BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

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COVID-19: INFORMATION FOR HEALTH CARE PROVIDERS REGARDING ALCOHOL USE DISORDER AND WITHDRAWAL MANAGEMENT

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EXECUTIVE SUMMARY

Individuals with untreated or undertreated alcohol use disorder are at greater risk of experiencing negative health outcomes during the COVID-19 pandemic. In addition to having a range of comorbidities, including an impaired immune system and reduced cognitive functioning, which may increase their likelihood of contracting COVID-19, individuals may also experience disruptions of their alcohol supply as a result of social distancing measures and impacts to the health care system. Unlike withdrawal from other substances (e.g., stimulants, opioids), those at risk for severe complications of alcohol are at risk of severe morbidity and mortality related to alcohol withdrawal.

To help mitigate the health risks affecting people with alcohol use disorder and reduce the demand on the healthcare system, this document provides a brief overview of interventions to prevent alcohol withdrawal symptoms and treat alcohol use disorder while observing social distancing measures. Specifically, this text provides guidance for providing withdrawal management pharmacotherapy and long-term AUD pharmacotherapy in outpatient settings with remote monitoring measures. Additionally, this document provides advice for healthcare providers to support sustained access to alcohol for patients not receiving treatment for alcohol use disorder.

BACKGROUND

On March 11, 2020, the World Health Organization declared COVID-19, caused by a novel coronavirus, a pandemic, citing concern over alarming levels of spread and severity across the globe. The novel coronavirus has caused a global outbreak of respiratory infections since its discovery in December 2019. For most, this coronavirus causes only mild to moderate symptoms including fever and cough, however, older adults and those with pre-existing health problems are at greater risk for more severe symptoms such as pneumonia. The impact of COVID-19 continues to evolve in BC, Canada, and other jurisdictions around the world.

As part of their comprehensive response to this pandemic, federal and provincial health officials have urged individuals on chronic medications to acquire an adequate supply of prescription drugs. Patients who have untreated alcohol use disorder or who engage in high-risk drinking may require access to alcohol and may be at increased risk of experiencing severe alcohol withdrawal if access is disrupted. Currently, liquor retail is considered an essential service in British Columbia, meaning the Provincial Health Officer has encouraged the service to remain open, where possible. While larger alcohol retailers are anticipated to remain open, smaller, independent shops may close, making it difficult for patients to access alcohol by traditional means. Access to non-beverage alcohol supplies may also be interrupted. Additionally, with physical distancing, isolation, and quarantine measures in place, individuals who consume alcohol may face reduced overall access to alcohol.

Alcohol withdrawal can result in potentially life-threatening complications, including generalized tonic-clonic seizures and delirium tremens, if left untreated. In order to prevent these complications, and to help reduce demands on the province's emergency departments at this time, individuals at risk of alcohol withdrawal should be identified and plans to manage or avoid withdrawal should be made.

Health care providers, community services, outreach teams, and/or homeless support services are all encouraged to be mindful of risk factors and aid in identifying individuals who are at risk of serious complications related to alcohol withdrawal. Signs of risk include:

- Drinking more than one bottle of spirits per day or equivalent (e.g., 3 bottles of wine or 15 bottles of beer)
- Prior experience of severe alcohol withdrawal symptoms including seizures, hallucinations, or delirium tremens
- A history of combining alcohol with other substances (in particular, other CNS depressants like benzodiazepines or opioids)
- A history of experiencing moderate withdrawal symptoms (e.g., tremor, sweating, nausea, or vomiting) upon abrupt reduction or discontinuation of alcohol use

The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) should be used by clinicians to stratify risk of severe complications related to alcohol withdrawal.

INFORMATION FOR PRESCRIBERS

Healthcare providers should regularly screen their patients for high-risk alcohol use and alcohol use disorder, and use the guidance in this bulletin to develop a plan for patients who are at high risk of serious complications related to alcohol withdrawal. Health care providers should inquire whether patients' usual access to alcohol has been disrupted. The diagnostic criteria for alcohol use disorder and high-risk drinking are provided in the Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder.

Plans to avoid or manage alcohol withdrawal may include outpatient withdrawal management, inpatient withdrawal management (where capacity exists), long-term alcohol use disorder treatment and recovery supports, or—where available—managed alcohol programs. Health care providers should create individualized plans to support patients to prevent or manage withdrawal, based on each patient's needs, wishes, and circumstances.

While abrupt discontinuation of alcohol use should be discouraged in patients who have alcohol use disorder or engage in high-risk drinking, health care providers should use the COVID-19 pandemic as an opportunity to motivate clients who drink to reduce or stop alcohol consumption. Care providers should inform clients that high level alcohol use may suppress various organ systems, including the immune system, increasing vulnerability to COVID-19 infection.

To the extent possible, health care providers are encouraged to conduct patient assessments and visits using telehealth or video conferencing software. Where this is not possible, maintain appropriate physical distance, where possible, and use appropriate personal protective equipment (PPE).

WITHDRAWAL MANAGEMENT

To select the appropriate withdrawal management pathway, assess the patient's risk of developing severe complications of withdrawal (i.e., seizures and delirium tremens) using the PAWSS tool. See Remarks and Cautions for important information on using the PAWSS tool.

Withdrawal management for patients at low risk of severe withdrawal symptoms (PAWSS < 4)

Patients with PAWSS <4 can generally safely undergo alcohol withdrawal at home

- Arrange frequent follow-ups. Follow-ups can be conducted remotely (i.e., telephone and video calls)
- Ensure that the patient has the basic resources they need to undergo withdrawal (e.g., safe housing, adequate nutrition and hydration, a reliable family member to monitor symptoms and support adherence to medication)
- For patients who lack necessary resources, connection to outreach workers, shelters, or other appropriate resources should be considered
- Discuss accessing recovery support over the phone or online, for those interested. For example, AA, SMART Recovery, and LifeRing are all offering online meetings

Prescribing pharmacotherapy and monitoring measures for withdrawal management

- All patients should be offered pharmacotherapy for withdrawal management
- Patients with mild-to-moderate AUD may experience negligible withdrawal symptoms and may decline medication for withdrawal management. In this case:
  - AUD pharmacotherapy can be directly offered and initiated (see AUD pharmacotherapy, below)
- Monitor patient for emerging withdrawal symptoms, regardless of treatment pathway selected
  - Inform patients of possible withdrawal symptoms including tachycardia, pyrexia, tremor, nausea, vomiting, sweating, agitation, anxiety, and insomnia
    - Patients may be instructed to use the Short Alcohol Withdrawal Scale (SAWS) to monitor and report their own symptoms
  - Arrange for daily video or voice follow-ups, if possible, during the first 3-5 days
    - Community pharmacists or other members of the health care team (e.g., nurses) can also be an important source of support and guidance for patients experiencing unexpected withdrawal symptoms
  - Consider prescribing over-the-counter pain relievers and anti-emetics for the management of mild symptoms

Gabapentin dosing				
Approx. day	Daytime Dosing	Evening Dosing	PRN Dosing	Total daily dose
Day 1	300mg TID	600–1200mg HS	300mg PRN	Up to 2400mg
Day 2-3	Titrate quickly as tolerated: 600mg TID	600-1200mg HS	If symptoms persist: Additional 300mg TID PRN + 600–1200mg HS PRN	Up to 3600mg
Day 4	When symptoms resolve, taper to 600mg TID	600–900mg HS	—	Up to 2700mg
Day 5 +	Taper to zero over next 3-5 days by 600mg per day	—	—	—

Note: Risk for non-medical use. If selected for outpatient withdrawal, gabapentin should be prescribed in shorter intervals and in blister packages, with frequent monitoring through telehealth visits or other remote means (see Considerations for Medication Delivery, below).

To determine whether additional gabapentin is needed for treatment of breakthrough withdrawal symptoms, the patient can be instructed to use the Short Alcohol Withdrawal Scale (SAWS) to determine PRN dosing. Regardless of whether the patient is at 300mg or 600mg TID regular, additional doses of gabapentin 300mg TID PRN can be taken if SAWS scores are ≥12 or the patient is experiencing craving, insomnia, or irritability. Drowsiness indicates that the patient should not increase their dose.

- Information and detailed guidance on other withdrawal management pharmacotherapies are available in the Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder

Withdrawal management for patients at high risk of severe withdrawal symptoms (PAWSS ≥ 4)

- Refer to inpatient withdrawal management ONLY if space is confirmed
  - Note that inpatient services may have limited capacity during this time
- If inpatient withdrawal management is unavailable, or declined by the patient, consider the following options for individuals at high risk of developing severe withdrawal symptoms:
  - Provide support for accessing alcohol (see Supporting Access to or Providing Alcohol, below)
  - If patient chooses to undergo detoxification, consider prescribing benzodiazepines for withdrawal management. Prescribers should be mindful of the risks associated with benzodiazepine use and make arrangements for increased monitoring:
    - Benzodiazepines have potential for non-medical use
    - If used concurrently with alcohol, benzodiazepines may potentiate sedation and respiratory depression
    - Prior to prescribing benzodiazepines, establish a daily follow-up pathway and ensure that patient has a reliable family member or community contact (e.g., outreach worker) to monitor adherence to medication
    - A sample dosing schedule for diazepam is provided below

Diazepam (Valium) dosing		
Day	**Prescribe**	**Total Daily Dose**
Day 1	10mg QID	40mg
Day 2	10mg BID	20mg
Day 3	10mg BID	20mg
Day 4	10mg HS	**10mg**
Note: Risk for non-medical use. If selected for outpatient withdrawal, benzodiazepines should be prescribed in shorter intervals and in blister packages, with frequent monitoring (see Considerations for Medication Delivery, below)		

AUD PHARMACOTHERAPY

This section offers general guidance for the provision of long-term treatment to support the sustained reduction or cessation of alcohol use. As outlined in the Withdrawal Management section above, the completion of detoxification is not required for all patients wishing to initiate AUD pharmacotherapy; patients with mild-to-moderate alcohol use disorder who experience mild withdrawal symptoms may choose to directly initiate long-term pharmacotherapy without withdrawal management. However, the adequate management of withdrawal symptoms can increase the likelihood of achieving long-term treatment goals.

Selection between first-line options—Naltrexone and Acamprosate:

- Naltrexone and acamprosate are the recommended first-line medications for AUD in BC
- Naltrexone is contraindicated in people currently using opioids (analgesia, opioid agonist treatment, or non-medical use)
    - Naltrexone is recommended for people with the goal of reduced alcohol craving or heavy drinking and is appropriate for patients with the goal of abstinence
    - Naltrexone dosing:
        - Start at 12.5mg PO BID for three days
        - Titrate up as tolerated to 50mg PO OD
- Acamprosate is appropriate for patients with concurrent opioid use (including opioid agonist treatment)
    - Acamprosate is appropriate for patients with the goal of abstinence
    - Acamprosate dosing:
        - Two 333mg tablets PO TID (Total daily dose: 1998mg)
- Both naltrexone and acamprosate are safe to start while patient is using alcohol, but may be more effective if started following completion of withdrawal management

When to consider second-line options—Topiramate and Gabapentin:

- Based on the specific circumstances of each patient (e.g., contraindications, patient preference, unsuccessful experience with first-line options), consider whether second-line options, topiramate and gabapentin, may have more utility and efficacy. Review the contraindications and cautions of medication prior to selection
- Further information and detailed guidance are available starting on p. 67 of the Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder

Considerations for medication delivery

- Prescribers should identify pharmacies that have capacity to deliver medications and prioritize delivery services for patients who are self-isolating
- If pharmacies do not have capacity, consider other delivery options (e.g., delivery by outreach workers or other designated individuals)
- Naltrexone, acamprosate, and topiramate do not have potential for non-medical use and can be prescribed and dispensed in monthly intervals
- Benzodiazepines and gabapentin, in particular, have potential for non-medical use; on a case-by-case basis, prescribers can consider weekly or biweekly prescription and delivery in blister packages
- Prescribers should remind patients to plan to safely store benzodiazepine medications (e.g., medication lock box, personal safe, or request supportive housing staff to store it, where applicable)
- For homeless or precariously housed patients in shared living spaces, patients may be referred for isolation at specified shelters or other locations, in cases of suspected or confirmed COVID-19. Delivery of medication could be arranged for these locations

SUPPORTING ACCESS TO OR PROVIDING ALCOHOL

Some individuals will decline withdrawal management support or AUD medications. For these individuals, it is important to provide individualized education (i.e., based on their current alcohol use, history, concurrent substance use, and co-morbid physical and mental health conditions) on the risks of abrupt alcohol cessation ("going cold turkey"), and create a personalized plan to continue to access alcohol. Individualized alcohol management plans can be made by a nurse, outreach worker, or case worker, in consultation with a physician.

Support for individuals who are able to access alcohol independently

- Assess each patient's level of alcohol use, and talk to patients about what they need to avoid withdrawal. Consider consulting the RACEline or an addiction specialist if needed.
    - Care providers and clients may refer to simplified online standard drink size conversion information and calculators to gauge alcohol consumption
- Based on each patient's level of alcohol use, provide information and guidance on how to self-manage alcohol use to avoid withdrawal, including consuming regular amounts (1 standard drink) of alcohol equivalent hourly as needed up to 12 drinks per day, avoiding non-beverage alcohol
- Encourage individuals to assess their daily intake of alcohol and stock up to the degree possible, in order to reduce the number of trips needed to buy alcohol
- Help patients identify potential "buddies" who could deliver alcohol, food, and necessary medications if patient has to self-isolate or quarantine
- Encourage individuals to look into delivery of alcohol from online sources to reduce the number of trips to stores (some small breweries and liquor stores are offering delivery)
- Provide information on community sources, such as local managed alcohol programs or bulk purchases from community organizations
- 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, for example facilitated by a community organization or housing service (see forthcoming Managed Alcohol Guidance)
    - There are several managed alcohol programs operating in BC. Please see this link for more information. Please note that most programs have strict eligibility criteria and limited capacity
- If managed alcohol support is not possible, discuss with patient how they can manage their own alcohol supply and reduce alcohol intake safely. Measures include instructing the client to:
    - Reduce drinking by 1-2 drinks per day
    - Switch to a lower strength beverage (e.g., from wine to beer)
    - Diluting drinks with water/juice

RESOURCES

Health care providers are encouraged to work with their patients to develop a plan to manage their alcohol use safely in the context of the COVID-19 pandemic. The Canadian Institute for Substance Use Research (CISUR) has released a bulletin with tips on how to practice safer drinking during COVID-19. This can be shared with patients and includes information on planning for reduced availability of alcohol, a self-assessment of the likelihood of experiencing alcohol withdrawal, and ideas for managing and buying alcohol supplies.

Visit the BCCSU website for further guidance relating to COVID-19 and substance use, as well as the Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder.

GENERAL COVID-19 PREPAREDNESS PRACTICES

Clinicians should follow hand hygiene, respiratory etiquette, and social distancing measures and advise patients to do the same. Clinics should have hand sanitizer available and consider face masks for those who present with respiratory symptoms.
Clinicians should ensure patients have an adequate supply of other required medications (e.g., for HIV, hepatitis C, other chronic conditions) that may be necessary during a period of quarantine, providing extra refills as appropriate.

Clinicians should provide information about COVID-19 to patients, including about social distancing measures when visiting the pharmacy or clinic, and refer patients to the BC Centre for Disease Control for more information.

ADDITIONAL RESOURCES

Ministry of Health self-assessment tool for COVID-19 symptoms.

811 can provide medical advice, information on COVID-19, and instructions on what to do if patients are experiencing symptoms.

For non-medical information about COVID-19, **1-888-COVID19 (1-888-268-4319; call)** or **604-630-0300 (text)** from 7:00 am to 8:30 pm every day provides information about physical distancing and what kinds of support, resources, and assistance are available from the provincial and federal governments.

The First Nations Health Authority (FNHA) has published *Alcohol Use: Risk Mitigation Strategies During a Pandemic*.

British Columbia Centre for Disease Control

- For health care providers (link)
- For the public (link)
- For people who use drugs and registered harm reduction and naloxone sites (link)

Rapid Access to Consultative Expertise (RACE) line:

- Monday to Friday 0800–1700
- Vancouver Area: 604-696-2131
- Toll Free: 1-877-696-2131
- Website: http://www.raceconnect.ca/