontinued or significantly curtailed in most countries. The need to maintain access to OST for existing clients is a common theme and ensuring this has required a great deal of coordination and the development of innovative service and policy approaches. There is concern around the greater danger of overdose as some services prescribe larger take-home packs of OST. The effort to accommodate those entering or seeking to maintain OST may have the effect of making less resources available for those who use other drugs. Telemedicine, by phone or video, have largely replaced face-to-face contacts. There are obvious benefits to using these technologies as contacts with clients can be maintained and counselling sessions continued. However, there have been difficulties in persuading clients to engage with remote technologies and the inability of service users to access the devices needed to use them.

New York

At the federal level, the Drug Enforcement Administration (DEA), the lead agency for domestic enforcement of the Controlled Substances Act, has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA), to ensure authorised practitioners may admit and treat new patients with opioid use disorder. The DEA states that practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation during this public health emergency. Patients presenting with respiratory symptoms should be evaluated by a medical provider who will decide on a safe number of take-home doses, up to 28 days of medication, taking into consideration the patient's stability in treatment and ability to safely store and protect the medication.

Federal law requires a complete physical evaluation before admission to an Opioid Treatment Program (OTP). Under exemptions to the Controlled Substances Act, practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation. New patients treated with buprenorphine can be assessed using telehealth systems, but this exemption does not apply to methadone patients, who are not permitted to receive escalating doses for induction as take-home medication.

Patients who only have access to one take-home or do not use this service should be considered for a staggered take-home schedule. Patients can still be evaluated frequently and do not receive more than two days of take-home medication at any one time. Based on the more favourable safety profile of buprenorphine, programs should seek to maximise the ability of patients to take their buprenorphine at home during the COVID-19 crisis.

As there are no time-in-treatment take-home regulatory requirements for patients being dispensed buprenorphine, patients should be evaluated for flexible take-home doses as clinically warranted. An OTP can provide delivery of medication to an individual patient's home or to another controlled treatment environment. A responsible adult can serve as a designated other or surrogate to pick up an OTP patient's medication.

SAMHSA urges providers to consider utilising benzodiazepines for individuals with alcohol use disorder where they believe there would not be a benefit from administration of anticonvulsant medications. Medications such as gabapentin, topiramate, or carbamazepine are useful in preventing seizures related to alcohol or benzodiazepine withdrawal. These medications also possess a much lower abuse

potential. Limited doses of benzodiazepines might be considered for specific symptom relief for a short duration (several days).

British Columbia

Specialised substance use services, including withdrawal management services, are delivered primarily through five regional health authorities, the First Nations Health Authority and the Provincial Health Services Authority. Canada's Controlled Drugs and Substances Act 1996 has been amended to permit pharmacists to extend, renew and transfer prescriptions and verbally prescribe controlled substances, which can be delivered by pharmacy technicians to a private address, not necessarily that of the patient receiving the prescription. Changes of pharmacy regulation allow emergency supplies to patients with expired prescriptions and the provision of carries (take-home medication) to reduce exposure to COVID-19.

The BC Centre on Substance Use (BCCSU) general prescribing guidance advises general practitioners to send OAT prescriptions to pharmacies with the capacity to deliver or deliver medications directly to patients, weekly if necessary with advice on storage. In order to reduce the risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply, the BCCSU recommends replacing illicit and licit products with prescribed or regulated substances. For patients who use opioids the Centre recommends offering OAT or increasing doses or providing carries for existing current patients. Co-prescription of oral morphines will help to reduce withdrawal symptoms.

For patients using street opioids in addition to their OAT or who decline OAT, prescriptions should be made according to current use and patient preference and clinical judgment to select appropriate medications and dosage. Dose and medication will depend on if they are being co-prescribed OAT, and patterns of substance use. The dose can be adjusted over time, with a goal of the person being comfortable and not needing to access the illicit drug market. Witnessed ingestion is not required and prescription of up to seven days supply of take-home doses, preferably in blister packages, can be considered where clinically appropriate. Similar guidelines apply to prescription of buprenorphine/naloxone and patients can receive longer duration take-home doses because of the reduced risk of overdose. Micro-induction may be considered for individuals transitioning from another OAT medication to buprenorphine/naloxone, to avoid the need for a washout period and moderate withdrawal to be reached prior to induction.

Similar guidelines are provided for prescribing sustained release oral morphine and methadone and guidance on injectable OAT (hydromorphone and diacetylmorphine) is forthcoming. As with other OAT medication, prescribing will depend on stability of the patient and their capacity to store. In all cases clear communication with pharmacies is essential. Risk of overdose, diversion or risks to household members must be carefully considered when deliveries or extended carries are being considered. Telehealth is especially recommended for use when dealing with patients accessing OAT.

For those at risk of severe withdrawal from alcohol, the BCCSU recommends inpatient withdrawal management which may include prescribing benzodiazepines. For those declining this treatment advice on withdrawal, including safely reducing alcohol and accessing alcohol should be given. If the patient is at low risk of complicated withdrawal prescribers should consider gabapentin and/or clonidine and/or carbamazepine. The BCCSU recommends psychostimulants, such as dexedrine and methylphenidate, as part of replacement therapy for those with stimulant use disorder. Prescription must come with advice regarding possible worsening of symptoms and side effects of medication. For users of illicit benzodiazepines, the BCCSU recommends relatively low doses of clonazepam or diazepam with up titration as needed.

A Health Canada class exemption enables a flexible approach to supervised consumption services that may include drug checking and virtual supervision of drug consumption. The BCCSU has published an overdose prevention protocol in the context of COVID-19, taking account of the change in regulations and making recommendations on safer injecting, take-home Naloxone kits and observation of consumption in any health or social service sector environment.

Scotland

Responsibility for the National Health Services (NHS) in Scotland is a devolved matter and rests with the Scottish Government. The Scottish Drugs Forum works with policy makers, service planners and commissioners, service managers and staff as well as people who use or have used services to ensure service quality and evidence-based policy and practice. The Forum has published comprehensive guidance to help treatment services plan, manage, and deliver services for people who use drugs during the COVID-19 pandemic.

Supervision of self-isolating OST patients can be relaxed and 14 days of take-home medication provided where needed and arrangements can be made for home delivery. The patient can nominate a representative to collect and deliver medication, including controlled drugs. Provision should be made to ensure medication is still available should a pharmacy be closed. Take away supplies of safe injecting equipment for up to 14 days should be encouraged. Take-home supplies have largely replaced daily supervised dispensing and there is guidance around managing home delivery. Priority should be given to those seeking treatment as a result of the reduction in the supply of heroin. Doorstep titrations, of methadone or buprenorphine depending on the patient's circumstances, using existing protocols are used by some services and guidelines on this approach are provided.

Serious Shortage Protocols legislation may be enacted to allow pharmacists to supply branded products, different preparation strengths and methadone tables, which are not currently licensed, may be used if oral solution is not available. Conversion to various formulations of buprenorphine is possible with caution, the risk of precipitated withdrawal and micro-dosing to support a slower transition. Injectable buprenorphine and modified release preparations may be considered.

For those with alcohol use disorder, the priority should be to avoid the abrupt changes in alcohol consumption patterns which might trigger serious withdrawal symptoms. Relapse prevention medications such as acamprosate, disulfiram (Antabuse), naltrexone and baclofen can be crucial to recovery and prescriptions should be maintained. It has been reported that more vulnerable stimulant users are seeking treatment. While psychosocial interventions are typical for problematic stimulant use, the guidelines note the harm reduction approach being pursued in Canada. Scotland has decided to allow prescribing of benzodiazepines to those at risk of harm, while acknowledging the absence of peer reviewed and established evidence-based guidance on benzodiazepine prescribing. While it is not possible to estimate tolerance when illicitly-produced benzodiazepines are being used, estimated equivalents of prescribed drugs serve as a guidelines.

New South Wales

The federal Minister for Health administers Australia's national health policy, and state and territory governments. State governments have responsibility for funding and managing community and mental health services, which includes drug and alcohol services. A national guidance document suggests sublingual buprenorphine, with transfer to depot buprenorphine, as it requires less clinical monitoring and a shorter period of supervised dosing. Patients should be categorised into high, moderate or low risk groups, and this will determine the dosing regimen. Guidance is provided on collection and delivery of medication for those in isolation including the selection of the agent responsible. Prescribers should advise all OAT patients to obtain take-home naloxone as a safety precaution.

Question 4: How are drugs and alcohol services being restructured to meet clients' needs in light of COVID-19, especially clients with complex needs and who are most vulnerable?

New York

OASAS states that an inability to keep take-home doses of medication safe due to a chaotic living situation (e.g., certain types of homelessness) would be grounds for patients being deemed ineligible for an emergency, take-home exemption. For these patients who, for safety reasons, need to continue daily dosing, every precaution should be made to limit exposures from patients possibly symptomatic

for COVID-19, as well as to older and/or medically fragile patients. However, OASAS do not provide any further guidance in relation to this.

British Columbia

Vancouver Coastal Health published comprehensive guidance for implementing and operating COVID-19 facilities for homeless and under-housed residents who are unable to self-isolate. They identify that long-term substance users are at high risk from complications of COVID-19 and that their needs should be addressed.

Scotland

In February 2020, 26% of the prison population were receiving a daily supervised OST, which is difficult to sustain under COVID-19 due to efforts to comply with social distancing and elevated rates of staff absence. The Scottish Government guidance recommend transferring appropriate patients receiving daily OST via oral methadone or solid dose buprenorphine to monthly injections of slow-release buprenorphine (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. There are likely to be 350-400 people released under the scheme from prison before the end of May.

Guidance from Pathway has been developed in a UK / English legal context but is of use to those planning and delivering service in Scotland. The guidance states that patients with alcohol, drug or nicotine addiction should be able to access a variety of approaches to prevent withdrawal, with input from specialist addiction services to minimise their need to leave isolation.

NSW

The NSW Department of Communities and Justice has developed guidance for providers that are delivering services for people experiencing homelessness during COVID-19. They advise that consideration should be made in relation to assisting clients in accessing ‘take-away’ supplies of replacement drug therapies i.e. methadone and buprenorphine, in consultation with the local health network/methadone clinic.

1 Introduction

1.1 Policy context

The COVID-19 pandemic presents particular challenges for people who are using drugs and for those providing services to vulnerable populations. Social distancing requirements are hampering effective operation of services and many treatment centres are temporarily closed. We are also aware of the further dangers faced by socially excluded groups, already enduring poor health outcomes and having poor access to healthcare services. We know that restrictions in services and in contacts with vulnerable people are exacerbating the everyday life challenges faced by people with substance use problems. People who are homeless and people who use drugs often have multiple comorbidities and early mortality compared with the general population. The older cohort of opioid users are particularly vulnerable because of their high level of pre-existing health problems. There is a high prevalence of chronic obstructive pulmonary disease, asthma, and cardiovascular disease among people who inject drugs and use cocaine. These chronic medical conditions will put clients of drug treatment services at particular risk for serious respiratory illness if they become infected with COVID-19.

This rapid evidence brief will help the Department of Health put the response to the COVID-19 crisis in an international context. The findings will enable the Department and health services to make comparisons in other countries and to identify initiatives that may be relevant to the drugs situation in Ireland.

1.2 Research questions

The primary research question is what approaches have been taken in Scotland, New South Wales, New York City and British Columbia to deal with the impact of the COVID-19 epidemic on people who use drug treatment and harm reduction services and other people who use drugs.

There are four sub-questions:

1. How has COVID-19 impacted on people who use drugs?
2. How has COVID-19 impacted on the demand for drug and alcohol services?
3. What guidelines and supports have been provided for drug and alcohol services in light of COVID-19?
4. How are drugs and alcohol services being re-structured to meet clients' needs in light of COVID-19, especially clients with complex needs and who are most vulnerable?

2 Methods

Given that the context of this evidence brief, it was clear that traditional literature sources such as bibliographic databases would be of limited value in terms of identifying relevant and current information to answer the research questions. Instead, the approach was to look broadly across grey literature sources as well as traditional published material.

The inclusion criteria were that documents were relevant to one of the four research questions, and relevant to the countries/regions in question. Evidence in the form of reports, guidance, journal articles, news sources, websites and legislation were included.

2.1 Country/region selection

The country, two states and one province included in this review – New South Wales, Scotland, New York State and British Columbia – were chosen because they are developed economies and have been disrupted by the COVID-19 epidemic and official documentation is available in English. They also have patterns of problem drug use similar to Ireland and provide a comparable range of treatment and harm reduction responses.

2.2 Search strategy

This brief relied primarily on government publications, government websites, and country reports published by international organisations and independent agencies.

2.2.1 Grey literature search

The grey literature searches were conducted as follows:

1. Identification of relevant government or state websites to ascertain the organisational structure for bodies responsible for drug and alcohol policy and legislation; and the nature of service administration within the country/state or province.
2. The search facility of the relevant Government bodies (such as the Department of Health) were searched using the individual terms substance; alcohol; drug; addiction; mental health.
3. The COVID-19 online section of the relevant lead departments or organisations were reviewed to find relevant information and publications.
   Specific documents within the COVID-19 section were manually searched using the terms: substance; alcohol; drug; addiction; prison; homeless.
4. To find additional material, the Google.com search engine was used to do a site-specific search for drug treatment services, for example: 'Drug treatment service COVID site:.nsw.gov.au'
5. Health, homeless and prison services, and non-governmental organisation sites were searched for resources and information about treatment and harm reduction data, services and relevant COVID-19 related issues. Organisations were identified through our initial search, and through a Google.com search of the country/state or province.

Note: When searching for documentation for New York, US national and federal agencies were also searched, as these agencies have oversight of aspects of drug and addiction services and policy. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the US Department of Health, and the Drug Enforcement Administration (DEA) is the US federal law enforcement agency under the Department of Justice, these websites were also searched for COVID-19 related resources.

References to further organisations and resources were noted and followed. Additional material, for example, relevant news articles were included. Supplemental material was collected through social media notices and general searches during the routine work of the librarians of the HRB National Drugs Library.

Searches took place between 9 and 22 May 2020.

All relevant documents were imported into Endnote X9 reference management software and the full text was obtained for screening by the review team.

2.2.2 Google search:

A broad search of the Google.com search engine was undertaken as follows:

'[Country] drug service COVID'

'[Country] alcohol service COVID'

'[Country] drug alcohol COVID'

Searches took place between 9 and 22 May 2020.

All relevant documents were imported into Endnote X9 reference management software and the full text was obtained for screening by the review team.

2.2.3 Database search

The majority of research regarding health services responses to the COVID-19 pandemic is currently found in a combination of biomedical databases, pre-print servers or COVID-19-specific collections from international organisation and publishers. The approach to retrieving relevant published research evidence for this brief was to search broadly using general terms (substance; alcohol; addiction; mental health; homelessness) and the name of the country/state/province) in the following databases.

Table 1: Search of online databases between 9 and 22 May 2020

Database	Number of articles retained for screening
COVID Evidence Alerts https://plus.mcmaster.ca/COVID-19/	0
LitCovid (Pubmed) https://www.ncbi.nlm.nih.gov/research/coronavirus/	9
medRxiv (COVID-19 SARS-CoV-2 preprints from medRxiv and bioRxiv) https://connect.medrxiv.org/relate/content/181	0
Society for the Study of Addiction. Bibliography on COVID-19 and Addiction: 26 May 2020. https://www.addictionjournal.org/files/download/documents/26%20May%20COVID-19%20bibliography.docx	
WHO COVID-19 Database https://search.bvsalud.org/global-literature-on-novel-coronavirus-2019-ncov/	3

All databases were searched on 20 May and updated on 29 May 2020. Duplicates were removed and results were imported into Endnote X9 for screening by the review team.

2.3 Data extraction

Relevant data from the included sources were extracted and analysed. The findings from the four regions were then used to identify the key components of a health system response to the COVID-19 pandemic.

3 Irish and European context

3.1 Ireland: organisational structure and legislation

The Health Service Executive (HSE) is responsible for the provision of all publicly funded drug treatment. Drug treatment is provided through a network of HSE services and non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment. Harm reduction services are provided either directly by the HSE or through community-based organisations (CBOs) such as Merchants Quay Ireland (MQI) and the Ana Liffey Drug Project (ALDP).

3.2 Addiction treatment services

A range of treatment options is available for problem drug users, mainly in outpatient settings, but also in residential settings. The majority of opiate substitution treatment (OST) clients receive methadone in specialist outpatient clinics, with a smaller number receiving it from specialist general practitioners and an even smaller proportion (less than 5%) in prison. The number of clients registered for OST on 31 December each year has increased over the past 20 years, from 3,689 in 1998 to 10,332 in 2018.[1] Most drug treatment (more than 75%) is provided through publicly funded and voluntary outpatient services.[1]

Outpatient services include low-threshold and specialised OST GPs in the community. Inpatient treatment is mainly provided through residential centres run by voluntary agencies. Opioids (mainly heroin) are the main problem illicit drug used by entrants to treatment, followed by cannabis and cocaine. For new entrants to treatment, cannabis has been the most frequently reported main problem drug since 2010. The most notable trend recently is the increase in the number of cases presenting for treatment for problem cocaine use.[1]

Harm reduction initiatives include free needle exchange, supplying alcohol wipes, sterile water, citric acid filters, spoons and condoms; and providing methadone and naloxone therapy, as well as rehabilitation, education and community/family support. Pharmacies provide needle exchange in each Regional Drug and Alcohol Task Force (RDATF).

3.3 Impact of COVID-19: Ireland

3.3.1 People who use drugs

EMCDDA Mini-European Web Survey

In April and May 2020 the EMCDDA conducted a Mini-European Web Survey as part of its trendspotter study[2] on the impact of COVID-19. The aim of the study was to gather information about how patterns of drug use may have changed in Europe due to COVID-19, the impact on people who use drugs and challenges for service providers.

There were 633 respondents from Ireland at the end of May. Some of the findings from this response are presented below. This survey did not attempt to estimate prevalence or the extent of particular drug using behaviours in Europe. It is part of rapid response to a quickly evolving situation so its results should be treated with caution. Nevertheless, it is useful as a snapshot of patterns among a small cohort of people who are using drugs and chose to respond to the survey.

We can see from Table 2, that respondents who used cannabis more frequently (daily or almost daily) in the 30 days prior to introduction of restrictions were much more likely to use drugs more frequently or to use greater amounts in one session than they had before. Only a small number reported that they had used cannabis less frequently, despite anecdotal information that cannabis had become more difficult to obtain.

Table 2: Change in cannabis use behaviour among Irish respondents to EMCDDA trendspotter survey following introduction of restrictions to stop spread of COVID-19 virus

Frequency of use prior to pandemic (last 30 days)	No change	Used less frequently or stopped	Used more frequently or greater quantity in a session	Other	Total
Daily	36	9	94	10	149
Almost daily	10	10	50	9	79
Not daily but more than once a week	15	23	21	3	62
Once a week	15	9	2	8	34
Less than once a week	19	34	5	20	78

The number reporting cocaine use in the 30 days prior to the introduction of restrictions was small (Table 3), but there is a similar pattern to that among cannabis users. Those who reported using more frequently than once a week were more likely to report no change in use or greater use since the introduction of restrictions than those who had less frequent use.

Table 3: Change in cocaine use behaviour among Irish respondents to EMCDDA trendspotter survey following introduction of restrictions to stop spread of COVID-19 virus

Frequency of use prior to pandemic (last 30 days)	No change	Used less frequently or stopped	Used more frequently or greater quantity in a session	Other	Total
Almost daily/daily	3	0	8	1	12
Not daily but more than once a week	9	2	11	0	22
Once a week or less	32	72	14	24	132

In answer to the question 'In general, would you say you have used more or less illicit drugs, since the start of the COVID-19 epidemic in your country?' 209 (33%) respondents replied less, 142 (22%) replied more, and 90 (14%) replied the same amount. In answer to the question 'Has there been a change in your intention to seek professional support (counselling or drug treatment) to reduce or abstain from use of illicit drugs since COVID-19 containment measures were introduced?' 45 respondents said there had been a slight increase and 26 replied that there had been a strong increase. A total of 14 respondents were less likely to seek professional support. Demand for drug treatment and harm reduction services.

The HSE reported that an additional 647 people commenced OST in the period January to end May 2020. Drugs.ie, the HSE's drug and alcohol information and support website provides a list of services that are operating during the pandemic.

3.3.2 Guidelines and supports

Guidelines for OST

The HSE has developed new guidelines or adapted a number of its guidance information documents and shared these with service providers. Guidelines on contingency planning recommend[3] a number of actions, in particular for people who are unable to access services either through their own isolation or because services are not currently available. There is a particular concern around the needs of people who are homeless. All services working with vulnerable groups have a role to play in

identifying those in need of OST. The guidelines state it may not be necessary to go through a prolonged assessment process in the following circumstances, which are also relevant to rapid/emergency induction:

- The person is a known opioid dependent person through engagement with the service.
- There are visible track marks.
- The person has a previous history and has been on OST treatment before - this can be verified through the Central Treatment List as necessary.
- The person is/was in treatment in another jurisdiction.

The process by which a clinical review for OST clients can be undertaken remotely (with video link or smartphone) is spelled out in detail in guidance documents. [4] A number of options are available for a person on treatment who is isolating at home including provision of sufficient dose for the duration of the self-isolation, provision of medication to family members or a driver or key worker. The guidelines provide advice regarding securing the stored doses, general safety and record keeping is provided. The HSE have also produced documents supporting those adapting their services to the new situation. These include:

- Standard operating procedures (SOP) for emergency induction of OST; medicines management policy.[5]
- Medicines management policy to support with people with a history of addiction who are in self-isolation.[6]
- SOP for dispensing medication in isolation.[7]
- Guidance on remote consultation.[4]
- Guidance on recent legislative changes designed to facilitate the safe supply of medicines during the pandemic.

3.3.3 Restructuring of services

Since the beginning of the pandemic, HSE Addiction Services have focused on continuity of care for people already in treatment. The focus has been on inducting people who are identified as opioid dependent on to OST as quickly as possible in order to reduce the potential for viral transmission among this cohort and to reduce the risk of harm to the person.

Administrative changes have allowed a much faster processing of clients into treatment. The wait for methadone treatment has been reduced from 12 weeks to 3 days. [8] Benzodiazepine prescriptions have increased to enable easier stabilisation of drug use during isolation. Resources have been provided to support cocooning and isolation of vulnerable homeless people. An extra 500 single rooms with bathrooms have been made available. An Taoiseach, Leo Varadker TD, said in the Dail on 30 April 2020, "*The Government has taken a focused approach towards vulnerable groups, including homeless people, Travellers, Roma, drug users, prisoners and residents in Department of Justice and Equality accommodation centres. This involves testing, treating, isolating and cocooning, as well as tending to other health conditions.*"[9]

Outreach services have been active in providing information on COVID-19 to clients when delivering needle and syringe exchange services.[10] This is an important service as many people were unaware of the dangers or had become fearful or frustrated. This presented challenges for outreach teams, but they are well versed in safety and health measures and infections among them are low.[11]

Changes in regulations

In response to the outbreak of COVID-19, temporary amendments to the Medicinal Products (Prescription and Control of Supply) Regulations 2003 (as amended)[12] and the Misuse of Drugs Regulations 2017 (as amended) have been made by the Minister for Health.[13] These temporary provisions are designed to ensure that patients can continue to access their ongoing treatment and 'regular' medicines during the ongoing emergency and to assist in easing the additional burdens on prescribers and pharmacists arising from the pandemic. The amendments allow for the electronic transfer of prescriptions between doctors and pharmacies and remove the need for a paper

equivalent. The legislation also extends the validity of prescriptions from six to nine months and enables pharmacists to make additional supplies of prescription-only medicines to patients from an existing prescription. This additional authority to pharmacists must only be used where, in the pharmacist's professional judgement, continued treatment is required and it is safe and appropriate to make an additional supply.

Challenges in treatment provision

Health services have identified a number of particularly vulnerable groups or situations where people who use drugs may be at greater risk.[3] COVID-19 is a respiratory illness with possibility of respiratory depression, especially for people with existing respiratory problems. People with a history of drug use have high rates of chronic respiratory diseases and so would be at increased risk. Some people may not be able to self-isolate if they are sleeping rough or using one-night-only accommodation, hostels, bed and breakfasts and hotels. There are also mental health risks as those who quarantining may be find the isolation intolerable. Greater levels of stress can result in relapse or worsening of an existing mental health condition.

There are greater risks from overdose as people stockpile drugs in response to shortages, they may be using drugs on their own or increasing their alcohol and non-prescribed drugs.[11] People may not have sufficient access to clean injecting equipment due to limited access to needle exchange or due to isolation or be able to avail of harm reduction advice.[10] Added to the dangers of transmitting blood-borne viruses, there is an increased risk of COVID-19 infection when injecting or smoking equipment is shared. HSE advice to harm reduction services includes taking requests for equipment by phone and delivering it safely.

Remote Services

The HSE provides lists of treatment and other support services being made available remotely. Software to enable video consultation was identified and licences have been made available to HSE Addiction Services. A guide on providing remote consultations was developed by Martin Jones and Dr. Bobby Smyth in the HSE.[4] Clinical review for OST services can take place remotely via Smartphone. A number of HSE addiction services provided Smartphones to people in treatment isolating at home or in an isolation hub to facilitate eConsultations.

Not all services are comfortable with maintaining services using internet-based group platforms, and for some it is not possible as they don't have the facilities to ensure a secure service. There are concerns with disrupting group dynamics which may undermine an important feature of group therapy.[14] The psychological burden from COVID-19 has an effect on resilience and increases the risk of relapse as patients must spend long periods away from the protective treatment environment with the support that it brings. Telephone consultations can have the same efficacy as face-to-face consultation, but they do require precautionary measures.

OST treatment services have continued. The use of eConsultation software and the delivery of medication have ensured people in isolation can continue their treatment. Clinics have implemented social distancing measures and provided people with letters stating the date and time of their appointment to ensure permission to travel during the period of restricted movement.

Recovery groups are now provided online in a number of areas. These groups include but are not limited to Alcoholics Anonymous (AA), Cocaine (CA), Narcotics Anonymous (NA), and Smart Recovery. Key workers are engaging with clients via phone, communication apps and video chat to discuss harm reduction.

Using telehealth to deliver recovery services in the Southeast.

Better Together is a response to the challenge of continuing to provide structure and support for people in recovery in the Southeast during the COVID-19 pandemic using online video conferencing technology. The team coordinating this response comprises a HSE Counsellor, HSE Drug Education Officer, Special Community Employment Scheme (CES) co-ordinators, four people with lived experience of substance misuse and mental health challenges, and a Regional Drug and Alcohol Task Force Development Worker. The team began by discussing the importance of structure and daily routine to help keep people motivated and connected in their recovery. The importance of co-

production in the provision of the supports was seen to be a vital component of the response. It was very important that people could avail of counselling support in addition to peer support almost immediately. The sessions facilitated through the video conferencing system are not structured by topic. They're open sessions where people can decide what they want to discuss on that day. The team developed a weekly routine of supports that included the following:

A **Recovery Check in** session which runs each morning at 10:30am. The purpose of this session is to discuss goals and challenges for the day ahead and receive support and encouragement. People can receive counselling interventions by phone or using Microsoft Teams online meeting technology. Between 12 and 19 people attend this session each day.

A **Recovery Reflection** session runs every evening at 19:30 pm. The purpose of this session is to discuss how the day went, goals achieved or challenges experienced. This builds on reflective learning from the morning session. Generally the same numbers attend this session as the morning session.

A **Methadone & Medically-Assisted Recovery and Me** Session which runs twice a week at 12pm Monday and Friday. The purpose of this session is to provide peer and professional support for people who are on an OST programme of medication and are facing mental health challenges. On average between 5-8 people attend these sessions and it is expected that this will grow steadily.

A **Recovery Life Skills** session which runs twice per week on a Wednesday and Friday at 2pm.The purpose of this session is to get support with managing thoughts, feelings, behaviours, urges and cravings. Participants hear from people in recovery on how they managed different challenges in recovery in addition to counselling support. Between five and ten people attend these sessions each week with numbers growing steadily

An **Eat Right 4 Recovery** session which runs twice per week for 4 weeks. The purpose of this session is to educate people to eat healthily to support recovery. Individual plans in addition to recipes and diaries are used to achieve this and 12-16 participants attend these sessions each week

A **Better Sleep in Recovery** session which runs once per week on Thursday at 12pm.The purpose of this session is to help people to achieve better sleep and coping as a result. Attendance ranges from five to eight people.

An **Opening the Door to Recovery** session which runs three times per week at 9:15am. This session is to introduce people who may still be using or trying to reduce or a completely new to the concept of recovery an opportunity to learn about the different experiences and routes to recovery. Two to three people attend these sessions with numbers growing with referrals

A **Women's Recovery Group** session held at 12pm each Wednesday, which enables women discuss issues in recovery privately. It supports mothers with children who have been placed under a protective order. The first meeting is scheduled for the 3 June with 15 participants confirmed to join.

A **Story of Us, Family in Recovery** session which will run each Thursdays at 2pm. This session is for parents, partners or loved ones who need a space to learn and receive support about recovery.

3.4 Impact of COVID-19: European Union

In early March the EMCDDA established a task force to monitor the impact of COVID-19 on the drugs situation in Europe and the responses to it. The EMCDDA trendspotter study[2] is an investigative rapid assessment using a variety of information gathering tools including a series of online surveys to national focal points, an expert network of trendspotters and a European survey for people who use drugs. As part of its analysis of the impact on drugs markets and crime, the EMCDDA has produced a report on activity on darknet markets[15] and has collected further information through a survey in cooperation with Europol.[16] The second wave will examine patters of use and harms.

3.4.1 People who use drugs

EMCDDA Mini-European Web Survey

In April 2020 the EMCDDA conducted a Mini-European Web Survey as part of its trendspotter study on the impact of COVID-19.[17] The aim of the study was to gather information about how patterns of drug

use may have changed in Europe due to COVID-19, the impact on people who use drugs and challenges for service providers.

3.4.2 Demand for drug treatment and harm reduction services

Treatment services
Four countries (Bulgaria, Ireland, Lithuania and Portugal) reported preliminary data on treatment demand and these show a decline of almost 50% between January and March 2020 in the numbers entering treatment, while other countries (Czechia, France, Italy and Luxembourg) saw increases in demand for OST. The reduction in demand from both existing and new clients was attributed to COVID-19-related restrictions on movements and limitations on service capacity due to social distancing requirements and staff shortages. The increase reported may be due to reduction in the availability of heroin on the illicit marketing and greater concentration in demand on services remaining open. The reduction in entries to treatment for cannabis use has been partially explained by the drop in referrals from the criminal justice system, even as people who use other drugs become more aware of their problem use as restrictions on movement continue. The EMCDDA mini European Web Survey on Drugs: COVID-19 found that there was not a marked change generally in the numbers intending to seek support among those who use drugs, but 15% of respondents from Ireland did intend to seek support.

Harm reduction services
Harm reduction services have reported an increase in demand for social support, often from sex workers or from people recently released from prison. Increases in alcohol and benzodiazepine use as result of higher levels of anxiety among service users have required increased support from harm reduction services.

3.4.3 Guidelines and supports

The World Health Organization (WHO)[18], the European Centre for Disease Prevention and Control (ECDC)[19] and other international organisations have published public health recommendations, and many countries have adapted these for use at the national level. Eleven countries have produced specific guidelines for drug services or drug-related problems, some of which have published at the national level and some separately by non-governmental organisations (NGOs). Much of Europe's harm reduction services are supported by extensive collaboration between NGOs, health services and other private and public care providers. The COVID-19 situation has necessitated an increase in this collaboration to provide a rapid response to the difficulties faced by users of these services.

A sample of guidelines available from international institutions and in other countries is presented below:

UNODC

Suggestions about treatment, care and rehabilitation of people with drug use disorder in the context of the COVID-19 pandemic.[20]

This document refers to the International Standards for the Treatment of Drug Use Disorders (UNODC/WHO, 2020) and emphasises the importance of maintaining access to health and social care for people who use drugs. This includes low-threshold services as well as psychosocial treatment and pharmacological treatment in a range of settings.

United Kingdom

Department of Health and Social Care

COVID-19: guidance for commissioners and providers of services for people who use drugs or alcohol [21]

The document emphasises that services should keep operations open but keep face-to-face contacts between staff and service users to a minimum. It includes information on safety for staff, recognising COVID-19 symptoms, identifying those who are in a particular risk category and working with people who are clinically extremely vulnerable. Commissioners, managers and staff are advised to make contingency plans for interruptions in the supply of medicine, reduced access to illicit drugs, an

increase demand in services and associated problematic behaviour, greater vulnerability to the effects of COVID-19, particularly breathing difficulties, among people who use drugs and the risks to partners and children of people who use drugs. In dealing with problems related to OST, commissioners and staff should, where possible, transfer to take-home doses, nominating individuals to pick up prescriptions, deferral of detoxification and dose reduction, offering buprenorphine for entrants into treatment and close working with policy and local services. Care should be taken to have adequate stocks to supply needle and syringe programmes. The guide recognises the difficulty in providing non-medical support and suggests using phones or, when possible, online support to work with service users.

Royal College of Psychiatrists

COVID-19: Working with vulnerable people[22]

This guidance document includes sections on people who use drugs and people with alcohol dependence. The guide advises that it would be appropriate to relax the requirement to attend community pharmacy and remove barriers to treatment as much as possible. Take-home medication is a far safer option to using street opioids and should be encouraged. Two weeks supply should be considered and extended if needed. Buprenorphine formulations carry less overdose risk than methadone and may be more suitable for new entrants into treatment. Moving from supervised consumption should be robustly considered. Buprenorphine titration should be considered when only remote assessments are possible. It should be possible for a service user to nominate an individual to collect prescriptions. All such arrangements should be supported by the provision of take-home Naloxone, safe storage boxes and harm reduction advice.

Germany

Conference of the Chairmen of Quality Assurance Commissions of the Associations of Statutory Health Insurance Physicians in Germany

Information on opioid substitution and Sars-CoV-2/COVID-19 - Advice for physicians [23]

Changes in regulation around OST allow for greater use of take-home medication, and so visits to general practitioners and outpatient clinics should only be made when absolutely necessary. Prescriptions that had been for seven-day supply can be extended up to four weeks. The decision as to whether take-home provision is suitable for the client will be made by the prescribing doctor. For non-stable patients the prescribing doctor must decide if it is in the best interests of the patient to begin a course of medication. Crowding can be avoiding by extending dispensing and open hours and limiting the direct observation of patients, even in practices with a high proportion of patients who are routinely observed. Patients who are quarantining at home may receive a prescription for self-administration or can be treated by an outpatient nursing services. Before the first prescription is issued, a doctor must visit the patient at home and the medication is then delivered directly to the patient's home by a pharmacy. For unstable patients in quarantine, prescriptions can be issued for a few days and contacts can in the meantime be made by video on mobile phones. Distribution of substitution medicines from the practice/outpatient clinic remain criminal offences according to the substitution law even in the current situation.

3.4.4 Restructuring of services

While around half of EU countries report a slight or strong decrease in the availability and provision of treatment and harm reduction services, as healthcare providers there is a need for these services to remain operational under restricted conditions. Like other public and specialist health services, many drug services operate through face-to-face contact with individuals or groups and fundamental operational changes have been needed. Many providers, including drop-in centres, low-threshold and consumption rooms not been able to implement these protection measures and have closed. The EMCDDA's trendspotter study[2] found service providers were facing a number of staffing challenges as many staff were unable to work due to family commitments or quarantining. This places additional burden on remaining staff who are in positions of increasing vulnerability to infection and unable to access personal protective equipment. It is important to provide information to services users on the dangers that COVID-19 presents and the importance of prevention measures. A small number of

services have reported that clients have become infected, and this places additional burdens in managing the anxiety and confusion that this can cause among marginalised populations. Service providers also acknowledge the need to increase the capacity of outreach programmes to cater for more vulnerable and excluded groups.

Initiation of OST for people entering treatment generally requires several face-to-face meetings between the client and the prescribing clinician. Many countries have reported challenges in starting treatment for new clients, and this problem is particularly acute in residential settings. Detoxification has been discontinued or significantly curtailed in most countries. The need to maintain access to OST for existing clients is a common theme and ensuring this has required a great deal of coordination and the development of innovative service and policy approaches. There is concern around the greater danger of overdose as some services prescribe larger take-home packs of OST. The effort to accommodate those entering or seeking to maintain OST may have the effect of making less resources available for those who use other drugs.

Remote services
Telemedicine, by phone or video, have largely replaced face-to-face contacts. There are obvious benefits to using these technologies as contacts with clients can be maintained and counselling sessions continued. However, there have been difficulties in persuading clients to engage with remote technologies and the inability of service users to access the devices needed to use them.

Changes in regulations
Many countries have introduced adaptations to OST services to maintain access to medication for those in treatment to respond to new clients. This has included a relaxation of regulations or legal frameworks on take-home OST for stable clients. The impact on low-threshold services has been severe and many have tried to replace existing services with remote alternatives. Other adaptations include providing increased quantities of injecting materials, self-service provision and use of postal services.

Challenges in treatment provision
Preliminary findings from the first wave of the trendspotter study show that there has been a reduction in the capacity of treatment services but also a move of activities onto mobile and online platforms and most countries have developed guidelines to assist services deal with the situation. Challenges include accessing sufficient personal protective equipment (PPE) for staff and staff shortages. There are problems enrolling new clients and managing services users who have become infected. Initial reports suggest a marked decline in new entrants to treatment, particularly among people who are using opioids. Among the changes drugs services expect to result from the current crisis is greater flexibility in OST and more attention on telemedicine approaches.

Drug markets
EU drug markets: Impact of COVID-19[16] was published by the EMCDDA and Europol in May. Using a network of expert informants in from various international institutions and expert groups, data collected from EMCDDA national focal points, open source information and independent experts, the authors compiled a review of impacts and consequences, an account in changes in the market for main drug types, activities among criminal groups and the law enforcement response. The study found that disruptions to the supply chain in the illicit drugs market, due to travel and other restrictions, was most evident at the distribution level.

There are also higher levels of violence at the distribution level in many countries and a slight decrease in some. Authorities have been alerted to the possibility of organised crime groups (OCG) taking advantage of economic upheaval to launder money through the property and construction sectors. Also, criminality may increase because of the collapse of opportunities in the legitimate economy. Domestic production of cannabis has been significantly disrupted and prices have increased significantly. Heroin is less available, and prices are higher with some signs of substitution with synthetic opioids or other drugs. Significant cocaine seizures were made in early 2020 and maritime smuggling has continued or increased in some cases. Drug drops, or ‘dead drops’, often following payment in cryptocurrencies are increasingly replacing face-to-face transactions. Home deliveries,

facilitated by impersonating professions such as drivers to get past traffic restrictions, are becoming more common. The postal system is also used to distribute drugs.

Domestic production of herbal cannabis has not been disrupted but there have been distribution problems, including cross border travel, leading to higher prices in particular for cannabis resin, especially in northern Europe. A consistent picture of heroin distribution at the consumer level has not emerged yet, but there does not appear to have been a significant impact at the local level. International commercial transport has continued, enabling the movement of bulk quantities of drugs and organised crimes groups remain intact, as evidenced by some large maritime seizures in recent months. While the supply of cocaine has been maintained, prices have increased in some countries and purity is less. As producing countries peaked later than European countries, production was maintained, and it feared that there will be less resources available now to counter exports from South America and other sources of cocaine. While demand for recreational drugs has fallen sharply, synthetic drug production in Belgium and The Netherlands has not diminished.

An EMCDDA special report, *COVID-19 and drugs. Drug supply via darknet markets*[15] is based on a rapid analysis of three darknet markets and qualitative information from a number of online forums. There appears to have been an increase in cannabis-related activities in darknet markets during the first three months of 2020, but purchase for resale has decreased as social distancing has disrupted the physical illicit drug market. There is a decline in demand for the type of drugs typically used at large social events. The United Kingdom, Germany and the Netherlands are the most frequently cited origins of drugs for sale. There are signs that vendors are employing various marketing techniques and customer supports, such as 'dead drop', to retain customers. The number of reviews on a site, a proxy indicator for activity on Darknet sites, has increased on two of the sites reviewed.

4 New York

4.1 Introduction

With an estimated 2018 population of 8,398,748. New York City is the most densely populated major city in the United States (US). The city is the centre of the New York metropolitan area, the largest metropolitan area in the world by urban landmass with almost 20 million people. The metropolitan area includes New York City, Long Island, the Mid and Lower Hudson Valley in the state of New York, and the five largest cities in New Jersey. There are 62 counties in the state of New York.[24]

4.1.1 Substance use in New York

According to recent treatment data, alcohol and opiates (both 37%) were the most commonly reported primary substances among those receiving treatment. Opiate users included heroin (32%) and other opiate use (6%). A further 13% reported cannabis as their primary substance and 8% reported cocaine.[25] Similar to the rest of the USA, opioid use is a significant problem in New York. While New York has lower levels of heroin and other opiate use and lower mortality from overdose, there was a 200% increase in the number of opioid overdose deaths in New York between 2010 and 2017. In 2017, opioids caused 16 deaths per 100,000 population. This increase is mainly driven by an increase in the use of synthetic opioids, especially illicitly manufactured fentanyl.[26]

4.1.2 Addiction treatment services

The Office of Addiction Services and Supports (OASAS) is the designated single state agency responsible for the coordination of state-federal relations in the area of addiction services. OASAS plans, develops and regulates all certified or funded addiction treatment providers across the state to ensure strict compliance with agency regulations and state and federal laws. OASAS provides information and instruction on emerging issues or trends in the field of addiction treatment services; how these developments relate to the laws and regulations in effect; and any actions that providers should take as a result.[27] In New York 71% of treatment services are operated by private non-profit organisations, 17% are private for-profit, and the remainder are operated by local, state or federal government organisations; 69% of facilities are outpatient, 27% are residential, and 9% are hospital in-patient.[28]

4.1.3 Relevant organisations

- The **Office of Addiction Services and Supports** (OASAS) is the designated single state agency responsible for the coordination of state-federal relations in the area of addiction services.
- The **Substance Abuse and Mental Health Services Administration** (SAMHSA) Is a branch of the US Department of Health and Human Services. It is charged with improving the quality and availability of treatment and rehabilitative services in order to reduce illness, death, disability, and the cost to society resulting from substance abuse and mental illnesses. The Administrator of SAMHSA reports directly to the Secretary of the US Department of Health and Human Services.
- The **Drug Enforcement Administration** (DEA) is a US federal law enforcement agency under the United States Department of Justice, tasked with combating drug trafficking and distribution within the United States. The DEA is the lead agency for domestic enforcement of the Controlled Substances Act.
- The **Centre for Disease Control** (CDC) is a US federal agency, under the Department of Health and Human Services. Its main goal is to protect public health and safety through the control and prevention of disease, injury, and disability in the US and internationally.

4.1.4 Substance use issues that have arisen since the outbreak of COVID-19

- A number of newspapers have reported findings from the DEA stating that drug trafficking operations, production, packaging, transportation, distribution, and money laundering are all more costly right now and that the street price of drugs have increased. Since March, cannabis prices increased by 55%, cocaine prices by 12%, and heroin prices by 7%.[29]

- At a national level, it has been identified that COVID-19 could be a serious threat to those who smoke cannabis, and those with opioid use disorder or methamphetamine use disorder due to these drugs' effects on respiratory and pulmonary health. Chronic respiratory disease increases overdose mortality risk among people taking opioids while methamphetamine constricts the blood vessels, which can contribute to pulmonary damage.[30 31]
- Individuals with a substance use disorder are more likely to experience homelessness or incarceration with more than half of prisoners having such a disorder, which can expose people to environments where they are in close contact with others who might also be at higher risk for infections.[30]
- The prospect of self-quarantine and other public health measures may also disrupt access to syringe services, medications, and other support needed by people with OUD.[31]

4.1.5 Legislation/regulations that have been amended since the onset of COVID-19

The Controlled Substances Act is the statute establishing federal US drug policy under which the manufacture, importation, possession, use, and distribution of certain substances is regulated. Exceptions to this Act may be made if the Secretary of Health and Human Services declares a public health emergency, which occurred with regard to COVID-19 on 31 January 2020. Since that declaration, the DEA in conjunction with SAMSHA has allowed changes to normal practice. Typically, a prescription for a controlled substance issued by means of the internet (including telemedicine) must include an in-person medical evaluation. DEA-registered practitioners may now issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation. This exemption does not apply to new patients treated with methadone for whom the requirements of an in-person medical evaluation remain.[32,33] Due to reduced staffing and other limitations imposed by COVID-19, some treatment programs have had difficulty delivering take-home doses of methadone to patients. They are now permitted to temporarily set up off-site locations to deliver take-home methadone doses to their patients without separately registering that location with the DEA.[34]

4.2 Question 1: How has COVID-19 impacted on people who use drugs?

No relevant information identified

4.3 Question 2: How has COVID-19 impacted on the demand for drug and alcohol services?

No relevant information identified.

4.4 Question 3: What guidelines and supports have been provided for drug and alcohol services in light of COVID-19?

Governor Cuomo issued an Executive Order stating that licensed outpatient addiction treatment programs are essential services and their staff are essential healthcare workers. OASAS programs may remain open and operational and are not subject to non-essential workforce reductions.[35]

4.4.1 General guidelines regarding service provision

SAMHSA recommend that outpatient treatment options be used whenever possible and that inpatient facilities and residential programs should be reserved for those for whom outpatient measures are not adequate (e.g. for persons with life threatening substance use disorders who may be at high risk for overdose or complications from withdrawal). Comprehensive long-term residential treatment programs, where COVID-19 related precautions can be implemented (social distancing, isolating, testing, etc.) remain a viable treatment option when clinically indicated.[36]

For out-patient services OASAS states that programs must maximise the use of telehealth services, including for psychosocial services and supports and medication management services. Programs

should not be running any in-person groups until otherwise instructed by OASAS. Programs should be doing individual counselling sessions using telehealth methods, unless there is a specific need to do otherwise (e.g., a patient has no phone access, urgent risk assessment or crisis management). Toxicology should not be performed until instructed by OASAS. Programs should not be performing in-person procedures (e.g., laboratory specimen collection, physical examinations, tuberculosis screening), unless it is critical for the near-term health and safety of a patient. An outpatient program intake and induction on medication-assisted treatment can be safely performed through telehealth, without any in-person procedures. Non-critical procedures required by regulations are waived during the COVID-19 public health emergency.[37]

4.4.2 Guidelines for providers of opioid treatment programs

At the national level, the DEA has partnered with SAMHSA. to ensure authorised practitioners may admit and treat new patients with opioid use disorder. The DEA states that practitioners may prescribe controlled substances using telemedicine without first conducting an in-person evaluation.[32] Patients with lab-confirmed COVID-19 should receive 28 days of medication immediately and should not present for dosing to the clinic. Patients with signs/symptoms of a respiratory infection should be evaluated by a medical provider using appropriate PPE, who will decide on a safe number of take-home doses, up to 28 days of medication. They should consider the patient's stability in treatment and ability to safely store and protect the medication.[37] Based on the more favorable safety profile of buprenorphine, programs should seek to maximise the ability of patients to take their buprenorphine at home during the COVID-19 crisis. Existing patients using methadone can be treated via telehealth (including use of telephone, if needed).[33]

4.4.2.1 New patients entering treatment

Federal law requires a complete physical evaluation before admission to an opioid treatment program. Following exemptions to the Controlled Substances Act, for new patients treated with buprenorphine, an in-person physical evaluation is not required if a program physician, primary care physician, or an authorised healthcare professional under the supervision of a program physician, determines that an adequate evaluation of the patient can be accomplished via telehealth. This exemption does not apply to new patients treated with methadone for whom the requirements of an in-person medical evaluation will remain. Patients starting on methadone are not permitted to receive escalating doses for induction as take-home medication. This means that a person starting methadone would get a maximum dose of 30 mg/d and may be on this dose, which for most people with OUD would be a low dose that will potentially be inadequate, for extended periods (up to 14 days if the clinic is using a blanket exception during the current medical emergency). The methadone dose could only be increased by a small amount (e.g., 5 mg/d) meaning that the person would be on what are considered subtherapeutic doses of methadone to treat opiate use disorder for an extended period. An initial in-person physical evaluation is needed for providers to address such risks in each newly admitted methadone patient.[33]

4.4.2.2 Take-away doses (TADs) and deliveries

All patients with significant medical comorbidities and/or patients over 50 can be eligible for take-home medications up to 28 days, at the clinical discretion of the program physician. Patients who have already qualified for 1 or more additional take-home doses and suggest likely ongoing compliance and stability should be provided 7-28 days of medication as clinically and medically appropriate. Patients with none or only one take-home, as determined by the medical provider to be appropriate should be considered for a staggered take-home schedule whereby half the treatment program's patients present on Mondays, Wednesdays and Fridays, and the other half present on Tuesday, Thursday, Saturdays, with the remaining doses of the week provided as take-home medication. This reduces the clinic's daily census by half, patients are still evaluated frequently and do not receive more than 2 days of take-home medication at any one time. As there are no time-in-treatment take-home regulatory requirements for patients being dispensed buprenorphine, patients should be evaluated for flexible take-home doses as clinically warranted.[38] Treatment services can provide delivery of medication to

an individual patient if they cannot leave their home, or to another controlled treatment environment. A responsible adult can serve as a designated other or surrogate to pick up a patient's medication.[39]

4.4.3 Guidance on alcohol use disorder

An additional concern has arisen for those with alcohol use disorder and benzodiazepine use disorder, which increase the risk of seizures. Benzodiazepines are frequently utilised in a tapering fashion for medical withdrawal from alcohol or benzodiazepine dependence. It is likely that individuals will have difficulty being admitted to a facility that could safely administer these medications and there will be a need for outpatient management of these conditions during the COVID-19 pandemic. SAMHSA urges providers to consider utilizing benzodiazepines in situations in which they believe that the individual would not benefit from administration of anticonvulsant medications that have been effective in treatment of alcohol withdrawal. Medications such as gabapentin, topiramate, or carbamazepine are useful in preventing seizures related to alcohol or benzodiazepine withdrawal. These medications also possess a much lower abuse potential. Limited doses of benzodiazepines might be considered for specific symptom relief for a short duration (several days).[36]

4.4.4 Guidance for stimulant users

No relevant information found

4.4.5 Guidance for benzodiazepine users

See guidance on alcohol use disorder

4.4.6 Overdose guidance

Following reports that some first responders and law enforcement officers have been more reluctant to administer naloxone due to fear of contracting COVID-19, SAMHSA have recommended that for those first responders who have gloves and facial protection, intranasal naloxone should still be considered. If they feel that the use of intranasal naloxone poses too great a risk, intramuscular naloxone can be injected into the thigh muscle thereby reducing the risk of infection.[40]

4.4.7 Use of telehealth

The DEA states that practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation.[41] The use of telehealth wherever possible is recommended. OASAS state that programs must maximise the use of telehealth services, including for psychosocial services and supports and medication management services. While programs are allowed to maintain as many staff onsite as necessary to address urgent needs for in- person services, most staff should be working remotely until otherwise instructed by OASAS. Programs should not be running any in-person groups until otherwise instructed by OASAS. Programs should be doing individual counselling sessions using telehealth methods, unless there is a specific need to do otherwise (e.g., a patient has no phone access, urgent risk assessment or crisis management). An outpatient program intake and induction on medication-assisted treatment can be safely performed through telehealth, without any in-person procedures.[37] SAMHSA also recommends the use of telehealth and/or telephonic services to provide evaluation and treatment of patients. These resources can be used for initial evaluations including evaluations for consideration of the use of buprenorphine products to treat opioid use disorder. Further, these resources can be used to implement individual or group therapies such as evidence-based interventions including cognitive behavioural therapy for mental and/or substance use disorders.[36]

4.5 Question 4: How are drugs and alcohol services being re-structured to meet clients' needs in light of COVID-19, especially clients with complex needs and who are most vulnerable?

There was little information regarding vulnerable clients or those with complex needs.

4.5.1 Guidance for homeless people

The CDC simply recommend that homeless services arrange for continuity of, and surge support for mental health, and substance use treatment services, without providing any explicit guidance.[42] OASAS state that an inability to keep take-home doses of medication safe due to a chaotic living situation (e.g., certain types of homelessness) would be grounds for patients being deemed ineligible for an emergency take-home exemption. For these patients who, for safety reasons, need to continue daily dosing, every precaution should be made to limit exposures from patients possibly symptomatic for COVID-19, as well as to older and/or medically fragile patients. However, OASAS do not provide any further guidance in relation to this.[38]

5 British Columbia

5.1 Introduction

British Columbia (BC) is the westernmost province in Canada, with an estimated population of 5.1 million in 2020. The capital of British Columbia is Victoria and the largest city is Vancouver.[43]

5.1.1 Substance use in British Columbia

BC, like the rest of Canada, is currently experiencing an opioid epidemic, which was declared in April 2016 following an escalation of hospitalisations and deaths due to heroin, fentanyl, and other opioids. Opioids are responsible for the most drug-related deaths in Canada; in 2018, opioids caused 12 deaths per 100,000 population, with the highest death rates found in BC and Alberta.[44]

5.1.2 Addiction treatment services

In BC, specialised substance use services, including withdrawal management services, are delivered primarily through five regional health authorities, the First Nations Health Authority and the Provincial Health Services Authority. The publicly funded system is supplemented by private treatment centres located across the province.[45]

5.1.3 Relevant organisations

- **British Columbia Centre on Substance Use (BCCSU)** is a provincially networked organisation with a mandate to develop, help implement, and evaluate evidence-based approaches to substance use and addiction.
- The **College of Physicians and Surgeons of British Columbia** regulates the practice of medicine under the authority of provincial law. All physicians who practise medicine in the province must be registrants of the College.
- The **British Columbia Centre for Disease Control** is a program of the Provincial Health Services Authority and provides provincial and national leadership in disease surveillance, detection, treatment, prevention and consultation.
- **Health Canada** is the department of the Government of Canada that is responsible for the country's federal health policy, overseen by the Minister of Health.
- **Vancouver Coastal Health** (**VCH**) is a regional health authority providing direct and contracted health services including primary, secondary, tertiary and quaternary care, home and community care, mental health services, population and preventive health and addictions services in part of Greater Vancouver and the Coast Garibaldi area.

5.1.4 Substance use issues that have arisen since the COVID-19 outbreak

- As the effects of the pandemic continue, the drug supply may become significantly more adulterated and toxic, based on limited importation and availability, and illicit substances may become significantly more difficult to procure.[46]
- The environments in which patients access illicit opioids is becoming more dangerous as the supply decreases.[47]
- Individuals seeking illicit substances to prevent withdrawal risk both overdose and exposure to and transmission of COVID-19.[46]
- Individuals with unstable housing (those who are homeless or living in a shelter, single room occupancy, or supported housing unit) may face additional challenges physical distancing or self-isolating, in order to reduce community spread of COVID-19.[46]
- Fentanyl and other opioids can slow breathing rates, so COVID-19 may increase the risk of overdose death when using opioids.[48]
- Many patients on opioid agonist therapy (OAT) currently receive daily witnessed medications. Immunocompromised patients and those who exhibit symptoms or are under quarantine or self-isolation may not be able to attend medical appointments or present to the pharmacy for their witnessed dose or to pick up their carries.

- Individuals with alcohol use disorder have an impaired immune system and reduced cognitive functioning, which may increase their likelihood of contracting COVID-19.
- Individuals may experience disruptions of their alcohol supply due to closure of smaller outlets and non-beverage alcohol supplies may also be interrupted. Those experiencing severe withdrawal are at risk of severe morbidity and mortality.[47]

5.1.5 Legislation/regulations that have been amended since the onset of COVID-19

Health Canada amended the Controlled Drugs and Substances Act 1996 to allow the following temporary exemptions:

- Permit pharmacists to extend and renew prescriptions.
- Permit pharmacists to transfer prescriptions to other pharmacists.
- Permit prescribers to verbally prescribe prescriptions for controlled substances.
- Allow pharmacy employees including pharmacy technicians and pharmacy assistants to deliver prescriptions of controlled substances to patients at their homes or an alternate location.
- Permit delivery to a location that is not the patient's home address if it: is safe for both the patient and the pharmacist; is private; maintains patient confidentiality.[49]

The College of Pharmacists of BC has amended its bylaws relating to the Pharmacy Operations and Drugs Scheduling Act 2003 and the Health Professions Act 1996 such that they can accept verbal or fax prescriptions for medications that fall under the Controlled Prescription Program.[49] Pharmacists can provide emergency supplies to patients with expired prescriptions. Where clinically appropriate, providing take away doses (TADs) is an option to ensure that these patients continue to have access to their medications and reduce their opportunity for exposure to COVID-19. The College of Pharmacists of BC Board approved amendments to *Professional Practice Policy 71 – Delivery of Methadone for Maintenance* to allow pharmacists to authorise regulated health professionals to deliver OAT.[47]

5.2 Question 1: How has COVID-19 impacted on people who use drugs?

An Omni survey in March measured changes in alcohol and cannabis consumption since COVID-19. Unlike the other countries analysed in this review, cannabis is legal in Canada since 2018. The results from BC show that 18% report their alcohol consumption has increased and 10% report that it has decreased. In relation to cannabis, 6% report their cannabis consumption has increased and 7% report it has decreased.[50] In a survey of youth-serving organisations addressing the needs of youth at-risk of or experiencing homelessness, organisations reported that harm reduction services and supplies are needed to manage the potential for increased risk behaviour among young people that are isolated and struggling with substance use challenges. Youth Homelessness and COVID-19 A second survey is currently being undertaken.[51]

There have been no published data on the impact of COVID-19 on drug-related harm with the exception of a newspaper article which reported that in March, there was 112 deaths of suspected drug overdose; this is the first time in over a year that monthly overdose deaths exceeded 100. In April 2020, there were 117 suspected illicit drug toxicity deaths, a 39% increase over the number of deaths in April 2019.[52]

5.3 Question 2: How has COVID-19 impacted on the demand for drug and alcohol services?

No relevant information identified.

5.4 Question 3: What guidelines and supports have been provided for drug and alcohol services in light of COVID-19?

Supervised consumption and overdose prevention services are listed as essential services.[48] These sites are also exempt from the Provincial Health Officer's order of no gatherings, as they are clinical spaces providing essential services. Treatment service delivery should also continue as much as possible.[47]

5.4.1 General prescribing guidance

The BC Centre on Substance Use has provided general prescribing guidance:[46]

- In order to reduce the risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply, replacing illicit and licit products with prescribed or regulated substances is recommended.
- Prescriptions will be sent to those pharmacies that have delivery services and have the capacity to transport medication to the client's place of residence.
- Deliver medications directly to the patients; client identity will be confirmed prior to provision of medication, while maintaining at least 2 metres distance.
- In circumstances in which capacity is severely limited, consider the capacity of providing weekly delivery rather than daily.
- Where medications are not able to be provided daily, individuals will be encouraged to store medications in personal safes or medicine lock boxes in patient-specific lockers.
- Make initial prescription at least 23 days in length to support ongoing isolation and social distancing, extending length as necessary, but ensuring it does not end on a weekend or statutory holiday.
- Wherever possible, provide support to patients via telemedicine. info oat
- It is acceptable for prescribers to fax prescriptions, or give verbal prescriptions for controlled drugs to pharmacists, and then deliver (by mail courier or other means) a hard copy of the original duplicate prescription at a later date.

5.4.2 Prescribing guidance for opioids

Contingency plans should be developed with patients if they are unable to come in for appointments or access their OAT through regular means. Alternatives should be considered that both reduce the number of patient visits (e.g., extending prescription durations) and promote social distancing (e.g., telemedicine). This may also include pharmacy delivery of OAT, where services exist.[53] In order to reduce the risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply, the BCCSU recommends replacing illicit and licit products with prescribed or regulated substances. For patients who use opioids they recommend:[46]

- Offering OAT or if they are already on OAT, consider increasing their dose and provide carries and delivery as needed.
- To avoid the need for moderate withdrawal, consider using a microdosing protocol to initiate patients onto buprenorphine/naloxone. To avoid withdrawal and patient discomfort, consider co-prescribing hydromorphone, slow-release oral morphine (Kadian), or sustained-release oral morphine (M-Eslon) during microinduction. Some prescribers are starting patients at 40mg methadone per day for both new starts and missed doses, based on clinical judgment
- If patient is using street opioids in addition to their OAT or declines OAT, prescribe according to current use, and use patient preference and clinical judgment to select appropriate medications and dosage.
- Dose and medication will depend on if they are being co-prescribed OAT, how much money they spend each day on illicit drugs, and patterns of substance use. The dose can be adjusted over time, with a goal of the person being comfortable and not needing to access the illicit drug market.
    - Prescribe oral hydromorphone 8mg tablets (1-3 tabs q1h as needed up to 14 tablets), provided daily AND/OR prescribe M-Eslon 80-240mg PO BID provided daily

    - (avoid sprinkling doses). Doses should be started at the lower end of the range unless there is a known tolerance and up-titrated based on patient comfort, withdrawal symptoms, and cravings
    - It is helpful to prescribe a long-acting opioid in conjunction with a short-acting opioid for those not on OAT
    - Witnessed ingestion is not required.
    - In circumstances in which capacity for daily delivery is limited, consider prescribing a limited quantity of TADs (i.e., up to 7 days), where clinically appropriate. Blister pack for safety.

The BCCSU provide additional specific guidance for different types of OAT in their document *Information for Opioid Agonist Treatment Prescribers and Pharmacists*.[53] Specific guidance for individuals on injectable OAT (hydromorphone and diacetylmorphine) is forthcoming.

Buprenorphine/naloxone

- If possible, consider transitioning to buprenorphine/naloxone, the first-line treatment for opioid use disorder. Given the superior safety profile, patients can receive longer duration carries and there is reduced risk of overdose and diversion.
- Micro-induction may be considered for individuals transitioning from another OAT medication to buprenorphine/naloxone, to avoid the need for a washout period and moderate withdrawal to be reached prior to induction.
- Where clinically appropriate, prescribers should prescribe carry doses in blister packages, if available, by indicating this on the prescription for the pharmacy to arrange.

Sustained release oral morphine (SROM or Kadian)

- Prescribers should temporarily prescribe carry doses, whenever clinically appropriate (e.g., stable patient with secure place to store up to a week's supply of medication).
- For daily witnessed ingestion doses, when a patient is deemed too unstable or is unable to safely store a week's supply of medications, consider not recommending 'sprinkling' (i.e., opening capsules and sprinkling medications) in the prescription. Indicate this clearly on the prescription and communicate with the pharmacy if necessary. This will reduce the amount of time patients spend in pharmacy and reduce medication handling and interactions with pharmacy staff.

Methadone

For any formulation of methadone (Methadose, Metadol-D, compounded methadone, or Sandoz methadone [Sterinova] or compounded methadone), where clinically appropriate, prescribers should consider temporarily allowing carry doses in adequately stable patients, including longer take-home intervals and fewer in-person appointments, supporting uninterrupted access to these essential medications

The guidance report also recommends:

- For patients with symptoms or in quarantine, services should consider how patients can have medications safely delivered for daily witnessed doses or increase TADs to ensure adequate medication.
- When prescribing longer duration of TADs, clinicians must weigh the benefits of larger dispenses with the risk of overdose, diversion, or risk to household members. If TADs are provided, counselling on safe storage of medication is critical. Patients should have naloxone kits and be trained in their use
- Urine drug tests should only be used when clear clinical utility exists. A negative urine drug test is not required in order to prescribe TADs.

Further information on recommended dosages may be accessed in the pharmacotherapy protocol developed by Vancouver Coastal Health.[54] They advise offering OAT (Kadian, methadone, suboxone) according to the existing clinical guidelines. If a patient is already on OAT, consideration should be

given to increasing the dose and providing TADs and delivery as needed. If the patient declines standard OAT or is using opioids in addition to their OAT, the following are approved for temporary use: Oral hydromorphone 8 mg tablets (1–3 tabs q1h as needed, up to 14 tablets; daily dispensed) and/or M-Eslon 80–240 mg BID; daily dispensed (avoiding sprinkling doses).

5.4.3 Guidance for alcohol use disorder

Liquor retail is considered an essential service. While larger alcohol retailers are likely to remain open, smaller shops may close, making it more difficult to access alcohol. In addition, non-beverage alcohol supplies may also be interrupted. Patients with alcohol use disorder may be at risk for severe withdrawal, which can result in potentially life-threatening complications. To prevent these complications, and to help reduce demands on the province's emergency departments, the BCCSU recommends the following:[55]

- Patients at low risk of severe withdrawal symptoms can generally safely undergo alcohol withdrawal at home. Patients at high risk of severe withdrawal symptoms should be referred to inpatient withdrawal management if space is confirmed. If this is unavailable, or declined by the patient, consider providing support for accessing alcohol. If patient chooses to undergo detoxification, consider prescribing benzodiazepines for withdrawal management.
- For individuals who decline withdrawal management support or medications, provide education on the risks of abrupt alcohol cessation. Create a personalised plan to continue to access alcohol; assess the patient's level of alcohol use, and provide guidance on how to self-manage alcohol use to avoid withdrawal, including consuming regular amounts (1 standard drink hourly) as needed up to 12 drinks per day, avoiding non-beverage alcohol.
- Help patients identify potential 'buddies' to deliver alcohol, food, and necessary medications if patient has to self-isolate or quarantine and encourage individuals to look into delivery of alcohol from online sources to reduce the number of trips to stores.
- Assist with the arrangement of alcohol delivery by an outreach team or other community service support.
- For individuals who are not able to access alcohol independently, arrange the provision of alcohol through a formal or informal managed alcohol program.

In the pharmacotherapy protocol, it is recommended that prescribers offer relapse prevention pharmacotherapies for alcohol use disorder. If the patient is at low risk of complicated withdrawal prescribers should consider Gabapentin and/or Clonidine and/or Carbamazepine.[54]

5.4.4 Guidance for stimulant users

For those with stimulant use disorder replacement therapy with psychostimulants can reduce risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply. The BCCSU recommends that the following two options may be taken:[46]

- Prescribe Dexedrine: Dexedrine SR (dextroamphetamine) 10-20mg PO BID provided daily with a maximum dose of 40mg BID per day *AND/OR* Dexedrine 10-20mg IR PO BID-TID with a maximum dose of 80mg Dexedrine per day; or
- Prescribe Methylphenidate: Methylphenidate SR 20-40mg PO OD with maximum dose of 100mg/24hrs *AND/OR* Methylphenidate IR 10-20mg PO BID daily to maximum dose of 100mg methylphenidate per day.

The guidance also recommends:

- Medication selection should take into account patient preference and current use, and may include only slow-release, only immediate-release, or a combination of the two.
- Patients with concurrent psychotic or bipolar disorder should be warned of the potential worsening of symptoms with prescribed stimulant medications.
- Patients should be educated on potential side effects and advised that medication effects may be different than usually experienced with illicit stimulants.
- Those with unstable angina or uncontrolled hypertension should not be prescribed stimulants.

- Prescribe with caution in those with a cardiac history.

5.4.5 Guidance for benzodiazepine users

The BCCSU state that most users of illicit benzodiazepines use bars of adulterated or counterfeit Xanax (alprazolam) that are combinations of unknown substances in unknown dosages, which makes it difficult to estimate tolerance based on patient report. To reduce the risk of overdose from newly prescribed benzodiazepine medication (on its own, or in combination with ongoing concurrent alcohol or illicit drug use), it is important to start with a relatively low dose and titrate up as needed. A taper protocol should generally be offered, however, to support social distancing and self-isolation, a temporary maintenance protocol may be offered. The BCCSU recommends:[46]

- If initiating a taper, clonazepam or diazepam are preferred, as they are long-acting.
- If temporary maintenance is being prescribed, generally consider switching to a long-acting benzodiazepine and reduce dose by 50% to start.
- Start at a lower dose than what your patient regularly purchases and titrate up.
- Review the signs and symptoms of benzodiazepine toxicity with the patient

When prescribing benzodiazepines, ensure telemedicine or in-person follow-up, where possible. If there are concerns of complicated withdrawal, consider regular follow-up by an outreach team (where available).[46] The Pharmacotherapy Protocol states that a taper protocol should be offered in all cases, however, to support social distancing and self-isolation, a temporary maintenance protocol may be offered. When initiating a taper, clonazepam or diazepam are preferred as they are long-acting. If temporary maintenance is being prescribed, consider switching to a long-acting benzodiazepine and reduce the dose by 50% to start. For example, if a patient describes buying diazepam 10 mg, three times a day, then consider starting diazepam 5 mg TID; daily dispensed. If a patient uses 1–4 bars of Xanax, start with clonazepam 0.5mg–1mg BID.[54]

5.4.6 Overdose guidance

On 6 April 2020, Health Canada indicated issued a class exemption to each province and territory, which will enable BC to: establish new temporary spaces within existing supervised consumption services, shelters, or other temporary sites, as needed, so that people can respect physical distancing and self-isolation measures, and stay safe from overdose; establish other activities with controlled substances such as drug checking or virtual supervision of drug consumption; and allow municipalities to exercise this authority on the province's behalf, if desired.[48]

The BC Centre for Disease Control has published an overdose prevention protocol in the context of COVID-19, where they recommend:

- Provide necessary supplies for safer injection / safer substance use, harm reduction education, overdose prevention education, and take-home naloxone kits if needed.
- Allow the person to consume drugs in the most private and hygienic environment that is immediately available. Monitor them for signs of overdose, and ensure that any overdose that may occur is managed and treated immediately.
- Episodic overdose prevention services can be provided in a number of settings, including acute care to prevent patients leaving health care facilities against medical advice, as well as community isolation shelters and housing settings to support clients who are suspected or confirmed positive for COVID-19 who would otherwise use substances alone.
- As the need arises, staff with appropriate training in overdose management may observe consumption of substances by people in any health or social service sector environment, in order to prepare for and respond to any overdose that may occur.

5.4.7 Use of telehealth

The use of telehealth to reduce the number of patient visits and promote social distancing in BC is promoted throughout the guidance cited in this review. This includes the College of Physicians and Surgeons who supports the increased use of telemedicine with patients in the context of COVID-19, including changing doses and initiating prescriptions. They recommend that physicians who use phone

or video appointments should continue to document all key information in medical charts and should obtain consent at the beginning of the conversation.[49] The BCCSU encourage health care providers to conduct patient assessments and visits using telehealth or video conferencing software. Telehealth is especially recommended for use when dealing with patients accessing OAT.[47,56]

5.5 Question 4: How are drugs and alcohol services being re-structured to meet clients' needs in light of COVID-19, especially clients with complex needs and who are most vulnerable?

5.5.1 Guidance for homeless people

Some guidance has been provided regarding those who are homeless. The BCSSU recommend that people with suspected or confirmed COVID-19who are homeless or precariously housed in shared living spaces, may be referred for isolation at specified shelters or other locations. Delivery of medication should be arranged for these locations.[46] Harm reduction services should ensure that harm reduction supplies are available for homeless people to eliminate the sharing of supplies for persons using substances (i.e., pipes, needles).[57] Vancouver Coastal Health published comprehensive guidance for implementing and operating COVID-19 facilities for homeless and under-housed residents who are unable to self-isolate. They identify that long-term substance users are at high risk from complications of COVID-19 and that their needs should be addressed. In relation to these individuals they recommend:[58]

- Facilities must have safe and secure storage for medications, including controlled substances such as methadone.
- Regarding mental health and substance use care, develop plans/protocols to manage increased severity of mental health conditions and emerging trauma and stress arising from the quarantine experience. This includes access to 24/7 crisis intervention, ensuring staff capacity to conduct suicide risk assessments, critical incident debriefing for staff and clients, and availability of mental health providers, with video conferencing the preferred method.
- When providing substance use care there should be: awareness of the potential for withdrawal and its associated health risks; adoption of pandemic pharmacotherapy protocols for withdrawal, support for clients who experience withdrawal, and support for clients to self-isolate. Patients are encouraged to work with their existing general practitioner or nurse practitioner, but if this is not possible, they should refer to the overdose outreach team.
- Availability of a space to designate as a safer use room/overdose prevention site, while paying attention to disinfection of surfaces.
- In relation to security and safety, consideration needs to be given to developing a protocol for clients accessing substances and how to support this while minimising the likelihood of them leaving the facility.

6 Scotland

6.1 Introduction

Scotland's population is estimated to be 5,463,300. Although Scotland is part of the United Kingdom, responsibility for the National Health Services (NHS) in Scotland is a devolved matter and rests with the Scottish Government. Legislation about the NHS is made by the Scottish Parliament.[59]

6.1.1 Substance use in Scotland

Problematic alcohol and drug use are significant issues in Scotland. Scotland has the highest overdose mortality rates in Europe and a dramatic increase has been observed since 2012/13. In 2018, there were 1,187 drug-related deaths, which is the largest number ever recorded, and an increase of 27% from 2017. Most deaths were associated with opioids (9 in 10) and benzodiazepines (7 in 10) but almost 85% involved more than one drug. Recent increases were primarily in the 35–44 and 45–54 age groups.[60] The most recent treatment figures show that opiates are the most commonly reported primary drug at 43% (heroin 38%, other opiates 5%), followed by cannabis (19%) and cocaine (19%).[61]

6.1.2 Addiction treatment services

The NHS boards, councils and voluntary sector organisations provide a range of treatment options for people who experience problems related to alcohol and drug misuse. In addition, 30 Alcohol & Drug Partnerships across Scotland form the focal point for local action on drug misuse, and receive support from the Scottish Government.[61]

6.1.3 Relevant organisations

- **Scottish Government** – alcohol and drugs are the responsibility of the Population Health Directorate and the Justice Directorate. The senior minister is the Cabinet Secretary for Health and Sport and who is supported by the Minister for Public Health, Sport and Wellbeing and the Minister for Mental Health.
- **Scottish Drugs Forum** works with policy makers, service planners and commissioners, service managers and staff as well as people who use or have used services to ensure service quality and evidence-based policy and practice. They have a range of funders including the Scottish Government, The Big Lottery Fund, charitable trusts, health boards, and local authorities.
- The **Drugs Deaths Taskforce** was established in July 2019 to tackle the rising number of drug deaths in Scotland.
- **Scottish Health Action on Alcohol Problems** (SHAAP) is a partnership of the Medical Royal Colleges in Scotland and the Faculty of Public Health. SHAAP provides a medical and clinical voice on the need to reduce the impact of alcohol-related harm and the evidence-based approaches to achieve this.

6.1.4 Substance use issues that have arisen since the COVID-19 outbreak

- Those with drug and alcohol use may have greater vulnerable to infection from COVID-19; substance use may also risk exacerbation of breathing impairment.[62]
- People with drug problems have a high prevalence of multiple co-morbidities including respiratory and cardiovascular disease, which increases their risk of morbidity and mortality from COVID-19.[63]
- The supply of illicit drugs has been disrupted resulting in people diverging from substances they are used to, and consuming unfamiliar substances of variable strengths and in different ways.[63]
- There are reports of new drug variants, unstable benzodiazepine pills and some increase in the use of dangerous solvents and gas.[64]
- It has been reported that availability of street benzodiazepines has increased, including drugs such as etizolam and alprazolam.[63]
- Changes in the illicit drug market are likely to push more people into seeking opioid substitution therapy due in part to a reduction in heroin supply and quality.[63]

- Frontline workers report increased requests for naloxone, which may indicate that people are wary of what they are taking, or more conscious of potential risks.[64]
- There are likely to be 350-400 people released from prison before the end of May. Many will be drug users and a significant proportion will be homeless at the time of release.[65]

6.1.5 Legislation/regulations that have been amended since the onset of COVID-19

Emergency legislation has been introduced to enable the supply of controlled drugs:

- Registered pharmacies are now allowed to supply substances in Schedule 2, 3 and Part 1 Schedule 4 to the Misuse of Drugs Regulations 2001 to patients receiving these as part of on-going treatment without a prescription.
- These substances may be supplied under a Serious Shortage Protocol to allow on-going treatment with alternative products where prescribed items are unavailable or are in short supply.
- Pharmacists without prescribing rights may change the frequency of instalments on instalment prescriptions without the immediate need for a new prescription from a prescriber.
- The emergency supply of prescription-only medicines during a pandemic is enabled by the Human Medicines Regulations 2012 but this does not extend to controlled drugs in Schedule 2, 3 and Part 1 Schedule 4. Legislation is proposed to allow registered pharmacies supply these drugs without a prescription, where the patient has been receiving them as part of on-going treatment. The capacity for supply by pharmacists without prescription would only apply to patients receiving the drug as part of on-going treatment, be subject to the pharmacist's professional judgment, and remain subject to existing safeguards.[66]

6.2 Question 1: How has COVID-19 impacted on people who use drugs?

A survey on drug markets during COVID-19 was undertaken by Crew, a Scottish drug treatment and education charity, among drug users and service providers. Throughout April, 142 Scottish responses were received; 44% were from services and people who work with people who take drugs. Almost two thirds (64%) had noticed changes to the supply of drugs since the outbreak COVID-19. Over half (56%) reported product shortages, 42% noted a price increase, 35% noted that there was less variety of products available, and 26% noted that the drug was of poorer quality. There were no reports of improved quality. The changes around how drugs are bought, sold or taken has caused worry or anxiety to 74%. Unintended withdrawal symptoms were reported by 43%, which was mainly due to reduced access to drugs, either caused by reduced availability, or affordability; 41% noted difficulty accessing prescriptions, and 63% reported difficulty accessing support for drug use.[67]

The Drug Death Taskforce has received feedback from services and communities which suggests that service-level provision is being scaled back in some areas.[68] It has also been reported that injecting equipment provision has been constrained by a reduction in the number of these sites, a reduction in their opening hours including pharmacies, and decreased accessibility with service-users sometimes needing to join lengthy queues.[63]

6.3 Question 2: How has COVID-19 impacted on the demand for drug and alcohol services?

The Scottish Drugs Forum has reported that some areas have seen an increase in the number of people seeking access to treatment and support. This is in response to the disrupted drug supply, and particularly includes more vulnerable stimulant users who may not have been previously visible to services.[63]

6.4 Question 3: What guidelines and supports have been provided for drug and alcohol services in light of COVID-19?

The Scottish Government has identified that drug and alcohol services are essential services and has recommended that pre-COVID-19 service levels be maintained. OST and injecting equipment provision are also identified as essential services to be maintained by pharmacies, however, 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.[68] The Scottish Drugs Forum has published comprehensive guidance to help treatment services plan, manage, and deliver services for people who use drugs during the COVID-19 pandemic.[63]

6.4.1 General guidelines regarding service provision

The Scottish Drugs Forum recommends:[63]

- For patients instructed to self-isolate, an immediate relaxation of drug supervision arrangements should be considered. Supervision is not a legal requirement and pharmacists can exercise professional judgment when relaxing supervision.
- Pharmacy businesses should liaise with health boards and local drug treatment; if 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 at alternative locations.
- In the event of closures, pharmacies should provide replacement prescriptions to another pharmacy, or explore alternative models of dispensing and delivery.
- Encourage clients attending injecting equipment provision services to take away injecting equipment to last 14 days and return at similar intervals thereafter. Large sharps containers should be provided to facilitate safe home disposals. All clients should be aware of how to clean injecting equipment should the need arise.
- Staff should not be redeployed elsewhere.

6.4.2 Guidelines for providers of opioid treatment programs

6.4.2.1 New patients entering treatment

A reduction in heroin supply and quality may push people not already in treatment into seeking OST. Services should prioritise timely OST provision for this cohort. To facilitate this, some services have developed and operationalised doorstep titrations using existing protocols. 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 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 is not possible because of reductions in pharmacy provision or if a person needs to 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.

6.4.2.2 Take-away doses (TADs) and deliveries

There have been significant changes to the dispensing arrangements for OST due to COVID-19, with a high proportion of people now receiving TADs of their medication. To comply with self-isolation, patients may need 14 days of take-home medications. For the majority, this has been a radical shift from the previous practice of daily supervised dispensing and presents risks for the more vulnerable people using services. Patients affected by homelessness may not have a safe storage option for their TADs; 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 include the collection of OST daily by a nominated person on behalf of the patient. Nominated persons (such as family members, friends, health and social care staff, police, and volunteers) can collect OST medication with the patient's consent. The pharmacist should receive 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. Home delivery will be essential for those who are self-isolating, shielding, or who are have underlying health conditions. Alternative means of providing home delivery have been developed including drug and alcohol staff, volunteers and redeployed employees undertaking the delivery of medication. 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.

6.4.2.3 Medication shortages

In the event of a medication shortage existing supplies may be moved within the community pharmacy network as permitted within the relevant legal framework, or may be substituted by alternative opioid agonist formulations. Dispensing relaxation should be reviewed for each patient so that pharmacy visits are reduced. If there is a severe disruption to medication supplies, the Serious Shortage Protocols legislation may be activated and the substitution therapy options detailed below can be considered:

- Generic formulations – pharmacists may supply branded products against a generic prescription, although generic medications should be used in the first instance if available.
- Sugar containing and sugar-free preparations – using all stocks of methadone oral solution may require patients to receive sugar-containing methadone or sugar-free preparations.
- Different preparation strengths – a small amount of alternative methadone oral solution formulations are available. This includes 10mg/ml oral concentrate solution.
- Methadone tablets – these are not licensed for treating opioid dependence and are not normally recommended, but may be considered if methadone oral solution is not available.
- Conversion to alternative opioids – there are various formulations of buprenorphine available including buprenorphine sublingual tablets (including generics and Subutex), buprenorphine supralingual oral lyophilisate tablets (Espranor), and buprenorphine and naloxone combination alternative opioids. Depot injectable buprenorphine (Buvidal) may be considered, which requires additional titration steps and may be useful in secure settings. Buprenorphine transdermal patches may be considered where no other alternatives exist. Dihydrocodeine may be considered as an alternative to methadone if other options are unavailable; it is regularly used in custodial settings or when acute management of opioid dependence is necessary quickly.
- Symptomatic withdrawal management – if there is a complete breakdown of the OST supply chain, symptomatic relief packs should be provided for enforced withdrawal. These 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.

6.4.3 Guidance on alcohol use disorder

SHAAP recommends that alcohol liaison services in acute hospitals should be continued and have up to date knowledge of current local alcohol services to facilitate early discharge. People undergoing detoxification should be helped to complete that process. Relapse prevention medications such as Acamprosate, Disulfiram (Antabuse), Naltrexone and Baclofen can be crucial to recovery and prescriptions should be maintained. In community detoxification, social distancing and infection control measures makes supervision of home detoxification services difficult. Services should consider the opportunities of telephone and online contact to manage detoxification. If the staffing of these services diminish, guidance is provided for self-management of detoxification, with a harm reduction approach. The priority should be to avoid abrupt changes in alcohol consumption patterns which might trigger serious withdrawal symptoms.[69]

6.4.4 Guidance for stimulant users

There is anecdotal evidence that more stimulant users are coming into contact with services due to a reduced ability to source these drugs or due to changes in daily routine leading to users' realisation that their stimulant use is problematic. This includes more vulnerable stimulant users who may not have been previously visible to services. Psychosocial interventions are the typical treatment for

problematic stimulant use. Canada has taken a harm reduction approach and recommends the use of therapeutic drugs such as dexamphetamine or methylphenidate off licence to substitute illicit stimulants. Scotland is not following this approach citing an absence of licensed substitute treatments and a lack of understanding of the relationship of stimulant dependence and withdrawal in a polysubstance use setting as being problematic in trying to support people who use drugs in maintaining social distancing, lockdown, and shielding advice. Currently, individuals with significant 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.[63]

6.4.5 Guidance for benzodiazepine users

Due to the pattern of benzodiazepine use in Scotland, there are concerns regarding the potentially dangerous withdrawals that can occur, and the increased risks that might be taken in order to source an illicit supply. A decision has been taken to prescribe benzodiazepine to those at risk of harm. The rationale for this is similar to that of providing and supporting access to OST, in that it enables people who use drugs to comply with social distancing and self-isolation advice, and protects them from COVID-19. The absence of peer reviewed and established evidence-based guidance on benzodiazepine prescribing is acknowledged. However, experienced prescribers should weigh providing a safe supply of pharmaceutical benzodiazepines against the risk of harm from illicit use. The Scottish Drugs Forum recommend considering the following:[63]

- 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 that diazepam; 1 mg of etizolam is considered approximately equivalent to 5 mg of diazepam.
- 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. A temporary maintenance protocol can be considered if an individual feels they cannot stop during self-isolation.
- 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.

6.4.6 Overdose guidance

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. Naloxone should also be offered and/or promoted with every injecting equipment provision transaction.[63]

6.4.7 Use of telehealth

The Scottish Drugs Forum states that for those seeking the peer support, e-support is available although face to face group meetings and recovery cafes have had to be moved online. Regular telehealth follow-up and welfare outreach support is advised for those receiving OST.[63]

6.5 Question 4: How are drugs and alcohol services being re-structured to meet clients' needs in light of COVID-19, especially clients with complex needs and who are most vulnerable?

There was relevant information available for homeless people and those in prison.

6.5.1 Guidance for homeless people

Guidance from Pathway has been developed in a UK/English legal context but is of use to those planning and delivering service in Scotland. The guidance states that patients with alcohol or drug addiction should be able to access a variety of approaches to prevent withdrawal, with input from specialist addiction services to minimise their need to leave isolation. The delivery of this plan for people with an opioid use disorder is entirely dependent on the effective delivery of OST medication. It also states that protocols on supporting residents with substance misuse needs will be required for accommodation and further guidance is to follow.[70]

6.5.2 Guidance for those in prison

The Scottish Government has published guidance on the use of Buvidal for OST.[65] In February 2020, 26% of the prison population were receiving a daily supervised OST, which is difficult to sustain under COVID-19 due to efforts to comply with social distancing and elevated rates of staff absence. They recommend transferring appropriate patients receiving daily OST via oral methadone or solid dose buprenorphine to monthly injections of slow-release buprenorphine (Buvidal) in order to:

- Provide safe and continuous management of dependency in a group at high risk of developing COVID-19 infection, severe disease and at high risk of transmitting the infection to others.
- Ensure the continuity of OST in prison settings affected by COVID-19.
- Achieve a rapid reduction in the need for daily contact with NHS front line and prison staff, releasing these staff for other duties.
- Reduce the risk of transmission of COVID-19 to other vulnerable patients in prisons.

Only patients with at least 6 months of their sentence left to serve should be considered for transfer to Buvidal. Doses may be increased or decreased, and patients can be switched between weekly and monthly products according to an individual patient's needs and the treating physician's clinical judgement. A choice of OST should also remain; this will be 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. However, in the immediate future, those to be released from prison 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. There are likely to be 350-400 people released from prison before the end of May.

7 New South Wales (NSW)

7.1 Introduction

New South Wales (NSW), located on the east coast, is one of six states in Australia. It has a population of over 8 million residents with roughly 65% living in and around the state capital Sydney. The federal Minister for Health administers Australia's national health policy, and state and territory governments. State governments have responsibility for funding and managing community and mental health services, which includes drug and alcohol services.[71]

7.1.1 Substance use in NSW

In 2018, deaths caused by drug overdose in Australia – mostly a result of opioid abuse – reached a record high; opioids were present in nearly two-thirds of these deaths. The rate of opioid-induced deaths involving synthetic opioids (such as tramadol and fentanyl) has increased. Benzodiazepines were identified in 51% of deaths. There has been a rapid increase in the number of deaths involving methamphetamine and other stimulants, with the death rate in 2017 four times higher than that in 1999. The use of methamphetamine has been increasing in NSW. Treatment figures from 2017-2018 indicate that alcohol was the most common primary drug (38%) followed by amphetamines (27%), cannabis (16%), and heroin (8%). These figures do not include those who are receiving opioid pharmacotherapy, which are reported in the National Opioid Pharmacotherapy Statistics Annual Data; in 2019, NSW and the Australian Capital Territory had the highest rate of people receiving opioid pharmacotherapy treatment (26 clients per 10,000 people).[71-73]

7.1.2 Addiction treatment services

In Australia, publicly funded treatment services are available in all states and territories. Most of these services are funded by state and territory governments, while some are funded by the Australian Govenment.[74]

7.1.3 Relevant organisations

- The Government of **Australia's Department of Health** and Minister for Health are responsible for national drug policy.
- The **NSW Ministry of Health** funds and coordinates statewide drug and alcohol programs; its Centre for Population Health is responsible for coordinating the NSW Health contribution to whole-of-government policy development and implementation in alcohol and other drugs.
- The **Therapeutic Goods Administration** is the regulatory body for therapeutic goods in Australia. It is a division of the Australian Department of Health established under the Therapeutic Goods Act 1989.

7.1.4 Substance use issues that have arisen since the COVID-19 outbreak

At the national level, the following issues and concerns have been noted:[75]

- Increased vulnerability due to an ageing patient population, over-representation of Aboriginal and/or Torres Strait Islander people, and high rates of underlying respiratory and cardiac disease, that may cause immunosuppression.
- The potential increase in demand for treatment arising from disruption of drug distribution networks and street opioid drug availability.
- Increased demand for opioid treatment arising through reductions in access to other alcohol and drug treatment services (e.g. hospital admissions, residential rehabilitation programs, self-help groups), and increased release of patients into the community from prison.
- The incompatibility of daily supervised dosing of methadone and buprenorphine with the principles of social distancing and social isolation.
- An ageing workforce, particularly among prescribing medical practitioners.

- The requirement to perform a higher proportion of consults by telehealth, with limited use of clinical information available from physical examination and investigations such as urine drug screens.

7.1.5 Legislation/regulations that have been amended since the onset of COVID-19

- The Therapeutic Goods Administration has lifted restrictions on who can prescribe depot buprenorphine, which can now be prescribed by all accredited and unaccredited opiate agonist therapy (OAT) prescribers.
- The Ministry of Health has developed a memorandum to support a temporary relaxing of the numerical limits on takeaway doses as set out in the NSW Clinical Guidelines: Treatment of Opioid Dependence 2018.[76]

7.2 Question 1: How has COVID-19 impacted on people who use drugs?

There was no relevant information specifically related to NSW. An Australian survey found that 20% of households reported buying more alcohol than usual since the COVID-19 outbreak. In these households, 28% reported drinking alcohol to cope with anxiety and stress, 28% have been drinking alcohol on their own more often, 24% have started drinking alcohol and ended up drinking more than they thought they would have, and 20% reported having started drinking alcohol earlier in the day.[77]

7.3 Question 2: How has COVID-19 impacted on the demand for drug and alcohol services?

No relevant information

7.4 Question 3: What guidelines and supports have been provided for drug and alcohol services in light of COVID-19?

Non-governmental organisations contracted by the NSW Ministry of Health to provide drug and alcohol treatment services have received a letter from the Ministry confirming that they deliver health services for vulnerable populations. This letter also confirms that employees may be required to travel to deliver contracted health services, and that services need to access food and other necessary provisions. The NSW Ministry of Health considers opioid agonist treatment an essential service and is prioritising the prevention and mitigation of any disruption of services as a result of COVID-19.[76]

The NSW guidance related to the provision of opioid treatment programs only.

7.4.1 Guidelines for providers of opioid treatment programs

The guidance for providers of opioid treatment programs is predominantly from a national guidance document: *Interim Guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: a national response* and is promoted on the NSW Ministry of Health's webpage.

7.4.1.1 New patients entering treatment

For patients initiating treatment, consider buprenorphine which requires less daily monitoring and a shorter period (3-5 days) of supervised dosing than methadone, or transfer to depot buprenorphine (with either Buvidal or Sublocade) after one week. In contrast, patients commencing methadone generally require closer clinical monitoring and a longer period of supervised dosing. If services are unable to initiate methadone treatment due to their inability to regularly monitor the patient and/or provide supervised doses, clinicians should consider referring the patient to a specialist service with greater capacity for regular monitoring.

7.4.1.2 Take-away doses (TADs) and deliveries

Patients should attend dosing sites (community pharmacies and clinics) on no more than one or two occasions per week, and receive five or six take-away doses each week. Patients should be categorised into high, moderate or low risk groups according to Table 4.

Table 4: Guide to supervised and unsupervised dosing conditions for OAT

Level of risk	Risk factors for unsupervised dosing	Example of dosing regimen
High	Patients commencing methadone or buprenorphine treatment	Supervised dosing for at least 14 days methadone, 3-7 days Buprenorphine-naloxone. Consider direct induction to depot buprenorphine without need for sublingual buprenorphine dosing.
High	High risk use of other sedative drugs Recent overdose (past month) Recent history of unstable dosing No safe storage of TADs (e.g. homeless)	Continue supervised dosing with no TADs, unless pharmacy closed and/or no other dosing options available.
Moderate	Regular use in past month of sedative drugs History of frequent missed doses or intoxicated presentations Concerns regarding storage and use of TADs Concerns regarding mental and/or physical health	Methadone: intermittent TAD frequency (e.g. 2+3 or 2+2 per week). Buprenorphine-naloxone 1+ 6 TADs per week
Low	No significant use of sedative drugs, no recent injecting No significant physical, cognitive or mental health concerns No significant social concerns regarding safety of TADs Good attendance for dosing with no recent history of aberrant use of medication	Methadone: 1 supervised dose & 6 TADs per week. Buprenorphine-naloxone: 13 TADs per fortnight, or 27 TADs per 4 weeks.

If a patient is required to self-isolate or enter quarantine, a reliable agent can be authorised by the prescribing doctor to collect dispensed TADs from a clinic or pharmacy. The minimum number of TADs should be provided to maintain treatment continuity and comply with isolation requirements. In these instances it is recommended that:[78]

- The agent must be an adult, agreed to by both the prescriber and the patient. When deciding on suitability, consider risks of diversion, secure storage, and transport.
- Consent is provided and documented in clinical notes.
- The agent does not have a history of aberrant medication behaviours such as diverting medications; nor are there any concerns regarding domestic violence or interpersonal relationship issues.
- The pharmacist on duty must verify the agent's identity against photo ID in the patient records before any doses are given.
- Instructions regarding the safe storage and use of TADs are provided to the agent, who signs that they understand these conditions, and signs for the collection of the TADs.
- The patient must confirm receipt of the doses by email or phone call. If confirmation is not received, no further doses can be provided to the agent.
- The agent should be trained in the use of and have access to take-home naloxone
- Regular phone/telehealth contact with the patient must be maintained by the clinic or pharmacist to document any adverse outcomes and assess the safety of continuing the arrangement.[78]

Dispensed TADs can be delivered to an isolated patient if no responsible person can collect medications. It is recommended that:[78]

- Only a responsible adult, nominated by the pharmacist may deliver TADs. The delivery person does not have to be a pharmacist, however, they should have the skills, experience and knowledge to support the pharmacist in their duty of care.
- Processes and protocols should be in place to ensure safety and security of delivery staff.
- Medications should only be delivered to the nominated person (patient or authorised carer if patient unable to come to door). The patient's name and date of birth should be confirmed.
- The patient is required to confirm receipt of medication with the pharmacist as soon as practical – an email or phone confirmation (recorded by a call log) may be accepted in lieu of signing.

7.4.1.3 Use of depot buprenorphine treatment

The Ministry of Health is encouraging accredited prescribers to review patients on sublingual buprenorphine and assess their suitability and interest in switching to depot buprenorphine formulations such as Buvidal and Sublocade. They reduce: the need for regular attendance for dosing, the need for risk assessments, and staff and/or patient costs associated with preparation of TADs. Patients transferring from buprenorphine could transfer directly to monthly Buvidal or Sublocade products rather than weekly Buvidal to minimise attendance requirements. New patients entering treatment can commence on weekly Buvidal for one or two doses, and then transfer to monthly injections. However, seven days of prior treatment with sublingual buprenorphine (at least 8mg daily) is required before initiating Sublocade treatment. A medical addiction specialist should be consulted for the management of patients transferring from methadone. For patients required to self-isolate or enter quarantine, consideration should be given as to whether administration can be delayed until after isolation is complete, as many patients will not experience withdrawal effects for 6-8 weeks after their last monthly depot injection. If this is not possible (e.g. withdrawal discomfort) then the patient should receive supplemental doses of Suboxone (as TADs) until they can resume depot treatment.[75,76]

7.4.2 Guidance on alcohol use disorder

No relevant information

7.4.3 Guidance for stimulant users

No relevant information

7.4.4 Guidance for benzodiazepine users

No relevant information

7.4.5 Overdose guidance

Prescribers should advise all patients to obtain take-home naloxone as a safety precaution.[76] Naloxone, including Nyxoid (intranasal naloxone, 2 doses of 1.8mg) and Prenoxad (intramuscular naloxone 5 doses of 0.4mg) are available free of charge from participating community pharmacies as part of an Australian Government pilot for anyone at risk of experiencing or witnessing an overdose. Where there may be concerns regarding the safe storage and use of TADs, suitable carers should be engaged to assist in overseeing the use of medications, with patient consent. Patients receiving an increased number of TADs should be reviewed by telephone within the first 14 days and monthly thereafter.[75]

7.4.6 Use of telehealth

It is recommended that many of the activities that are undertaken during routine clinical reviews and monitoring can be undertaken effectively through telephone and telehealth consultations that include visual contact with patients. Clinicians are encouraged to transition and utilise telehealth approaches for regular monitoring and reviews of patients whilst recognising the potential gaps in clinical assessment arising from lack of physical examination and/or investigation (urine drug screens). Telehealth can include standard telephone and special telehealth software with appropriate confidentiality protections.[75]

7.5 Question 4: How are drugs and alcohol services being re-structured to meet clients' needs in light of COVID-19, especially clients with complex needs and who are most vulnerable?

7.5.1 Guidance for homeless people

The NSW Department of Communities and Justice has developed guidance for providers that are delivering services for people experiencing homelessness during COVID-19. They advise that consideration should be made in relation to assisting clients in accessing 'take-away' supplies of medication in consultation with the local health network/methadone clinic. Service providers may need to support clients to safely leave and return to premises to manage their addictions. Services should also work to provide telemedicine or telephone options and provide recommendations for online teleconferencing platforms or web-based support groups. Clients in isolation may need to refill prescriptions or need access to daily medications; providers should get harm reduction and addiction programs to deliver supplies directly to the facility, or support clients to get 14-day TADs to allow them stay home in self-isolation. Due to the likelihood of interrupted supply or reduced access to drugs or alcohol service providers should be prepared for clients to go through involuntary withdrawal. Staff should understand the signs of withdrawal so that they can be confident in responding to clients. Providers should: ensure the necessary medications, food and drinks that help detox are on hand; speak with a medical provider, on the client's behalf, about starting methadone or buprenorphine, where necessary; and ensure that sufficient treatment capacity is available if people look for withdrawal support or substitution with prescribed medications. Clients should be prepared for the possibility of syringe exchanges and drug treatment programs closing. Services may be required to stockpile harm reduction supplies (if this is in keeping with organisational protocols). Guidance around harm reduction practices should be communicated with clients to help them to avoid contracting COVID-19.[79]

8 Discussion

There was limited information on the impact of the COVID-19 pandemic on people who use drugs or on the demand for treatment services. The available information was mainly based on small surveys and anecdotal reports so it is not possible at this early stage to adequately assess with any certainty, the impact of COVID-19. Each of the four regions have published guidelines in relation to the operation of drug and alcohol services during COVID-19, particularly in relation to the provision of treatment for opiate use disorder. Much of the guidance in NY and NSW was provided by national level organisations. Apart from opiate use, NSW did not provide specific guidance in relation to any other substance use. In each region, drug treatment services were deemed essential services, and there were legislative changes, particularly in relation to loosening restrictions around prescribing controlled medications. The use of telehealth was promoted in each region's guidance. This was particularly evident in NY, where its use is recommended wherever possible.

The guidance for treating new patients entering opiate treatment programs differed by region. NY recommended treating with buprenorphine where possible as it can be prescribed by telemedicine without first conducting an in-person evaluation, but this does not apply to patients starting methadone. Buprenorphine was also recommended by NSW, followed by transfer to depot buprenorphine after one week. Scotland stated that either buprenorphine or methadone may be used but titration onto methadone is often safer when the medication can be provided on a daily supervised dispensing regime from a pharmacy. BC recommended considering buprenorphine but also provided comprehensive guidance for all other potentially suitable medications. The reasons cited for using buprenorphine include its superior safety profile and reduced risk of overdose and diversion.

In response to the COVID-19 pandemic, each region has introduced changes to their protocols around providing take-away doses to patients and delivering medications. This has led to patients being allowed to receive an increased number of TADs. While NY and NSW are prescriptive in their guidance around TADs, in BC and Scotland, provision of TADs seems to be at the discretion of the prescriber and based on the individual patient. In circumstances where patients cannot access their medications, in each region it is now permissible for pharmacies and treatment programs to deliver medication or alternatively, nominated persons are allowed to collect medication on the patient's behalf. Given the relaxation of the rules around prescribing controlled medications, the risk of overdose was cited, with BC, Scotland, and NSW all recommending that patients be provided with take-home Naloxone. Scotland recommends offering naloxone with injecting equipment provision transactions while BC has allowed the establishment of temporary spaces that comply with physical distancing within supervised consumption services.

Regarding other substance use, BC has published the most comprehensive guidance. It recommends replacing illicit and licit products with prescribed or regulated substances. It has also published a detailed pharmacotherapy protocol for opiates, alcohol, benzodiazepines, and stimulants. In relation to alcohol use, NY, BC and Scotland provide guidance on managing outpatient withdrawal and on the use of medication to do this. BC is the only area that has guidance on how to provide a managed alcohol program, and how to ensure that patients have access to an adequate alcohol supply to prevent the complications associated with severe withdrawal. For benzodiazepine use, NY, BC, and Scotland recommend prescribing benzodiazepines, with BC providing more detailed guidance on how to manage these clients. Just BC and Scotland provide guidance for stimulant use, which differs; BC recommends prescribing dexedrine or methylphenidate for stimulant users while the Scottish guidance does not recommend the use of these off-licence drugs.

There was some guidance in BC, Scotland, and NSW in relation to vulnerable people or those with complex needs. BC and NSW provided guidance for services dealing with people who are homeless; this guidance mainly related to ensuring they could access and store medications. Scotland was the only region to provide guidance in relation to prisons. They recommended transitioning those receiving daily supervised OST to Buvidal, which is a long acting buprenorphine depot injection, for people serving six months or longer. This was to achieve a rapid reduction in the need for daily contact with NHS front line and prison staff. It also recommended that those leaving prison be provided with naloxone.

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