# Summary of global approaches to Oral Replacement Therapy delivery during the COVID-19 pandemic

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## 1 Scope and Introduction

This report summarises key global opioid replacement therapy (ORT) recommendations in response to the COVID-19 pandemic, including recommendations and resources from government bodies, specialist addiction and harm reduction centres, and third sector organisations.

Ensuring uninterrupted access to ORT for patients with opioid use disorder is critical to reduce the risk of harms and death that can be associated with medication destabilisation. It is also important to minimise the risk of infection and onward transmission among those most vulnerable due to underlying health conditions, social marginalisation and homelessness.

## 2 Recommendations by Country

### Canada

The British Columbia Centre on Substance Abuse recommends that health services consider alternatives arrangements to get essential medications to patients to ensure continuity of treatment, reduce the number of patient visits and promote social distancing. [1] Advice includes:

- Renewable prescriptions to reduce the frequency of patient attendance at clinics;
- Individualised duration of take-home ORT doses;
- Home delivery of ORT via outreach teams or pharmacist delivery for patients with symptoms or in quarantine;
- Consultation and support to patients via telemedicine.

BCCSU recommends clinicians to weigh the benefits of larger take-home doses with the risk of overdose, diversion, or risk to household members. Counselling on safe storage of medication is critical, as is naloxone provision and training on their use.[2]

Patients should be encouraged to consider transitioning to buprenorphine/naloxone. Compared to methadone, buprenorphine has a superior safety profile meaning patients can receive longer duration take-home prescriptions and there is reduced risk of overdose. The Centre for Addiction and Mental Health (CAMH) adds that, given clinical judgement, up to four weeks of buprenorphine take-home doses may be prescribed, regardless of how long the patient has been on ORT. CAMH suggest that very stable patients on buprenorphine may be assessed less frequently (e.g., 6 to 12 weekly) [3]

For those prescribed methadone, BCCSU recommends that prescribers should temporarily allow take-home doses in adequately stable patients, including longer take-home intervals and fewer in-person appointments. CAMH suggest a renewed take-home schedule for those on methadone, which allows at least some non-consecutive take-home doses even to those previously denied them [3; see also Appendix 1].

If a patient is using street opioids in addition to their ORT, BCCSU recommends that prescribers should use their clinical judgment in selecting appropriate medications [2]. Suggestions include:

- Prescribe oral hydromorphone 8mg tablets (1-3 tabs q1h as needed up to 14 tablets), provided daily AND/OR
- Prescribe M-Eslon (retard release morphine sulphate capsules) 80-240mg PO BID (twice daily) provided daily;
- Make initial prescription at least 23 days to support isolation and social distancing, extending as necessary (ensure it does not end on a weekend or statutory holiday).

In regions where overdose outreach teams exist, they may support patients with pharmacy delivery issues, prescription changes, linkage to care and navigating support services, and harm reduction education and supplies.

## United States of America

The Centers for Disease Control and Prevention provide general interim guidance for both homeless service providers [4] and healthcare facilities [5]. Homeless service providers are encouraged to:

- Promote the practice of everyday preventive actions;
- Provide COVID-19 prevention supplies at your organisation;
- Plan for staff and volunteer absences;
- Be prepared to report cases of respiratory illness that might be COVID-19 to your local health department and to transport persons with severe illness to medical facilities;
- If possible, identify space that can be used to accommodate clients with mild respiratory symptoms and separate them from others;
- Identify clients who could be at high risk for complications;
- Plan for higher shelter usage during the outbreak;
- Identify and address potential language, cultural, and disability barriers associated with communicating COVID-19 information.

The Substance Abuse and Mental Health Services Administration has announced that stable ORT patients should receive 28 days of take-home ORT. Practitioners may also request up to 14 days of take-home medication for patients who are less stable [6]. They also provide basic social distancing and safe practice guidelines for practitioners delivering medication to patients under quarantine.[7]

The New York State Office of Addiction Services and Supports recommends that practitioners use take home medications to reduce clinic traffic. This includes, but is not limited to, assessment of patients who are medically compromised and at elevated risk of complications from COVID-19 as a preventive measure, and the provision of take-home ORT to them. They suggest considering delivering medications to quarantined or otherwise home-bound patients who cannot travel.[8]

The Drug Enforcement Administration has confirmed that practitioners may prescribe controlled substances to patients using telemedicine without first conducting an in-person evaluation during this public health emergency [9,10]

## Norway

The Norwegian Centre for Addiction Research [11] recommends that practitioners:

- Consider novel delivery methods to ensure continuity of care and reducing the risk of infection for patients and staff, including home care services;

- Plan for the provision of medication to ORT patients who need hospitalisation due to COVID-19;
- Consider the feasibility of longer take-home intervals and fewer appointments;
- Consider if physical attendance at outpatient consultations is necessary during this period;
- Balance the need for patient's travel to collect medication and the efforts to reduce risk of disease transmission;
- Consider whether there will be stable and predictable opening hours and delivery routines for those who receive ORT;
- Ensure that sufficient ORT medication is available and consider ordering stock for a longer period of time than usual order intervals.

## 3 Recommendations from international organisations

The International Society of Addiction Medicine (ISAM) [12] notes that where possible, treatment services should prescribe medications following telephone or video consultations. Prescriptions may be made for longer periods of time than usual, and can be delivered to pharmacies by mail, email or fax.

ISAM also recommend that take-home doses of medications be provided for longer periods of time in situations of self-isolation, and that maximal periods of time for take-home doses of medications be considered when the dose and social situation are stable. Buprenorphine is preferable to methadone where possible, especially with new patients who begin ORT during the pandemic. ISAM state that this is because it is easier to reach a stabilised dose of buprenorphine, and that it is also possible to prescribe transdermal buprenorphine (patches) or injectable long-acting (1 week to 1 month) treatment. For buprenorphine, individuals can be rapidly inducted to optimal maintenance doses of 16-24mg daily.

ISAM does not recommend relaxing the methadone dose protocol at an early phase of treatment, however they do suggest avoiding unnecessary visits and rigor on a case by case basis. If accelerated induction is necessary, an additional dose of 30-40 mg can be followed by a further dose if someone has been observed 2 hours after their initial methadone dose. If the patient is still experiencing withdrawal at this time, they can safely be given a further dose.

ISAM cautions clinicians to be aware of the difference between withdrawal syndrome and symptoms of viral COVID19 infection. They recommend that pupil size is normally the best guide to detect opioid withdrawal, as COVID-19 infection does not affect pupil size.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) [13] detail some underlying chronic medical conditions among people who use drugs, which increase the risk of more severe COVID-19 illness. These include chronic obstructive pulmonary disease, asthma, cardiovascular diseases, HIV, hepatitis and liver cancers. The EMCDDA identify potential difficulties relating to:

- Crowding and the need for social distancing in drug treatment centres, low-threshold services and social support services;
- Those experiencing homelessness, who often have no alternative but to spend time in public spaces and lack access to resources for personal hygiene. Self-isolation is very challenging for homeless people and access to health care is often very limited;
- Continuity of care in the face of staff shortages, service disruption and closure, self-isolation, and restrictions placed on free movement.

# 4 Summary

## Dispensing recommendations:

- If clinic visits are vital for unstabilised patients, prepare service delivery that avoids a large assembly of patients at the same time. Increase hygiene measures at the delivery points;
- The duration of take-home doses should be lengthened, and prescriptions made renewable, wherever possible. Counselling on safe storage and naloxone provision is critical;
- Support to stabilised patients via telemedicine;
- For patients with symptoms or in quarantine, delivery of ORT via outreach teams or pharmacist delivery.

## Dosage:

- New patients can best stabilised using buprenorphine, quickly reaching optimal maintenance doses of 16-24mg daily;
- Patients should be encouraged to consider transitioning to buprenorphine, which has a safer profile than methadone;
- For those new to methadone, if buprenorphine is not suitable, a dose of 30-40 mg can be followed by a further dose if someone has been observed to be experiencing withdrawal 2 hours after their initial dose;
- Stable ORT patients may be able to take home up to 28 days of ORT;
- Those considered less stable may be eligible to take home up to 14 days of ORT;
- Renewed methadone take-home dosage recommendations can be found in appendix 1.

## Clinical Symptoms:

- Practitioners should be aware of the difference between withdrawal syndrome and symptoms of viral COVID19 infection. Pupil size is the best guide.

## Staffing

- Continuity of care may be a challenge in the face of staff shortages, service disruption and closure, self-isolation, and restrictions placed on free movement;
- It is essential that staff are provided with proper protective equipment and procedures when delivering services, and are adequately supported psychologically.

**References**

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**Appendix 1 – Renewed methadone take-home doses recommended by CAMH [3]**

| Pre-COVID-19 "Carry Level" | "Carry Ladder" during COVID-19 community transmission | Nomenclature |
|---|---|---|
| 0 and unsuitable for carries | No carries | COV-0 |
| 0 and suitable for carries | Only non-consecutive carries (up to 3 per week)* | COV-3 |
| 1 | Up to 2 consecutive carries (up to 4 per week)* | COV-4 |
| 2 | Up to 3 consecutive carries (up to 5 per week)* | COV-5 |
| 3 | Up to 6 carries per week | COV-6 |
| 4 | Up to 1 to 2 weeks | COV-13 |
| 5 or 6 | Up to 2 to 4 weeks** | COV-27 |

* No clear UDS (Urine Drugs Screen) required.

**Monthly carry limits are a Ministry of Health recommendation regarding prevention of stockpiling of all medications during COVID-19.

There should be refrigeration of carries if more than two weeks are provided.

**COV-0 to COV-5 (i.e., up to 5 carries per week; max. 3 consecutive doses):**

- Do not require clear UDS.
- If assessed remotely, the patient does not need to provide a UDS.
- Positive UDS should always be a discussion point regarding safety, stability, and harm reduction. In most circumstances, level of take-home doses should not be reduced, if the patient remains suitable for carries. Carries may still be increased as per the "Ladder" up to COV-5.
- The prescriber may adjust the number of carries upwards or downwards on the "Carry Ladder" as per their clinical judgment around safety.

**COV-6 to COV-27:**

- Patient should generally provide a UDS when each prescription ends; clear UDS are generally expected given the safety issues associated with 6 or more carries.
- Positive UDS should prompt a discussion regarding safety, stability and harm reduction. Carries do not need to be reduced in light of a "slip" or isolated non-problematic use as long as the other parameters of stability remain intact. If the patient is less stable, carries can be reduced to COV-5 or less.
- For some patients with long-term stability (including long-term clear UDS), it may be appropriate to prescribe up to 6 or more carries on an ongoing basis, with remote assessments without UDS.