



Guidance on Contingency Planning for People who use Drugs and COVID-19 (v1.0)

19th March 2020

Who is this guidance for?

Anyone who is working with people who use drugs (PWUD) but in particular those working with people on opioid substitution therapy (OST) and those working with people attending services to obtain injecting equipment.

Who compiled this guidance?

This guidance was drafted by the Scottish Drugs Forum in collaboration with the Sexual Health and Blood Borne Virus Prevention Leads Network, co-ordinated by the Scottish Health Protection Network.

Disclaimer

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

Introduction

This guidance aims to assist contingency planning for the consequences of the COVID-19 pandemic in relation to people who use drugs (PWUD). The aim is to raise awareness of potential problems that may arise and offer suggestions as to how these challenges might be mitigated.

The COVID-19 outbreak is a rapidly evolving situation. The Scottish Government have already announced [and may announce further] a variety of containment or isolation advisories with implications for staff and people using services.

Specific service-user populations may be at heightened risk of COVID-19 related illness or complications. Typically, this includes women who are pregnant, people who are 70 years or older; have asthma or other chronic pulmonary, cardiovascular, liver, haematological, neurologic, neuromuscular, or metabolic disorders such as diabetes; are immunosuppressed; or are residents of a nursing home or other chronic-care facility. **People who use drugs (PWUD) are a particular risk group with very specific needs.** There are particular challenges in relation to Scotland's population of people who have a drug problem: over half of the 60,000 people with drug problems are aged over 35 and have multiple morbidities, often including COPD, so are a very vulnerable high risk group in relation to COVID-19.

This guidance relates **primarily to people on opioid substitution therapy (OST) and those attending services to obtain injecting equipment** and related paraphernalia. COVID-19 will also have an impact on PWUD who are not in receipt of either OST or Injecting Equipment Provision (IEP).

The guidance covers a number of key areas:

- Potential medication shortage
- Community Pharmacy disruption to dispensing
- Disruption of Injecting Equipment Provision
- Staff shortage
- Patient illness or quarantine

Background

In Scotland, an estimated 25,000 people are in receipt of Opioid Substitution Therapy (OST) at any given point in time. The main forms of OST in Scotland are methadone and buprenorphine both of which are Controlled Drugs.

Across Scotland, care for PWUD is delivered in different settings, with some areas providing only centralised services and others delivering OST through a mix of specialist services and primary care-based services.

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

In Scotland there are around 300 sites distributing injecting equipment, with around 300,000 attendances and over four million needles and syringes distributed per annum. Any reduction to the number of IEP sites or restrictions on opening hours or operation will reduce availability of new, sterile equipment and paraphernalia for PWUD. Shortages will increase the risk of equipment reuse as well as sharing which, in turn, increases the risk of skin and soft tissue infections, spore-forming bacterial infections and blood-borne virus infections in a population with already high prevalence of viral hepatitis and HIV. **It is essential to ensure that adequate IEP is maintained.**

1 Potential Medication Shortage

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

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

Any individual in receipt of OST and in contact with treatment providers should be offered and encouraged to take a supply of Naloxone - **even if they have previously received a supply** - and should be provided with overdose awareness training or advice.

Stock Shortages of Opioid Substitution Medication

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

Movement of existing supplies within the community pharmacy network

Medications, including Controlled Drugs, can be transferred between pharmacies within the same business organisation. Multiple site pharmacy businesses should be encouraged to have contingency plans in place to move stocks between premises to meet patient need.

Alternative Opioid Substitution Therapy options

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

It is also important to note that Controlled Drug regulations require a written prescription to state drug, form and dose in order to be legal. The following changes will require amended or new prescriptions to be provided in most cases.

A. Generic Formulations

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

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

B. Sugar Containing and Sugar-Free Preparations.

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

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

Depending upon the prescriptions as written, there may be limited capacity for pharmacists to supply sugar-free methadone against an existing prescription where this is not stated, however, it is likely that replacement prescriptions will be required in most cases.

C. Different Preparation Strengths

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

Care must be taken to clearly communicate the differences between this formulation and a typical 1mg/ml. Dilution of concentrate to lower final strength is advised and patient risk is increased through errors or misapprehensions.

D. Methadone tablets

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

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

E. Conversion to alternative opioids

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

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

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

- Conversion from methadone or other opioid agonists may risk precipitated withdrawal and so expert advice is recommended to support the titration. Conversion from buprenorphine to other opioid agonists is similarly complex and specialist support is recommended.
- Depot injectable buprenorphine (Buvidal) may be considered where available. This requires additional titration steps and may be of particular use in secure settings.
- Buprenorphine transdermal patches may be necessary to consider where no other alternatives exist (unlicensed use).

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

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

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

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

Other opioid agonists

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

F. Symptomatic Withdrawal Management

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

2 Community Pharmacy Disruption to dispensing

Community pharmacy closures or restricted opening hours are likely to occur at some point during the COVID-19 pandemic. In the event of closures, this will lead to disruption in the dispensing of OST and in the provision of injecting equipment.

It is imperative that the Scottish Government and health boards ensure that OST and IEP are included as essential core services to be maintained. It is vitally important that there is direction that OST and IEP services are formally recognised as priorities when considering those non-essential pharmacy services which will not be maintained in the event of an emergency.

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

Pharmacy businesses should liaise with health boards and local drug treatment services throughout the pandemic. When pharmacy sites are closed staff should ensure that Controlled Drug registers, active prescriptions and necessary stock are transferred to the new site. There will be limited capacity for single site businesses to mitigate the impacts in the same manner as larger multiple businesses and this should be taken into account.

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

- Replacement prescriptions provided to another pharmacy
- Exploring alternative models of dispensing and delivery.

Closure of pharmacies has the potential to be hugely challenging and clearly it will be important not to create situations where large number of vulnerable people with drug problems are put in close proximity to each other or exposed to unnecessary infection risk from wider public contact.

Home delivery of medication

This may be an option in some areas and businesses depending on current capacity and support. Home deliveries do not form part of the NHS contracted service and pharmacy companies provide this according to their own business needs. Some capacity may be achieved through existing delivery arrangements within the pharmacies. Alternatively, arrangement would need to explore the use of, for example, family and friends, redirection of redeployed staff or volunteer agencies.

Collection of medication by others

Nominated representatives (such as family members, friends etc) can collect dispensed medication, including Controlled Drugs, with the patient's written consent. Only the patient (not the prescriber) can authorise someone to collect on their behalf. No amendment is required to the prescription.

Pharmacists are advised to get written authorisation from the patient however it is acceptable to accept a phone call from the patient in exceptional circumstances. The person collecting is acting as the "patient's agent" and it is this authorisation that allows them to legally possess a Controlled Drug that has not been prescribed to them.

Collection by a nominated representative extends to health service staff, Police etc.

Staff shortages

In the best-case scenario, staff shortages will occur due to illness, self-isolation, or carer and childcare responsibilities. In the worst-case scenarios this will be the result of staff being redeployed directly to care for patients with COVID-19 within the NHS. These will impact on the ability of services to operate a full-service model and prioritisation of activities will be required.

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

3 Disruption to injecting equipment provision

Community pharmacy plays an important role in the provision of IEP in many areas and communities. This service may also be disrupted by pharmacy closures or access restrictions. Other IEP will also be disrupted.

There is a need to ensure that all IEPs have an additional one month's supply in stock of injecting equipment and Naloxone. This order should be generated for them without delay. NEO365 data should be monitored in each area to identify any unusual patterns of provision that may risk stock depletion from any given outlet. All areas should keep an additional contingency supply of IEP equipment at a local location for immediate uplift or delivery.

Consideration should be given on to how to address site closures by using other methods of provision i.e. mobile vehicle, foot outreach, satellite or postal delivery. Some of these methods may require the collection of personal information (i.e. name and address) to allow them to operate. The client should be aware of this and told exactly how this information will be used. An urgent audit of methods of communicating to service users if supplies interrupted/closures foreseen should be undertaken.

Clients should be asked to take away enough injecting equipment to last 14 days and return at 14 day intervals thereafter. However, this may not be realistic for many and the provision of enough new needles to meet the number of planned injections should be paramount.

Naloxone should be offered and promoted with every IEP transaction with the exception of IPEDS. Staff should also communicate the higher mortality risk related to a drug related overdose if airways are compromised due to virus.

Large 30 litre sharps containers should be provided to facilitate safe home disposals. These should be returned to the IEP when full.

Clients should be reminded of how to properly clean injecting equipment (bleach and three cup technique) should the need arise. All clients should receive advice on cleaning/reusing equipment with their supplies.

All IEPs should have hand sanitiser available and each client should be offered this on entry to the outlet.

COVID-19 avoidance strategies should be routinely promoted to clients through all IEPs. Staff should also communicate the increased risk of transmission if sharing smoking/inhalation equipment. There should be strategic discussion with local police regarding clients carrying extra IEP equipment.

4 Patient Illness / Quarantine / Attendance in Community Pharmacy

Individual consideration of OST (e.g. methadone or buprenorphine) supervision and instalment dispensing relaxation should be reviewed for each patient. Consideration should be given to relaxing dispensing arrangements for patients such that pharmacy visits are reduced. This will reduce the risks of exposure to the wider public in the pharmacy and help to reduce the impact on pharmacy

services. There will be higher and not insignificant overdose risk in some patients as a result of these relaxations – it is essential to have ensured naloxone is offered - even if supplied previously - and that risk assessment, safe storage, children at home, etc. is performed and documented for each patient.

For patients instructed to self-isolate for a number of days (government advice, and not simply self-imposed), an immediate relaxation of drug supervision arrangements will need to be considered. Supervision is not a legal requirement and pharmacists can exercise professional judgment when relaxing supervision. This should be done in consultation with the prescriber.

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

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

5 Other measures

Communication with pharmacy services

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

Communication with other IEP services

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

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

6 Communication with people who use drugs re COVID-19

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

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

Information of services for PWUD can be found here:

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

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

Or people can phone the Know the Score Helpline:

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

7 Carers and family of people who use drugs

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

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

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

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

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