January 2022

RISK MITIGATION

IN THE CONTEXT OF DUAL PUBLIC HEALTH EMERGENCIES

Update to Interim Clinical Guidance

BRITISH COLUMBIA

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

Risk Mitigation in the Context of Dual Health Emergencies—Interim Clinical Guidance

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Target Audience: Physicians, nurses and nurse practitioners, pharmacists, policy makers, health care administrators, allied health care professionals, and all other clinical and non-clinical personnel with and without specialized training in addiction medicine, who are involved in the care and management of individuals, families, and communities affected by opioid use.

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Land Acknowledgement

We would like to respectfully acknowledge that the land on which we work is the unceded territory of the Coast Salish Peoples, including the territories of the xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səlililwətaʔɬ (Tsleil-Waututh) Nations.

Authors and Reviewers

This update was developed by the authorship committee listed below. As part of the development process, broad consultation was sought from key stakeholders, including health systems partners, opioid agonist treatment prescribers in BC, and people with lived and living experience.

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Summary of Key Updates and Additions

This update to *Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance* provides several key updates and additions, based on clinical experience and expert consultation, which are outlined below.

- The document is more clearly situated in the context of the COVID-19 pandemic (throughout)
- Clinical experience with risk mitigation prescribing (p. 17)
- General principles for care planning (p. 19)
- Guidance on patient planning following initial medication trial (p. 22)
- Guidance on limitations of urine drug testing, and how to best use urine drug testing to support decision-making regarding continuing or discontinuing risk mitigation prescribing (p. 26)
- A section on informed consent (p. 27)
- Guidance on missed doses for opioids (p. 31) and stimulants (p. 36)
- Updated guidance on managing benzodiazepine withdrawal (p. 37)
- Guidance on supporting individuals at risk of cannabis withdrawal (p. 41)
- The role peer navigators and advocates can play to support engagement in care (p. 47)
- A section on rural and remote considerations (p. 48)
- Guidance on billing (p. 49)
- Updated and additional example clinical scenarios (p. 54)
- Footnoted citations have been converted to endnote citations (throughout)

Contents

1.0 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. In British Columbia (BC), a public health emergency due to COVID-19 was declared on March 17, 2020. British Columbia is in a unique situation, with the current crisis compounding an existing public health emergency declared in April 2016, due to escalating opioid overdoses and related deaths. At the intersection of these dual public health emergencies are a number of risks, including the risk for overdose and other harms related to an increasingly toxic illicit drug supply, the risk of infection and spread of infection among those with underlying health conditions and who face social marginalization, and risks due to withdrawal for those who must self-isolate or quarantine to prevent the spread of COVID-19. Extraordinary measures are needed to support people who use drugs (PWUD; including alcohol) and prevent ongoing community spread of COVID-19 among a vulnerable, often immune-compromised population. In response to these intersecting public health crises, the BC Centre on Substance Use, Ministry of Health, and Ministry of Mental Health and Addictions released the first iteration of this document, *Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance* in March 2020.

This document is intended to provide clinical guidance to health care providers to support patients to mitigate these compounded risks and enable physical distancing, self-isolation, and quarantine measures, where possible, to reduce and prevent the spread of COVID-19. This interim clinical guidance is not intended to guide the treatment of substance use disorders, but rather to support individuals with substance use disorders to self-isolate, quarantine, or physical distance, to reduce the spread of COVID-19.[a]

This update to *Risk Mitigation in the Context of Dual Health Emergencies: Interim Clinical Guidance* was undertaken at the request of the Ministry of Health and Ministry of Mental Health and Addiction, and in response to feedback from prescribers seeking additional clarity and guidance. At the time of publication of this update, it is unknown how the COVID-19 pandemic will evolve. Absolute risk of infection has decreased for many individuals through widespread vaccination, while it may increase for others who have yet to be vaccinated (or are unable to be vaccinated) due to highly contagious variants circulating in BC. As the pandemic continues and eventually resolves, it may be appropriate to consider trialling this intervention for individuals whose absolute risk of COVID-19 infection has decreased and who remain at high risk of overdose due to the toxic illicit drug supply, despite trials or offers of OAT. See *Opioid Use Disorder Practice Update* and forthcoming Stimulant Use Disorder Update for more information on prescribing these medications to reduce reliance on the illicit drug supply and overdose risk outside the context of COVID-19. Individuals who trialled this intervention to reduce the spread of COVID-19 and experienced significant benefit (e.g., reduced illicit drug use and overdose risk, increased clinical and psychosocial stability) should not be deprescribed simply

[a] Information on clinical experience with prescribing opioids to reduce the risk of overdose and reliance on the toxic drug supply outside of the context of COVID-19 risk can be found in Opioid Use Disorder Practice Update. Information on clinical experienc with prescribing stimulants to reduce the risk of overdose and reliance on the toxic drug supply outside of the context of COVID-19 risk can be found in the forthcoming Stimulant Use Disorder Practice Update. These documents help to enact, but are distinct from, Access to Prescribed Safer Supply in British Columbia: Policy Direction which was released in July 2021 by the MMHA, MoH, and the Office of the Provincial Health Officer.

because their risk of COVID-19 has decreased. See Patient Planning Following Initial Medication Trial in this document for more information.

As part of the update process, broad consultation was sought, including health systems partners, opioid agonist treatment prescribers in BC, and people with lived and living experience (PWLLE). Given the direction of government, this review focused on the clinical guidance contained in this document, rather than the concept of prescribing to reduce risks associated with both COVID-19 and the toxic illicit drug supply. As part of the update process, broad consultation was sought, including health systems partners, opioid agonist treatment prescribers in BC, and people with lived and living experience (PWLLE). Given the direction of government, this review focused on the clinical guidance contained in this document, rather than the concept of prescribing to reduce risks associated with both COVID-19 and the toxic illicit drug supply.

2.0 Evaluation and Monitoring

An evaluation of the 2020 *Risk Mitigation Interim Clinical Guidance* (RMG) is ongoing. The CIHR-funded evaluation, "A mixed methods evaluation of risk mitigation measures to address the dual public health crises of COVID-19 and overdose" is led by Investigators from the BC Centre for Disease Control,[b] Simon Fraser University,[c] and the Canadian Institute for Substance Use Research at University of Victoria.[d] The project uses mixed methods (qualitative and quantitative) to provide a comprehensive assessment of the impact of the RMG on overdose and COVID-19 transmission (primary outcomes) and other secondary outcomes, among people at risk of overdose. A participatory approach was used to develop and implement the evaluation through partnering with people with lived or living experience (PWLLE) of substance use, including representatives of a peer network embedded within the BCCDC (Professionals for Ethical Engagement of Peers), and a network of independent, autonomous grass-roots drug user groups from across the province (BC/Yukon Association of Drug War Survivors). Core team members include researchers and representatives from the First Nations Health Authority. The broader study is overseen by a consortium, which represents a diverse group of stakeholders (e.g., regional health authorities, researchers, representatives from the Overdose Emergency Response Centre, Ministry of Mental Health and Addictions, Ministry of Health, and other stakeholders) who review study findings and inform and support knowledge translation efforts

2.1 Preliminary Results from Evaluation[e]

Using PharmaNet[1] and other Ministry of Health[2-4] data available through the BCCDC COVID-19 Cohort,[f] an estimated 6,498 people were dispensed *Risk Mitigation* prescriptions (RMG) from March 27 2020 to February 28, 2021.[g] Risk mitigation opioid medications were identified as having been dispensed to 3,771 persons (58.0%) and RMG stimulant medications were dispensed to 1,220 persons (18.8%).[h] Overall, there were 179,349 unique RMG medication dispensations, more than 70% of which were for opioids, and approximately 20% of which were for stimulants.

Preliminary data from the BC COVID-19 Cohort indicates that, of 6,498 persons who were dispensed *Risk Mitigation* medications from March 27, 2020, to February 28, 2021, 82 persons died during that period.[5] Of the persons who died, 33 (40%) were prescribed opioids only, 9 (11%) were prescribed stimulants or stimulants and opioids, 6 (7%) were prescribed alcohol withdrawal medications and another RMG medication (unspecified), 17 (21%) were prescribed alcohol

[b] NPA: Dr. Amanda Slaunwhite
[c] PIs: Dr. Bohdan Nosyk and Dr. Natt Hongdilokkul
[d] PIs: Dr. Bernie Pauly, Dr. Karen Urbanoski
[e] Note: The data presented here is preliminary and incomplete and does not include interpretation. More complete data, including qualitative findings and interpretation, will be forthcoming from the BCCDC COVID-19 Cohort.
[f] All inferences, opinions, and conclusions drawn in this report are those of the authors, and do not reflect the opinions or policies of the Data Steward(s).
[g] The BCCDC COVID-19 Cohort was established at the Provincial Health Service Authority (PHSA) as a surveillance platform to integrate various datasets including data on BC-wide laboratory tests, COVID-19 surveillance case data, HealthLink 811 calls, prescription drug dispensations, medical visits, ambulance dispatches, Intensive Care Unit (ICU) admissions, and mortality—all integrated with existing administrative data sources such as the Chronic Disease Registry, hospital admissions, and the Provincial Client Roster.
[h] Alcohol withdrawal management medications (carbamazepine, gabapentin, and clonidine) were dispensed to 1,431 (22%) persons and benzodiazepines were dispense to 784 persons (12.1%).

withdrawal medications only, and 17 (21%) were prescribed benzodiazepines only. No individuals who died were prescribed both benzodiazepines and opioids.[5]

Of the 82 persons who died, 7 had an active dispensation on the day they died (n=4 opioids; n=3 alcohol withdrawal management medications).[i] The cause of death for a high proportion of deaths (n=37; 45%) is not specified due to the lag in Vital Statistics death data. Of those deaths where cause is specified (n=45; 55%), none were due to illicit drug toxicity death. Causes of death include gastroenteritis and colitis, cancer, heart failure, and other conditions. Among persons who received *Risk Mitigation* prescriptions that were not active on the day they died, the average length between RMG prescription end date and death was 41 (median 25) days for stimulant medications, 56 (median 39) days for opioid medications, 86 (median 83.5) days for benzodiazepine medications, and 72 (median 48) days for alcohol withdrawal management medications.[5]

In addition, mortality rates for persons who received *Risk Mitigation* prescribing have been reported based on drug type. Persons prescribed benzodiazepines had the highest mortality rate (27 deaths per 1000 person years), followed by alcohol withdrawal medications (17 deaths per 1000 person years) and opioid medications (11 deaths per 1000 person years).The mortality rate was the lowest among persons prescribed stimulant medications (8.9 deaths per 1000 person years).[5] While direct comparisons are not possible, for perspective, cohort data of people who inject drugs in Vancouver, BC, between 2006 and 2017 found a mortality rate of 22.7 per 1000 person-years,[5] while a 2019 meta-analysis (N=32, n=150,253) of cohort studies of individuals on buprenorphine/naloxone or methadone found a crude mortality rate of 16 deaths per 1,000 person years,[6] and a 2020 meta-analysis (n=229,274) of 101 cohorts of people with OUD involving illicit opioids found a crude mortality rate of 18.7 per 1000 person years.[8] In addition, a retrospective cohort study using the BC Provincial Overdose Cohort found a 12-month crude mortality probability of approximately 5% for individuals who had visited the emergency department with an overdose-related visit in the previous 12 months,[8] which accords with a cohort study out of Ontario that similarly found that 5% of individuals who had attended the emergency department for non-fatal opioid overdose within the past year had died of any cause (1.9% of opioid-related causes).[9]

Other findings from the BCCDC evaluation include that 94.3% of all *Risk Mitigatio*n prescriptions were daily dispensed.[5] Additionally, evaluation data up to September 30, 2020 found that 96% of all people who have opioid use disorder who received prescription opioids through *Risk Mitigation* had ever been on OAT.[11] More recent data (up to February 28, 2021) found that 68% of persons dispensed prescription opioids through *Risk Mitigation* prescribing had been dispensed OAT in the 30 days prior to first *Risk Mitigation* dispensation. Among those not prescribed OAT in the 30 days prior to *Risk Mitigation* dispensation, almost 2% received an OAT dispensation on the same day as their first *Risk Mitigation* dispensation, almost 15% were dispensed OAT within 7 days of receiving their first *Risk Mitigation* dispensation, and approximately 15% were not dispensed OAT in the 30 days following their first *Risk Mitigation* dispensation.

[i] To date, there is incomplete cause-of-death data for the Risk Mitigation cohort. In addition, the small number of deaths reported who had an active dispensation on the day of death precludes release of specific causes of death due to privacy considerations.

More recent data from BC Coroner's Service and the BC COVID-19 Cohort shows that 2,423 people died of illicit drug toxicity in BC from March 1, 2020, to May 31, 2021.[12] Hydromorphone was detected in 5.9% of illicit drug toxicity deaths (n=142) during this time. In addition, the monthly proportion of individuals with hydromorphone detected in post-mortem toxicology has remained relatively stable, with a range of 0–8.2% detected January 1, 2019–February 28, 2020 and 2.7–9.3% detected March 1, 2020–May 31, 2021.[12] Of the 5.9% of deaths where hydromorphone was detected, the vast majority included both hydromorphone and fentanyl (4.2% of total deaths, n=101) while hydromorphone without fentanyl or fentanyl analogues was detected in 1.7% (n=41) of total deaths. In a majority of these cases where fentanyl was not detected, hydromorphone was detected in combination with other substances, including morphine, etizolam, flualprazolam, and alcohol. A recently released knowledge update from the BCCDC that includes this data concludes that *Risk Mitigation* prescribing is not a direct contributor to the rising rates of illicit drug toxicity death in BC, and that fentanyl and its analogues remain the main contributors to illicit drug toxicity deaths.[12]

Several limitations to this data are also noted.[12] Hydromorphone toxicology data from the BC Coroners Service was not linked to PharmaNet, which makes it impossible at this time to determine whether the hydromorphone detected post-mortem was prescribed to the decedent. Hydromorphone is prescribed in BC outside the context of *Risk Mitigation* prescribing (e.g., analgesia, injectable OAT); hydromorphone toxicology data cannot be confirmed to reflect hydromorphone that was prescribed through *Risk Mitigation* rather than for other reasons. And, finally, toxicology data is derived through post-mortem testing of blood, tissue, or urine samples. Due to similar metabolization, it is possible that the detected hydromorphone originated from heroin or morphine (including SROM), rather than the consumption of hydromorphone.[12]

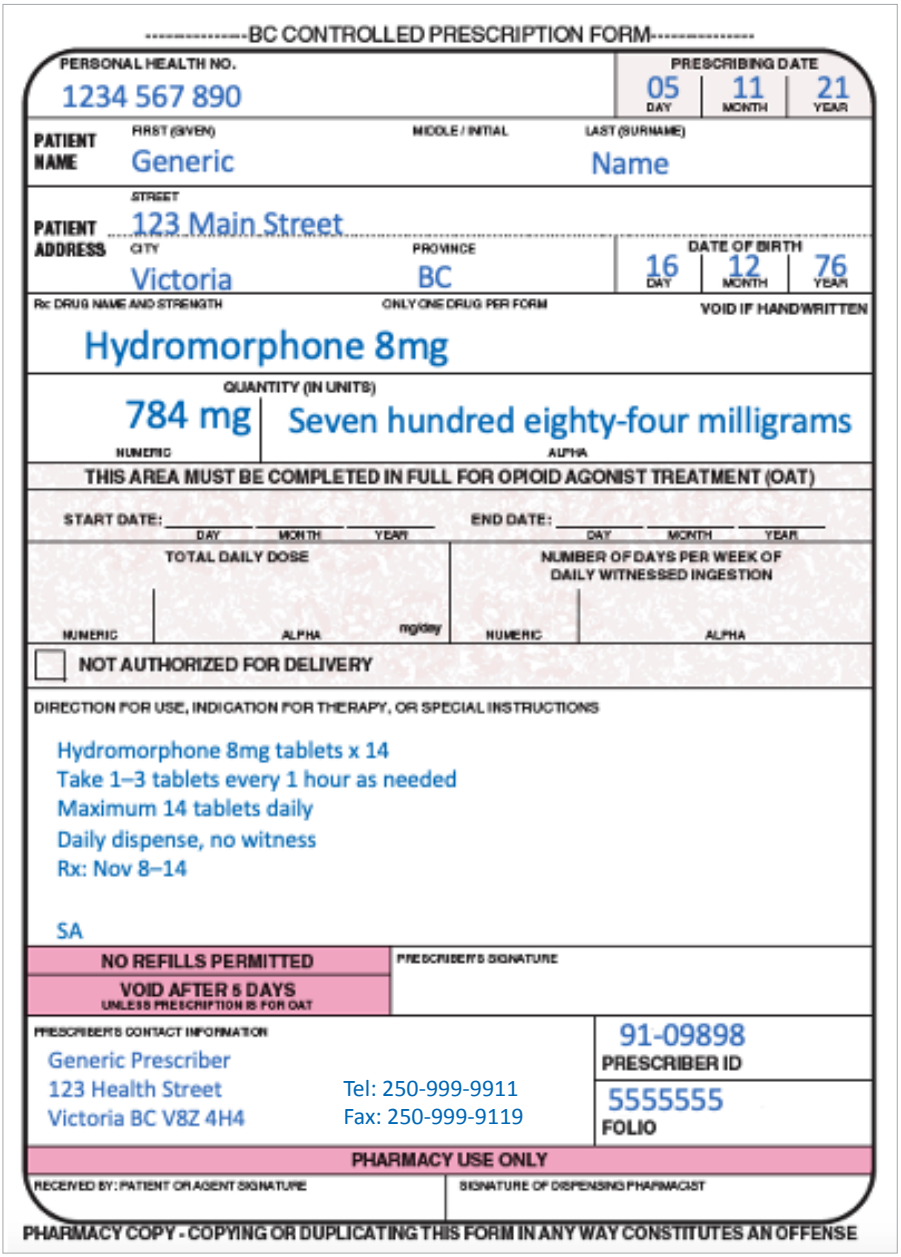
2.2 Prescriber and Pharmacist Procedures for Prescribed Harm Reduction Drugs: Risk Mitigation

The safety and sustainability of the prescribed harm reduction drug options outlined in the *Risk Mitigation Interim Clinical Guidance*, the *Opioid Use Disorder Practice Update*, and the *Prescribed Safer Supply Policy* are predicated on ongoing fulsome monitoring and evaluation to inform program effectiveness and identify any unintended risks or harms. Accurately capturing these prescriptions in PharmaNet is essential to enable comprehensive and rigorous evaluation.

Most of the drugs prescribed as alternatives to support people to reduce their reliance on the toxic illicit drug supply, both for risk mitigation and as a safer supply alternative, are used for additional indications; therefore, prescriptions for harm reduction and safer supply must be distinguished from other indications (e.g., pain). Prescribers and pharmacists are therefore being asked to assist as follows:

2.2.i Instructions for Prescribers:

Any prescription written for a drug to be used as an alternative to the toxic street supply including prescriptions written for risk mitigation during the dual public health emergencies or as a safer supply option should clearly include "SA" in the Instructions for Use section of the form, **BELOW** the instructions written on the form. This code is not part of the official instructions but indicates to the dispensing pharmacist that the prescription is to be tagged with the non-public facing code that will allow the prescription to be identified in the PharmaNet database. An example follows.



----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.: 1234 567 890

PRESCRIBING DATE: 05 (DAY) 11 (MONTH) 21 (YEAR)

PATIENT NAME: FIRST (GIVEN): Generic | MIDDLE / INITIAL: | LAST (SURNAME): Name

PATIENT ADDRESS: STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

DATE OF BIRTH: 16 (DAY) 12 (MONTH) 76 (YEAR)

Rx DRUG NAME AND STRENGTH | ONLY ONE DRUG PER FORM | VOID IF HANDWRITTEN

Hydromorphone 8mg

QUANTITY (IN UNITS): 784 mg (NUMERIC) | Seven hundred eighty-four milligrams (ALPHA)

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: ____ (DAY) ____ (MONTH) ____ (YEAR) END DATE: ____ (DAY) ____ (MONTH) ____ (YEAR)

TOTAL DAILY DOSE: NUMERIC | ALPHA | mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION: NUMERIC | ALPHA

☐ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Hydromorphone 8mg tablets x 14
Take 1–3 tablets every 1 hour as needed
Maximum 14 tablets daily
Daily dispense, no witness
Rx: Nov 8–14

SA

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898
PRESCRIBER ID

5555555
FOLIO

PHARMACY USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE | SIGNATURE OF DISPENSING PHARMACIST

PHARMACY COPY - COPYING OR DUPLICATING THIS FORM IN ANY WAY CONSTITUTES AN OFFENSE

2.2.ii Instructions for Pharmacists:

When a prescription for any drug that is identified as a safer alternative is processed (new or refill/part-fill prescription), it should be entered per usual prescription entry standards **with the addition of an "SA" intervention code** in the customary intervention code section of the software, not the Directions for Use ("sig") section. This code goes in the intervention code field and is simply a tag on the prescription that can be captured when monitoring and evaluating these harm reduction prescriptions for program evaluation. Entry of the intervention code with each prescription fill is the only **action required on the pharmacist's part and has no monetary reimbursement attached**.

2.2.iii Drugs to be Included:

Any drug prescribed for risk mitigation to support self-isolation or quarantine due to COVID-19 or drugs prescribed for safer supply should be identified on the prescription and tagged with the "SA" intervention code upon entry into PharmaNet. The list below identifies the most common drugs for prescribed for harm reduction, but all drugs prescribed for that purpose should be identified as per above:

Opioids:

All those prescribed for risk mitigation or prescribed safer supply, which include:

- Hydromorphone tablets
- Sustained-release oral morphine (M-Eslon)

Stimulants:

All those prescribed for risk mitigation or prescribed safer supply, which include:

- Dextroamphetamine IR or SR
- Methylphenidate IR or SR

Benzodiazepines:

All those prescribed for risk mitigation to support self-isolation or quarantine due to COVID-19, which include:

- Clonzapam
- Diazepam
- Lorazepam

3.0 Clinical Experience with Risk Mitigation Prescribing

Following the March 17, 2020, BC declaration of a public health emergency due to the COVID-19 pandemic, the BCCSU, Ministry of Health, and Ministry of Mental Health and Addictions mobilized a group of expert clinicians, people with lived and living experience, and other relevant stakeholders to rapidly develop interim clinical guidance, based on a guidance document published by Vancouver Coastal Health. It was recognized that the COVID-19 pandemic would compound the harms and challenges of the opioid overdose emergency declared in April 2016, and would increase a number of risks for people who use drugs, including the ongoing risk for overdose and other harms related to the illicit toxic drug supply, the risk of infection and spread of COVID-19 among those with underlying health conditions and who face social marginalization, and risks due to withdrawal for those who must self-isolate or quarantine to prevent the spread of COVID-19.

Clinical experience and initial evaluations of the implementation of the *Risk Mitigation* interim clinical guidance have revealed several key lessons, which inform this update.

1. Due to the rapidly evolving and unprecedented nature of the COVID-19 pandemic, the interim clinical guidance provided guidance to trial innovative approaches to support people who use other drugs to stay safe and prevent the spread of COVID-19. However, due to the limited evidence, innovative nature of these approaches, and the unknown nature of how the pandemic would progress, the interim clinical guidance did not include guidance on continuing care following initiation of *Risk Mitigation* prescribing.
2. Clinical experience suggests prescribed oral hydromorphone alone has been insufficient in completely separating many individuals from the toxic drug supply as they continue to experience cravings and withdrawal symptoms, though can be a useful tool in reducing dependence on the unregulated drug supply. Accordingly, clinical experience suggests that many individuals prescribed oral hydromorphone continued to provide fentanyl-positive urine samples.[i] Clinical experience also indicates that negative UDT in patients prescribed hydromorphone and anecdotes of diverted hydromorphone are not uncommon.
3. Although some individuals with stimulant use disorders have reported benefit from the prescription of stimulants in order to reduce the risk of COVID-19 transmission and reduce—but not sever—their reliance on the illicit drug supply, clinical experience indicates that many individuals have not experienced significant benefit nor been able to separate from the illicit drug supply.
4. The inclusion of oral hydromorphone prescribing in this document has allowed clinicians to trial PRN (*pro re nata*; as needed) prescribing of opioids to support initiation of oral OAT, which many patients have benefited from. Clinical experience suggests that hydromorphone PRN may have allowed patients to titrate their OAT dose up while reducing their need to access the illicit drug supply or using it minimally to manage cravings and withdrawal symptoms during titration, which may decrease the risk of both COVID-19 and overdose and supports continued

[h] It should be noted, however, that presence or absence of fentanyl alone does not indicate that a patient is or is not benefitting from the intervention. See Patient Planning Following Initial Medication Trial for more indication on assessing whether a patient is benefitting from the intervention or not.

engagement in care. More information on prescribing oral hydromorphone to support OAT titration, as well as prescriber involvement in provincial evaluation activities, can be found in Opioid Use Disorder Practice Update.

These key lessons inform the following key changes found in this updated document:

1. Increased clarity that this interim clinical guidance is specifically intended to support people who use drugs and alcohol to physical distance, self-isolate, or quarantine in order to prevent the spread of COVID-19, and does not provide guidance on initiating the prescription of pharmaceutical alternatives to the illicit drug supply outside of this context. Information on clinical experience with prescribing opioids to reduce the risk of overdose and reliance on the toxic drug supply outside of the context of COVID-19 risk can be found in Opioid Use Disorder Practice Update. Information on clinical experience with prescribing stimulants to reduce the risk of overdose and reliance on the toxic drug supply outside of the context of COVID-19 risk can be found in the forthcoming Stimulant Use Disorder Practice Update.
2. The inclusion of guidance on patient care planning in the context of an evolving pandemic. This includes clinical and psychosocial indications that *Risk Mitigation* prescribing is benefitting the patient and ongoing prescribing warrants consideration, as well as clinical and psychosocial indications that insufficient benefit is being experienced and discontinuation of prescribing should be considered along with exploration of other harm reduction and treatment options.
3. The addition of principles of care to guide clinical decision making.

4.0 General Principles for Care Planning

Overarching principles of care that should guide care planning and provision include: Indigenous cultural safety and humility, harm reduction, and trauma- and violence-informed care. See *A Guideline for the Management of High-risk Drinking and Alcohol Use Disorder* for more on principles of care. In addition, the following principles for care planning are intended to serve as a general framework to guide the provision of comprehensive, patient-centred care in the context of the COVID-19 pandemic. Clinical decision-making should be guided by individual patient circumstances, patient-identified needs and goals, patient and community safety, and the unique risk/benefit ratio for each patient.

1. Offer evidence-based treatment and referrals to psychosocial services

   Prescribers should offer all patients evidence-based treatment or referrals to available services based on patient-identified goals (e.g., OAT, alcohol use disorder [AUD] pharmacotherapy). Patients should also be offered referral to inpatient treatment, comprehensive primary care and psychosocial supports, such as counseling, harm reduction services, mental health supports, recovery-oriented services, and referral to services addressing social determinants of health, where available. This discussion should be documented.

2. Support continuation of current substance use treatment

   Prescribers should support patients to maintain current prescriptions, including strategies to support self-isolation or quarantine. This discussion should be documented.

3. Care planning should be individualized

   Health care providers should work with each individual and their chosen family/support people to determine how best to reduce the risk of withdrawal and support self-isolation or quarantine due to suspected or confirmed COVID-19. Care planning should be individualized and based on clinical discretion, social determinants of health, patient-identified needs and goals, and patient and community safety. Care planning may include determining prescription intervals, creating a plan to ensure patients can self-isolate or quarantine, providing education on safer use, harm reduction and access to appropriate harm reduction supplies, crisis intervention, and addressing any additional factors that compound the risk of adverse health outcomes. This discussion should be documented.

   When determining prescription interval, consider patient stability, the risk of missing signs of incorrect dosing (e.g., over-sedation), the risks of missed doses or treatment discontinuation, patient burden, the risks of exposure to COVID-19, and community safety. The rationale behind the chosen prescription interval should be documented. Some

patients may need additional supports to self-isolate or quarantine, such as housing, food delivery, and hygiene supplies (e.g., soap, cleaning supplies, menstrual products). Connect with local public health for support. Care planning should include assessment of each patient's unique risk factors (such as drug–drug interactions) and health needs (such as mental health, HIV, hepatitis C, diabetes, or lung disease); these individuals may need additional support and closer follow-up. The discussion around care planning should be documented.

4. Care planning should include continuity of care and treatment transitions

Providers should discuss and make plans for continuity of care, following initiation of *Risk Mitigation* prescribing (see Continuing Care Following Self-isolation for more information), including sharing the updated care plan with relevant team members, family, and other support people. The plan for continuity of care should be documented.

5. Care planning should include regular follow-up

To support continuity of care, prescribers should create a plan for regular follow-up appointments with patients. Follow ups should assess for clinical and psychosocial stability, in order to monitor the patient's safety and response to *Risk Mitigation* prescribing. If feasible and appropriate, utilize phone, telehealth platforms, or outreach services for follow-up.

6. Take-home dosing should be considered on an individual patient basis

Prescribers may consider take-home doses on an individual patient basis, depending on the known safety profile of the medication and individual client circumstances, in order to support physical distancing, self-isolation, or quarantine due to COVID-19. The decision to prescribe take-home, unsupervised doses must be made at the prescriber's discretion, through consideration of the patient's psychosocial stability (e.g., housing, social support), clinical stability (e.g., cravings, sleep quality and duration, overall wellbeing), their ability to manage and store their medication safely, the potential for harmful drug–drug interactions, risk of diversion, and other risks and benefits. Decisions regarding take-home doses may also be informed by individual risk of COVID-19 (e.g., individuals who have been fully vaccinated vs. those who have received zero or one dose) and the current state of pandemic-related restrictions. For patients who are given take-home medications, clinicians should discuss a safe medication storage plan. Take-home dosing should be re-evaluated on a regular basis and in the event of decreased clinical stability, diversion, a change in ability to securely store medications, or other harms. The rationale for take-home dosing should be documented.

7. Consider alternative strategies for dispensation of medication

When take-home doses are not clinically appropriate,[k] consider alternative strategies for dispensation of medication, in order to support physical distancing, self-isolation, or quarantine. This could be facilitated by different means, such as delivery by a pharmacy (depending on capacity and within appropriate regulations) or utilization of clinical outreach teams.

8. Telemedicine should be used to maximize safety and provider capacity

Utilizing telemedicine is advised, where possible to support self-isolation or quarantine; however, capacity and patient access may vary based on location. Prescribers should follow their regulatory college's practice standards concerning telemedicine, including limitations on prescribing opioids.[l] Guidance on using telemedicine for addiction care during the COVID-19 pandemic is available in the Canadian Research Initiative in Substance Misuse's (CRISM) *National Rapid Guidance: Telemedicine Support for Addiction Services*.

9. Consider the role of community organizations and outreach teams in care planning and provision of substances

Community organizations and outreach teams may be able to support patients while self- isolating or quarantining, for example, providing access to harm reduction supplies, supporting delivery of medication (depending on staff qualifications) or managed alcohol, and facilitating access to other supports and services, depending on capacity.

10. Follow established clinical guidance[m] for the treatment and management of substance use disorders

This guidance document is intended to provide strategies to support people who use alcohol and other drugs to physical distance, self-isolate, or quarantine in order to prevent the spread of COVID-19; it is not intended to provide guidance on treatment of substance use disorders and does not replace existing guidelines or standards of care.

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[k] Or the number of clinically appropriate take-home doses are insufficient to support self-isolation or quarantine (e.g., 1 witnessed and 6 take-home doses per week).

[l] For example, the College of Physicians and Surgeons of BC's standard can be found here and states that "physicians can only prescribe opioid medications to a patient they have a longitudinal relationship with and have examined themselves or are in direct communication with another physician or nurse practitioner who does have a longitudinal relationship, has examined the patient and agrees that opioids are indicated." The BC College of Nurses and Midwives Prescribing Drugs: Standards can be found here.

[m] See the BCCSU's Treatment of Opioid Use Disorder During Pregnancy—Guideline Supplement for guidance on case-by-case assessment of risk for children and when referral or report to MCFD is required.

5.0 Patient Care Planning Following Initial Medication Trial

This interim clinical guidance is intended to support individuals who use substances and are at risk of withdrawal to physical distance, self-isolate, and/or quarantine in order to prevent the spread of COVID-19. **This document does not provide guidance on initiating medications outside of the context of the COVID-19 pandemic.** However, as the risk associated with COVID-19 decreases due to widespread vaccination, but risk of overdose remains high due to the contaminated drug supply, it may be appropriate to continue this prescribing for patients who have shown clear indication of benefit based on the criteria outlined below. If patients are benefitting from this intervention (for example, reduced overdose risk; see below), their prescription should not be discontinued solely due to reduced COVID-19 risk or having completed self-isolation or quarantine. For guidance on initiating hydromorphone and/or M-Eslon to reduce risk of overdose and drug-related harms in individuals at high risk of overdose outside the context of COVID-19, see Opioid Use Disorder Practice Update. See the forthcoming Stimulant Use Disorder Practice Update for more information on trialling or ongoing prescribing of stimulant replacement to reduce risk of overdose and drug-related harms.

The assessment and informed consent process should include a discussion of the potential benefits and risks of *Risk Mitigation* prescribing, as well as a discussion of continuing care. This should include a discussion of patient goals, as well as which clinical and psychosocial parameters would indicate that the patient is benefitting from the intervention, and which clinical and psychosocial parameters would indicate that the patient is not benefitting from the intervention, and how the treatment plan would change if the patient is not benefitting.

If the assessment process outlined in 6.2 Screening and Assessment, below, indicates that *Risk Mitigation* prescribing is appropriate, a thorough assessment of clinical and psychosocial indicators, as well as patient goals, should be performed following the self-isolation or quarantine period, to determine whether the patient is benefitting from the intervention. The results of this assessment along with expert consultation, where appropriate, and patient preference should inform the decision to continue or discontinue this intervention. With patient consent, other care team members (e.g., outreach workers, social workers, primary care providers) may also provide information relevant for decision making. Patient report, clinical observation, collateral information (where possible), and objective measures should inform assessment. Clear indication of patient benefit, supported by clinical judgment and aligned with patient goals, supports the continuation of this intervention.

INDICATIONS THAT THE PATIENT IS BENEFITTING

Clinical

- Reduced (or cessation of) illicit substance use
- Reduced risk and incidence of overdose due to reduction or cessation of illicit substance use
- Reduced cravings
- Was able to self-isolate or quarantine
- Reduced emergency department or acute care usage
- Reduced exposure to infectious diseases due to reduced and/or safer use
- Increased engagement in primary care and other health services
- Management of withdrawal symptoms
- Functional outcomes such as increased focus and executive functioning (stimulant-specific)
- Patient report of improved overall wellbeing
- Urine drug tests consistently positive for prescribed medications and negative for illicit substances[n]

Psychosocial[o]

- Reduced need to engage in high-risk and criminalized activities (e.g., sex work) to support substance use
- Reduced risk of COVID-19 infection due to physical distancing
- Maintaining, seeking, or gaining employment or volunteer activities
- Improved attitude toward self
- Ability to set and meet goals in major areas (e.g., personal health, career)
- Enrolled in education or training programs
- Integrating new activities
- Reconnecting with family and friends (e.g., improved social functioning)
- Attaining safe housing and accessing other social services

[n] See p. 16 for more information on urine drug testing for individuals receiving Risk Mitigation prescribing.

[o] Structural barriers such as lack of affordable and accessible housing or suitable employment, as well as the short duration of prescribing to support self-isolation or quarantine may make these difficult to achieve for individuals who are otherwise benefitting from the intervention. Improvements in these domains are not required, but—where possible—may be additional indications that the patient is benefitting and should continue to receive this intervention.

INDICATIONS THAT THE PATIENT IS NOT BENEFITTING/EXPERIENCING HARM

Clinical

- No change or increased intensity of illicit substance use
- No change in or increased overdose risk
- Ongoing cravings and withdrawal symptoms
- Urine drug tests consistently negative for prescribed medication(s)
- No change in wellbeing or social functioning
- Consistently missed doses
- Development or worsening of mental health issues,
    - For example, development or worsening of psychosis or bipolar disorders in patients prescribed stimulants
- Development or worsening of physical health conditions
    - For example, new-onset angina or hypertension in patients prescribed stimulants
- Not taking the prescribed medication or selling the prescribed medication in order to access preferred illicit agents to manage cravings and/or withdrawal symptoms

Psychosocial

- No improvement in engagement in high-risk and criminalized income-generating activities
- No improvement in employment or housing
- Continued risk of COVID-19 infection due to a lack of physical distancing

If thorough assessment of patient-identified goals and indicators of clinical and psychosocial stability indicate that the patient is not benefitting from the intervention despite attempts at optimizing dosing and psychosocial supports, it may be appropriate to discontinue the intervention and explore alternative harm reduction and treatment options. Alternative options may include initiating evidence-based treatment, increasing existing OAT dose (as applicable), tapering *Risk Mitigation* medication dose, referral to an existing pharmaceutical alternative or safe supply program operating under the provincial Prescribed Safer Supply Policy, bed-based treatment options, or a combination. The assessment, treatment plan, and rationale should be documented in the patient's medical record. It may be helpful to consult the 24/7 Line (778-945-7619) for assistance in determining whether the intervention is or is not beneficial, and next steps.

6.0 Eligibility

Information on eligibility, screening and assessment, measures to reduce risk of diversion, and informed consent follow. Each of these elements should be documented in the patient's medical record.

6.1 Target Population

This guidance aims to support people who use drugs and alcohol to physical distance, self-isolate, or quarantine in order to prevent the spread of COVID-19.

Eligible clients must meet the criteria below:

- Individuals who require support to physical distance, self-isolate, or quarantine in order to prevent the spread of COVID-19[p]

  AND

- Those with a history of ongoing active substance use (opioids, stimulants, alcohol, benzodiazepines, tobacco, or cannabis)

  AND

- Those that are deemed at high risk of withdrawal, overdose, craving, or other harms related to substance use

Youth and people who are pregnant:

- Youth aged <19 may be eligible if there is informed consent by the patient to receive this intervention and additional education is provided. Efforts should be made to offer alternative treatment options (e.g., opioid agonist treatment, inpatient treatment, psychosocial treatment)
  - Clinicians are encouraged to consult an addiction specialist with experience treating youth and/or the 24/7 Line (778-945-7619) when considering prescribing to youth
- Clinicians are encouraged to consult a perinatal addiction specialist and/or the 24/7 Line (778-945-7619) for support when considering prescribing to pregnant patients
- For youth and pregnant individuals, in collaboration with the patient, referral to health and social services and connection to appropriate resources should be offered

[p] At the time of publication, it is unknown how the COVID-19 pandemic will evolve. Absolute risk of infection has decreased for many individuals through widespread vaccination, while it may increase for others who have yet to be vaccinated (or are unable to be vaccinated) due to highly contagious variants circulating in BC. As the pandemic continues and eventually resolves, it may be appropriate to consider this intervention for individuals whose absolute risk of COVID-19 infection has decreased and who remain at high risk of overdose due to the toxic illicit drug supply, despite trials or offers of OAT. See Opioid Use Disorder Practice Update and Stimulant Use Disorder Update for more information on prescribing these medications to reduce reliance on the illicit drug supply and overdose risk outside the context of COVID-19.

6.2 Screening and Assessment

Assessment for eligibility should include the following:

- Active substance use assessment (i.e., type of substance, quantity used, frequency of use)
  - Note: Not all patients who qualify for these medications will use substances daily. For example, people who use stimulants often have a binge pattern of use rather than daily use and would still benefit from support in order to self-isolate or quarantine due to suspected or confirmed COVID-19
- Substance use and treatment history
- History of overdose
- Comorbid mental and physical conditions
- Prescribed medication(s)
- Current access to a prescriber (i.e., GP, addiction medicine physician, nurse practitioner)
- Requirements for support in physical distancing, self-isolation, or quarantine in order to prevent the spread of COVID-19

6.3 Measures in place to ensure clinical eligibility and to reduce secondary harms such as drug diversion

- For any new potential patient unknown to the prescriber, eligibility will include a detailed clinical assessment (see above)[q]
- Offer all patients referrals to available evidence-based treatment programs based on patient-identified goals (e.g., OAT, recovery-oriented services—where available)
- All prescribed medications should be provided daily, when possible. This could be facilitated by the housing provider, pharmacy, or a clinical outreach team. If the patient is on take-home doses of OAT, their *Risk Mitigation* prescription can match their OAT prescription, with considerations for storage and safety
- 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 on their unit or home
- Regular follow-up with health care providers to assess clinical and psychosocial stability should be conducted

Urine drug testing is not required during self-isolation or quarantine, but may be used at the discretion of the prescriber and should be considered during ongoing prescribing. Urine drug tests consistently positive for the prescribed medication and negative for illicit substances, in concert with other clinical and psychosocial improvements may indicate that the patient is benefitting from the intervention, while UDT consistently negative for the prescribed medication may indicate that

[q] The College of Physicians and Surgeons of BC's standard can be found here and states that "physicians can only prescribe opioid medications to a patient they have a longitudinal relationship with and have examined themselves or are in direct communication with another physician or nurse practitioner who does have a longitudinal relationship, has examined the patient and agrees that opioids are indicated."

the patient is not benefitting from the intervention. However, there may be patients who continue to use illicit substances while benefitting from the intervention (who may, for example, have a UDT positive for the prescribed medication and for illicit substances). Decisions about continuing or discontinuing *Risk Mitigation* prescribing should not be based solely on UDT results. See Patient Planning in the Context of an Evolving Pandemic for more information on decision making around continuing or discontinuing prescribing. Note that patients prescribed slow- or sustained-release oral morphine (Kadian or M-Eslon) may have a positive UDT result for hydromorphone due to high morphine levels; morphine is metabolized to hydromorphone by a minor pathway, which may be detected in individuals taking high doses of oral morphine. See the BCCSU's *Urine Drug Testing: Breakout Resource* for additional information regarding urine drug testing for individuals with opioid use disorder, including information on cross-reactivity and confirmatory testing.

6.4 Informed Consent

As part of the screening and assessment process, clinicians should discuss and document the limited evidence supporting this approach and the risks and benefits of *Risk Mitigation* prescribing with their patients, including the plan for continuation or discontinuation of prescribing following initiation to support physical distancing, self-isolation, or quarantine to prevent the spread of COVID-19. This conversation should include what markers would indicate the intervention is benefitting the patient and should be continued (e.g., increased clinical and psychosocial stability, reduction or cessation of illicit substance use) or discontinued (e.g., no change in clinical or psychosocial stability, continued illicit substance use at the same intensity, diversion of prescribed medications in order to access illicit substances to manage cravings and withdrawal). See Patient Planning in the Context of an Evolving Pandemic for more information on decision making around continuing or discontinuing prescribing. Appendix 3 provides more information on informed consent.

7.0 Resources for Consultation

Several resources exist that may be consulted by clinicians seeking consultation or referral for their patients.

- Rapid access addiction clinics (RAACs) may be able to provide telehealth support, both consultation for prescribers and patient assessment.
  - **Victoria:** 250-381-3222
  - **Vancouver:** 604-806-8867
  - **Surrey:** 604-587-3755
- Rapid Access to Consultative Expertise (RACE) for Addictions is available M-F 8am-5pm for additional consultation and support, including for managing concurrent pain and substance use
- BCCSU 24/7 Addiction Medicine Clinician Support Line provides telephone consultation to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment in BC. Available 24 hours a day, 7 days a week, 365 days a year.
  - 778-945-7619
- OAT Clinics Accepting New Patients may be consulted for referral, for physicians and nurse practitioners who do not have extensive experience providing addiction medicine whose patients are at risk of withdrawal.

8.0 Pandemic Pharmacotherapy Protocols

As noted in the General Principles for Care Planning section above, prescribers should offer evidence-based substance use treatment according to provincial guidelines, where available. Not all patients who are eligible for this intervention will meet a diagnosis of substance use disorder. Of those with a diagnosed substance use disorder, not all will accept or stabilize on evidence-based treatment options for their substance use disorders. Where benefits outweigh risks and clinical judgment supports it, prescribing pharmaceutical alternatives or other provision of regulated substances to replace illicit (i.e., opioids, benzodiazepines, and stimulants) and licit (i.e., alcohol, tobacco, cannabis) substances may be considered in order to support physical distancing, quarantine, and self-isolation in order to prevent the spread of COVID-19. The prescription medications specifically listed in this section are full benefits for coverage under PharmaCare Plan G, Plan C, Plan W, and Plan I (Fair PharmaCare). Registration for PharmaCare Plan G is physician-initiated, through the use of a short form. Other substances addressed in this document (alcohol, tobacco, cannabis) are not covered by PharmaCare; patients requiring these substances to support self-isolation or quarantine are responsible for the costs of these substances.

Other alternate pharmaceuticals not specifically listed here may be available through health authority-run programs offering prescribed safer supply under the Prescribed Safer Supply Policy. Prescribers should consult their local regional health authority for information on facilitating access to alternate pharmaceuticals beyond the scope of this document.

Prescribing pharmaceutical alternatives may include prescribing practices that are outside of established norms of practice and established treatment pathways for substance use disorders. In this context, employing these alternatives is not considered substance use "treatment" for substance use disorders, but rather temporary measures to support people to self-isolate, quarantine, or physically distance to reduce the risk of COVID-19 transmission, while also reducing risks of withdrawal, overdose, and other substance-related harms.

When considering prescribing pharmaceutical alternatives or other provision of regulated substances, prescribers should consider the evidence supporting the use of each substance considered, document their assessment and justification of choice of medication or other substance, and document when standard, evidence-based treatment options have been ineffective or declined by the patient. Any pandemic care plan should include planning for continuity of care, including both transitions in setting (for example, hospitalization), and continuation or discontinuation of prescribing as circumstances related to COVID-19 change.

The harms associated with substance use may be intensified by the intersection of substance use and COVID-19 (for example, alcohol interferes with normal immune functioning[10] and people who smoke tobacco face a higher risk of COVID-19 progression[14]). When care planning, prescribers should consider and discuss these harms and, where aligned with patient goals, consider a reduction or cessation of substance use as a goal.

For individuals with co-occurring substance use or substance use disorders, the increased risk of overdose associated with co-ingestion of CNS depressants must be considered. For these individuals, clinical judgement should be used, with priority given to substances associated with risk of severe withdrawal. Patients should be counseled about not sharing smoking devices (e.g., cigarettes, joints, vapes, crack pipes). Consider consulting the 24/7 Line (778-945-7619) for support when prescribing.

8.1 Opioids

Individuals with opioid use disorder[r] who need to physical distance, self-isolate, or quarantine in order to prevent the spread of COVID-19 will need support in order to prevent withdrawal and avoid the need to access the illicit drug supply. For patients who use opioids:

- Assess current level of use and presence of withdrawal symptoms and cravings
  - Example questions include:
    - What drugs do you currently use? How do you use them?
    - What kind, how much, and how often?
    - How much money are you spending on drugs?
    - What does this substance help or provide you with?
- Offer OAT according to the BCCSU guideline or if they are already on OAT, consider increasing their dose and provide take-home doses and delivery as needed. https://www.bccsu.ca/opioid-use-disorder/
  - The provincial guideline linked above is in the midst of being updated, including titration protocols. If prescribing OAT for this population, more rapid dosing may be appropriate, per clinical discretion and expertise. More information on OAT dosing and other updates can be found in *Opioid Use Disorder Practice Update*.
  - Specific guidance for individuals on injectable opioid agonist treatment (iOAT) is available on the BCCSU website
- If the patient is using street opioids in addition to their OAT or declines OAT, prescribe *Risk Mitigation* medications according to current use and use patient preference and clinical judgment to select appropriate medications and dosage. The provincial OUD guideline or *Opioid Use Disorder Practice Update* should be used for OAT dosing; for patients needing access to a safe supply of opioids to support physical distancing, self-isolation, or quarantine in order to prevent the spread of COVID-19, the following guidance should be used.

Dose and medication should be decided on collaboratively with each individual, in a shared decision-making process. It will depend on if they are being co-prescribed OAT, how much money they spend each day on illicit drugs, the type of drugs they are consuming (e.g., fentanyl vs. heroin) and patterns of substance use (i.e., daily or binge). Prescribers should be aware that the illicit opioid supply is increasingly adulterated with benzodiazepines and benzodiazepine analogues; patients

[r] Or those who are at risk of overdose, with confirmed current opioid use, where seeking a diagnosis would constitute an unreasonable barrier.

may require support to manage benzodiazepine withdrawal due to unintentional exposure. See Illicit Benzodiazepines, below. 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[s]

  AND/OR

- Prescribe M-Eslon 80–240mg PO BID provided daily (avoid sprinkling doses
  - **Note:** 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
  - Multiple long-acting opioid formulations should not be prescribed concurrently. For this reason, extreme caution should be used if M-Eslon is being considered in conjunction with oral OAT.
  - Witnessed ingestion is not generally required during self-isolation or quarantine;[t] however, clinical discretion should be used
  - Discuss safe storage and develop a plan (e.g., lockbox or safe or delivery by pharmacy under appropriate regulations or clinical outreach team)
  - Prescription length should be based on individual patients' follow-up requirements
- Example clinical scenarios are provided in Appendix 4 to help guide prescribing

8.1.i Missed doses

If individuals are prescribed OAT and miss doses, follow the guidance in the provincial *Guideline for the Clinical Management of Opioid Use Disorder* for missed doses.[u] If individuals are receiving *Risk Mitigation* prescribing and indicate that they have not used their prescribed medication for 7 or more days, discuss the reasons for missed doses with the patient and adjust the treatment plan as appropriate. For example, if patients are reporting continued cravings and withdrawal while using oral hydromorphone, consider co-prescribing a long-acting opioid (such as SROM, methadone, or M-Eslon). If patients are reporting continued illicit use due to cravings and withdrawal during self-isolation or quarantine, consult the 24/7 Line (778-945-7619) for guidance and consider making a referral to local COVID-specific services and/or referral to health-authority run programs offering additional medications under the provincial Prescribed Safer Supply Policy, where available.

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[s] *Note, this maximum dose may be exceeded, based on clinical judgment, if there is clear clinical indication of benefit. Clinical exceptions, including rationale, should be documented.*

[t] *If the intervention is continued following the initial trial, clinical judgment and patient circumstances should guide dispensation and decisions regarding witnessed ingestion.*

[u] *See the following pages for medication-specific missed dose protocols: p. 39—methadone; p. 46—buprenorphine/naloxone; p. 52—slow-release oral morphine.*

Stopping a risk mitigation prescription due to missed doses is a clinical decision that will be made by the prescriber. The default action, in the absence of specific instructions, should be to not stop the prescription due to missed doses. Alternative instructions can be included on the prescription if needed.

8.2 Stimulants

Evidence-based psychosocial treatment should be offered to all individuals with stimulant use disorder. See the forthcoming Stimulant Use Disorder Practice Update for more information on treatment options for stimulant use disorder. However, the increasing toxicity of the illicit drug supply, limited signals of efficacy, overall safety in the absence of contraindications, lack of other effective pharmaceutical treatment for stimulant use disorder, and risks associated with transmission of COVID-19 suggests that replacement therapy with psychostimulants in order to support self-isolation or quarantine in order to prevent the spread of COVID-19 may be a reasonable clinical decision for some patients in the absence of contraindications (see below) in these extraordinary circumstances.

Assessment

Assessment for eligibility should include the following:

- Active substance use assessment (i.e., type of substance, quantity used, frequency of use, route of administration, withdrawal symptoms, and cravings)
    - Example questions include:
        - What drugs do you currently use? How do you use them?
        - What kind, how much, and how often?
        - How much money are you spending on drugs?
        - What does this substance help or provide you with?
- Substance use and treatment history
- History of overdose and other drug-related harms (e.g., infections, criminalization, history of stimulant-induced psychosis)
- Comorbid mental and physical conditions
- Prescribed medications
- Current access to a prescriber (i.e., GP, addiction medicine physician, nurse practitioner)
- Patient goals (e.g., self-isolate, reduce use, manage cravings and withdrawal symptoms)
- If not previously diagnosed, assess for stimulant use disorder using DSM-5 criteria
- Assess overall physical health, including blood pressure
- Cardiac assessment, including hypertension and history of any cardiac conditions (see contraindications below)

Cautions

- Use extreme caution if there is a known diagnosis or indications of psychosis or bipolar disorder or history of stimulant-induced psychosis. Prescribing stimulants may worsen

mental health symptoms for individuals with these conditions. A collaborative approach to care with the patient's psychiatrist or addiction psychiatrist is recommended, where available. If the patient does not have a treating psychiatrist, consultation with a psychiatrist or addiction psychiatrist is recommended.

- It should also be noted that most of the studies examining stimulant replacement for stimulant use disorder excluded individuals with severe psychiatric comorbidities (e.g., psychotic or bipolar disorders, suicidal ideation, and prescription of antipsychotic medication) and/or did not assess for other common comorbidities such as attention deficit hyperactivity disorder (ADHD)[15-19]; thus, the relative safety of stimulant prescribing for individuals with a history of or active psychiatric disease in this context is unknown
- Given the limited data on prescribing stimulant replacement to individuals with co-occurring stimulant use disorder and psychosis or bipolar disorder, relevant literature in other populations is included below, to help guide clinical decision-making
- A population-based case crossover study among young, stimulant-naive people (<25) receiving social assistance in Ontario who were hospitalized for psychosis or mania found that initiation of prescribed stimulants (for ADHD) was associated with an increased risk of hospitalization for psychosis or mania in the first 60 days of treatment (odds ratio: 1.86; 95%CI: 1.39 to 2.56).[12] Almost half of individuals (45%) who received a subsequent stimulant prescription following discharge from the hospital for psychosis or mania were readmitted for psychosis or mania (median 18 days following subsequent prescription)
- A Swedish study using linked national registries found that patients with concurrent ADHD and bipolar disorder who initiated treatment with methylphenidate had an increased risk of manic episodes within 3 months of initiation (hazard ratio: 6.7, 95%CI: 2.0 to 22.4) if they were not also taking mood stabilizers; for patients taking mood stabilizers at treatment initiation, the risk of mania in the first 3 months of treatment was reduced (hazard ratio: 0.6; 95%CI: 0.4 to 0.9)[13]
- A study of commercial insurance claims of youth (age 12–25) who started treatment with methylphenidate or amphetamine for ADHD (n=221,846) found that new onset psychosis occurred in approximately 1 in 660 patients,[22] with a higher risk of psychosis associated with amphetamines compared to methylphenidate (see Medication Selection, Dosing, and Dispensation, below), while a combination of outcomes across multiple trials of different stimulant medications arrived at an estimate of 1 in 400 children developing psychotic-like or manic-like symptoms[23]
- Patients with psychosis or bipolar disorder should be receiving treatment or offered or referred to treatment for these conditions when prescription psychostimulants are offered
- Patients with a history of severe psychosis that directly resulted in suicide attempts or aggression may experience worsening of mental health on psychostimulant prescribing, especially if use of street amphetamines does not decrease
- If clinical judgment indicates that the clinical judgment indicates that the need to support self-isolation or quarantine due to COVID-19 infection outweighs all other

risks of harm for these patients, and psychostimulants are prescribed as a trial, close follow up is indicated
    - Treatment decision and rationale, including weighing of risks and benefits, and any consultation should be documented
- Pregnancy
    - Extreme caution should be used
    - Care should be provided in collaboration with the patient's obstetrician if available
    - A perinatal addiction specialist should be consulted
    - A thorough discussion of alternatives, risks, and benefits should be had with the patient, including potential risks to the fetus
    - Safe use of dextroamphetamine in pregnancy has not been established. If considering prescribing this medication to a pregnant patient, the potential benefit must be weighed against the potential harm to parent and fetus[24]
    - There is limited experience with use of methylphenidate in pregnant people; however, cases of neonatal cardiorespiratory toxicity have been reported. Methylphenidate should not be prescribed to pregnant people unless the potential benefit outweighs the risk to the fetus[25]

Contraindications

- Do not prescribe stimulants for a person with unstable angina or moderate to severe hypertension. Prescribe with extreme caution in those with a cardiac history and document rationale. Consultation with cardiology is recommended, where available.
- Dextroamphetamine:
    - CAD, structural heart disease, cardiomyopathy, cardiac arrhythmias, or other serious cardiac conditions should generally not be treated with prescription stimulants, allergy or intolerance to the medication or any ingredients. If prescribing to a patient with a cardiac condition, ensure ongoing documentation that the benefits continue to outweigh any risks.
- Methylphenidate:
    - Marked anxiety, agitation, glaucoma, motor tics, a personal or family history of Tourette's, and concurrent use of MAOIs or within 14 days of MAOI administration since hypertensive crisis may result, serious cardiac conditions (as above for dexamphetamine), allergy or intolerance to the medication or any ingredients.

For patients with active stimulant use disorder:

- Prescribe Dexedrine[v]:
  - Dextroamphetamine SR (Dexedrine) 10–20mg PO BID provided daily with a maximum total daily dose of 40mg BID per day[w]

  AND/OR

  - Dextroamphetamine 10–20mg IR PO BID-TID with a maximum total daily dose of 80mg dextroamphetamine per day[x]

  OR

- Prescribe methylphenidate[y]:
  - Methylphenidate SR 20–40mg PO OD with maximum total daily dose of 100mg/24hrs

    AND/OR

  - Methylphenidate IR 10–20mg PO BID daily to maximum total daily dose of 100mg methylphenidate per day

Medication Selection, Dosing, and Dispensation

- 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
- Total daily doses of >60mg of both dextroamphetamine and methylphenidate may be more effective than lower doses[15]
  - It is unknown if risk of psychosis increases with dose; however, higher average methamphetamine dose has been associated with increased risk of stimulant-induced psychosis[27]
- A study of commercial insurance claims of youth (age 12–25) who started treatment with methylphenidate or amphetamine for ADHD (n=221,846) found that new onset psychosis occurred significantly more often in individuals prescribed amphetamines (hazard ratio: 1.65, 95%CI 1.31 to 2.09). It is unknown whether these findings can be extrapolated to adults with substance use disorders; however, the potential lower risk of psychosis may inform medication selection[22]
- The selected medication and dose should be documented in the patient's health record
- Frequency of dispensation should be guided by clinical judgment, prioritizing patient and community safety. Generally, daily dispensing should be prescribed. Exceptions and the reasoning behind them should be documented.

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[v] Dexedrine is FDA Pregnancy Category 3.
[w] In some clinical practices, doses of 60mg BID are being used; however, there is no empiric data to support this practice.
[x] Note, maximum daily dose is based on the average daily dose of a 2013 RCT that found daily SR dextroamphetamine is safe and feasible for methamphetamine use disorder.[26]
[y] Methylphenidate is FDA Pregnancy Category C.

Patient Education

The following discussion should be documented in the patient chart:

- Patients with concurrent psychotic or bipolar disorder should be warned of the potential worsening of symptoms with prescribed stimulant medications and advised to stop or reduce dose and/or present for medical help early should this occur
- Patients with concurrent psychotic or bipolar disorder should be warned of the potential worsening of symptoms with prescribed stimulant medications. Patients should be monitored closely and advised to stop or reduce dose and present for medical help early should this occur
- Discuss safe storage and develop a plan (e.g., lockbox or safe or delivery by pharmacy under appropriate regulations or clinical outreach team)
- Education on harm reduction and safer use strategies (see Harm Reduction, in this document)

Monitoring and Follow-up

- Provide close monitoring during initiation, including blood pressure
  - Telehealth, outreach teams, and pharmacy delivery support may also support monitoring
- Prescription length should be based on individual patients' follow-up requirements
- See Assessment of Benefit and Continuing Care, below

Example clinical scenarios are provided in Appendix 4 to help guide prescribing

8.2.i Missed doses

If individuals are receiving *Risk Mitigation* prescribing and indicate that they have not used their prescribed medication over 7 or more days, discuss the reasons for missed doses with the patient and adjust the treatment plan as appropriate. If individuals have not used their prescribed medication over 7 or more days while self-isolating or quarantining due to COVID-19, it may indicate that the medications are not providing significant benefit and should be discontinued.

8.3 Illicit Benzodiazepines

There is increasing concern regarding adulteration of the illicit opioid supply with benzodiazepines.[21] Since mid-2019, drug checking services in BC have documented a rapid upward trend in the proportion of benzodiazepine-positive opioid samples.[22,23] In January 2021, over 20% of opioid samples tested in BC drug checking facilities contained benzodiazepines, which marks a steady increase since August 2020, when 9% of samples tested positive for benzodiazepines.[11] Several novel benzodiazepines, or benzodiazepine analogues or derivatives

have been identified in drug samples that were sold as opioids, including etizolam, bromazepam, flualprazolam, and flubromazepam.[11,12] These illicit sedatives can be significantly more potent than pharmaceutical-grade benzodiazepines such as diazepam (Valium) and alprazolam (Xanax).[11]

This trend has compounded the risk of overdose mortality in BC, since people use who illicit drugs are increasingly likely to unintentionally use mixtures of potent opioids and benzodiazepines. A majority (70%) of drug checking samples confirmed to contain benzodiazepines also contain high-potency opioids such as fentanyl or carfentanil.[12] According to BC Coroner's toxicology reports, benzodiazepines were detected in 49% of suspected illicit drug toxicity deaths in January 2021, which is more than triple the percentage detected only six months prior, in August 2020 (16%).[10]

Abrupt discontinuation of prescribed or illicit benzodiazepines could lead to benzodiazepine withdrawal, which can constitute a medical emergency[31] and requires urgent treatment using symptom-triggered administration of benzodiazepines. Generally, benzodiazepine use disorder is managed through gradual tapering.[32]

In the context of the COVID-19 pandemic, a confirmed diagnosis of moderate to severe benzodiazepine use disorder may be managed through gradual benzodiazepine tapering or, in rare cases, a brief period of benzodiazepine maintenance therapy in order to support self-isolation or quarantine (i.e., 14 days) due to confirmed or presumed COVID-19 infection. Given the significant harm associated with benzodiazepine use (e.g., risk of fatal overdose,[33] worsening of mental health symptoms,[34] increased risk of hepatitis C[35] and HIV[36] among people who use illicit drugs), this should be considered an extraordinary response requiring ongoing follow-up.

Given the increasing adulteration of the illicit opioid supply with novel benzodiazepines, a clear distinction must be made between individuals who have a benzodiazepine use disorder and require prescribed benzodiazepines (whether initiating a taper or a brief period of maintenance) in order to safely self-isolate or quarantine without going into withdrawal, and those who primarily use illicit opioids and may have a urine drug test (UDT) positive for benzodiazepines and report mild benzodiazepine withdrawal symptoms. Benzodiazepine withdrawal symptoms may include muscle tension, diaphoresis, anxiety, agitation, depression, sleep disturbance, appetite loss, and tachycardia. Severe withdrawal symptoms include seizures, paranoia, hallucinations, and withdrawal delirium.[14]

Since benzodiazepine dependence may have developed as a result of unintentional exposure to adulterants, health care providers should monitor patients who discontinue illicit opioid use (e.g., those who start OAT) for symptoms of benzodiazepine withdrawal, even if they report only using opioids, and consider withdrawal management strategies as needed.

Mild benzodiazepine withdrawal symptoms are typically temporary (a few days to a week) and can be managed with supportive care. However, given the rapidly evolving landscape, with varying agents of varying concentrations adulterating the illicit opioid supply, it is impossible to provide generalized guidance for this population. For this reason, if benzodiazepine withdrawal is

suspected in an individual who does not report using benzodiazepines, clinicians are encouraged to provide supportive care and contact the 24/7 Addiction Medicine Clinician Support Line or RACE App for specialized case-based consultation. Due to the overlapping symptoms of opioid and benzodiazepine withdrawal, it may be challenging to assess the severity of withdrawal from each substance; close monitoring is recommended to facilitate prompt identification of worsening withdrawal symptoms. More information on benzodiazepine-adulterated opioids can be found in the BCCSU's Clinical Bulletin: Benzodiazepines and Opioids.

8.3.i Benzodiazepine Tapering

Anecdotally, most individuals using illicit benzodiazepines in BC are using bars of adulterated or counterfeit alprazolam (Xanax)[z] that may actually contain combinations of unknown substances in unknown dosages. For this reason, it is not possible to estimate tolerance based on patient report. In order to reduce the risk of overdose from the 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.

For patients at risk of benzodiazepine withdrawal, a taper protocol should generally be offered in all cases,[aa] given the known risks of long-term benzodiazepine use; however, to support self-isolation or quarantine due to presumed or confirmed COVID-19, a temporary maintenance protocol may be offered, with informed consent and documentation of rationale (see next section).

- Assess current use and presence of withdrawal symptoms and cravings
  - Example questions include:
    - What drugs do you currently use? How do you use them?
    - What kind, how much, and how often?
    - How much money are you spending on drugs?
    - What does this substance help or provide you with?
- If initiating a taper,[bb] clonazepam or diazepam are preferred, as they are long-acting
  - Lorazepam does not lead to any active metabolites and so is less prone to accumulation in patients who have severe liver disease or are elderly, and may be a preferred medication in these populations
- Starting at a lower dose than what your patient regularly purchases and titrating up is important due to varying potencies of illicit benzodiazepines. Be cautious when prescribing benzodiazepines for patients who use opioids, are on OAT, or use other CNS depressants such as alcohol as they increase overdose risk when used concurrently
- Review the signs and symptoms of benzodiazepine toxicity (CNS depression ranging from mild drowsiness to a stuporous state and respiratory depression) with the patient, as well as potential increased risk of opioid overdose
- Discuss safe storage and develop a plan (e.g., lockbox or safe or delivery by pharmacy under appropriate regulations or clinical outreach team)

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[y] Illicit alprazolam is sold in bars that mimic 2mg bars of Xanax. However, contents and potency are frequently unknown and can vary widely.

[w] Consult Deprescribing Benzodiazepine Receptor Agonists: Evidence-based Clinical Practice Guideline or the 24/7 Line for guidance on initiating a benzodiazepine taper. Clinical judgment and a patient-centred approach should be used when determining the pace of tapering.

[x] Initiating a benzodiazepine taper requires either a long-term prescriber-patient relationship, or transfer to a prescriber who can continue the taper. A taper should not be initiated without a plan for long-term, follow-up care.

- Due to the diverse range of benzodiazepines (see Appendix 2), confirming PharmaCare benefit status before prescribing a drug other than diazepam is recommended to avoid unintended out of pocket costs to the patient
- When prescribing benzodiazepines, ensure telemedicine or in-person follow-up, where possible. If concerns of complicated withdrawal, consider outreach team doing regular in-person follow-up (where available)
- Prescription length should be based on individual patients' follow-up requirements
- Example clinical scenarios are provided in Appendix 4 to help guide prescribing

Benzodiazepine Maintenance

If short-term maintenance prescribing is deemed clinically necessary after careful assessment, in order to support an individual with benzodiazepine use disorder and at risk of severe or complicated withdrawal to self-isolate or quarantine due to presumed or suspected COVID-19:

- Discuss the risks of benzodiazepine maintenance with the patient and collaboratively develop and document a treatment plan to initiate a taper following self-isolation or quarantine period
- Generally, consider switching to a long-acting benzodiazepine and reduce dose by up to 50% to start, with ongoing assessment for withdrawal symptoms and dose adjustment as needed
- Prescription of slow-onset, long-acting benzodiazepines should be considered, with increased support during stabilization and ongoing case-by-case assessment of risks and benefits
    - Example maintenance dosing:
        - If the patient describes buying diazepam 10mg x 3/day then consider starting diazepam at 5mg TID and increasing the dose as needed
        - If the patient describes using 1–4 "bars" of Xanax, start with clonazepam 0.5mg–1mg BID
- Starting at a lower dose than what your patient regularly purchases and titrating up is important due to varying potencies of illicit benzodiazepines. Be cautious when prescribing benzodiazepines for patients who use opioids, are on OAT, or use alcohol, as they increase overdose risk
- Review the signs and symptoms of benzodiazepine toxicity (CNS depression ranging from mild drowsiness to a stuporous state and respiratory depression) with the patient, as well as potential increased risk of opioid overdose
- Frequency of dispensation should be guided by clinical judgment, prioritizing safety. If daily dispense is appropriate during self-isolation or quarantine, work with a pharmacy to ensure daily delivery is feasible
- Discuss safe storage and develop a plan (e.g., lockbox or safe or delivery by pharmacy under appropriate regulations or clinical outreach team)
- Prescribers should inform and remind their patients that they should not drive nor operate machinery while intoxicated or sedated by any substance
- **Note:** If benzodiazepines and opioids (including OAT) are being co-prescribed to support

self-isolation or quarantine, the prescription should indicate that both medications can be dispensed, to avoid delays. Otherwise, pharmacy will have to contact the prescriber to ensure both medications should be dispensed

8.4 Alcohol and Tobacco

8.4.i Alcohol

Alcohol withdrawal can result in potentially life-threatening complications, including generalized tonic-clonic seizures and delirium tremens, if left untreated. Treatment for alcohol use disorder may include outpatient withdrawal management, inpatient withdrawal management (where available), and long-term alcohol use disorder treatment and recovery supports.

For patients with alcohol use disorder:

- Assess risk of complicated withdrawal using the Predictive Alcohol Withdrawal Severity Scale (PAWSS) and offer evidence-based pharmacotherapies to manage alcohol withdrawal, where indicated:
  - If low risk of complicated withdrawal (i.e., PAWSS ≤ 3) consider providing withdrawal management medications including gabapentin[cc] and/or clonidine or and/or carbamazepine See the BCCSU's *Guideline for the Clinical Management of High-risk Drinking and Alcohol Use Disorder*
  - Guidance for health care providers on treating individuals at high risk of complicated alcohol withdrawal, is available on the BCCSU COVID-19 webpage
  - See the BCCSU and Canadian Institute for Substance Use Research (CISUR)'s *Operational Guidance for Implementation of Managed Alcohol for Vulnerable Population* for guidance on implementing managed alcohol to support physical distance, self-isolation, or quarantine in order to prevent the spread of COVID-19 for individuals at high risk of serious complications related to alcohol withdrawal
- Offer evidence-based continuing care pharmacotherapies and other psychosocial treatment interventions for alcohol use disorder
- See the BCCSU's *Guideline for the Clinical Management of High-risk Drinking and Alcohol Use Disorder*

8.4.ii Tobacco

Tobacco consumption is associated with worse outcomes from COVID-19, with smokers facing higher odds of disease progression than individuals who have never smoked.[37] This increased risk may serve as motivation for cessation for some individuals who smoke.

[cc] Gabapentin will be added as a regular benefit under PharmaCare Plan G for the duration of the crisis as of April 1, 2020. Gabapentin is currently a regular benefit under other PharmaCare drug plans, including Plans W, C, and I (Fair PharmaCare).

For individuals with tobacco use disorder who are not ready to stop consumption (e.g., smoking, vaping):

- Provide nicotine replacement therapy (i.e., patch, gum, lozenge, inhaler)[dd]
- For more information on accessing NRT, visit: https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/bc-smoking-cessation-program
- For more information on supplemental coverage for NRT products available through First Nations Health Benefits, visit: https://www.fnha.ca/Documents/FNHA-Quitting-Tobacco-Product-Info-Sheet.pdf
- For prescription-based pharmacotherapies for tobacco cessation (i.e., varenicline,[ee] buproprion), consider writing longer prescriptions, to reduce the number of clinic visits required and monthly dispense, where clinically appropriate.
- Consider supporting access to tobacco products for individuals who are not ready or wanting to attempt cessation (e.g., NRT, pharmacotherapy) as a risk reduction measure to prevent sharing of cigarettes and to support self-isolation or quarantine due to presumed or confirmed COVID-19

8.5 Cannabis

Although research into pharmacological options to support individuals experiencing cannabis withdrawal, such as pharmaceutical cannabinoid agonists, is ongoing, these options do not have a strong evidence base as of yet. First-line treatment for cannabis use disorder includes psychosocial treatments such as cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET), or contingency management, where available. When indicated for a medical condition, health care providers may consider authorizing cannabis for patients who qualify for medical cannabis,[ff] though costs may be a barrier to access. Health care providers should also provide risk reduction counselling for patients using cannabis, for example, using non-combustible forms of cannabis.

For individuals who are not able or wanting to participate in psychosocial treatment for cannabis use disorder, consider harm reduction measures such as ensuring that patients are aware of cannabis dispensaries as a resource for accessing cannabis and informing them of the risks of sharing joints or other consumption equipment.

[dd] Note that combination NRT (i.e., two different forms of NRT such as oral and patch) is more effective than a single form.
[ee] Varenicline in combination with NRT may be more effective than varenicline alone; however, PharmaCare coverage and potential out-of-pocket cost would have to be considered.
[ff] See Information for Health Care Practitioners—Medical Use of Cannabis for more information

9.0 Harm Reduction, Overdose Prevention, and Naloxone

Although patients may be in isolation or practicing physical distancing, health care providers should encourage them not to use substances alone. If using with others, patients should maintain at least 2 metres separation and should be advised on the use of masks if adequate distance cannot be maintained.[gg] Health care providers should provide education on harm reduction best practices to prevent overdose and offer take-home naloxone (and training on its use, where needed). Take-home naloxone is associated with significant decreases in mortality in individuals who use illicit opioids, and should be considered a standard of care for all individuals who use opioids.[38] Patients may need support in determining how to avoid using alone while remaining in self-isolation or quarantine. Individuals may request a neighbour, loved one, or staff member (e.g., if living in supportive housing) check-in by knocking on the door, or may utilize a mobile app (such as the Lifeguard App) or phone, video, or instant messaging buddy system in which a friend or other support stays on the line and calls 911 if they are unresponsive. Health care providers should connect patients to overdose prevention or supervised consumption services where available.

Health care providers should offer information to patients on how to respond to an overdose in the context of COVID-19 and refer to specific guidance from their local jurisdiction, if available. In brief, in the case of overdose, call 911 and administer naloxone.[hh] As a general rule, rescue breaths and chest compressions should be avoided during the COVID-19 pandemic. Responders who choose to perform rescue breaths or chest compressions should wear the one-way face shield often found in take-home naloxone kits and other personal protective equipment (PPE), including gown, face mask, eye protection, and gloves, if available. Those not directly involved in overdose reversal should stand at least two metres away. More information can be found on the BCCDC website and in Section 2.3.5 "Responding to Overdose within Supervised Consumption Services," in CRISM's *National Rapid Guidance: Supporting People Who Use Substances in Shelter Settings During the COVID-19 Pandemic*.

Health care providers can consider offering harm reduction services by implementing episodic overdose prevention services (e-OPS) for clients who consume substances when accessing health care. This includes providing necessary safer substance use supplies, allowing the person to consume drugs in a private space that is immediately available, monitoring them for signs or overdose, and ensuring that any overdose that may occur is managed and treated immediately. Attempts to exclude people who use substances from facilities, or to exclude substance use from the visibility of staff, do not dissuade substance use but instead may push people to use alone, in less safe environments. More information on the COVID-19 Provincial e-OPS Protocol can be found on the BCCDC website.

[gg] See Non-Medical Masks and Face Coverings: About from the Public Health Agency of Canada.
[hh] Public Health Ontario advises that administration of intranasal naloxone does not produce aerosols and can be used safely on individuals with suspected or confirmed COVID-19.

There are specific health concerns associated with injection of medications intended for oral consumption. Many formulations include non-soluble particles that may cause harm if injected, including talc, dyes, emulsifiers, or other binding agents. When injected, these particles may cause local and systemic infections, skin or soft tissue infections, and pulmonary, cardiac, or vascular conditions.[32-34] Health care providers should provide education[ii] on the risks associated with injection of oral formulations and information on safer injection strategies—including the use of filters—to patients prescribed oral formulations who usually inject the substances they use.[jj] Prescribing practices should be used to reduce harm, when possible (for example, prescribing injectable formulations, where possible, or immediate-release hydromorphone over controlled-release hydromorphone[42]). When prescribing medications that patients may inject, support patient access to harm reduction supplies (e.g., sterile syringes, vitamin C powder, sterile water), where possible. Patients should also be counseled about not sharing smoking devices (e.g., cigarettes, joints, vapes, crack pipes).

[ee] Consider providing patients with Toward the Heart's "Safer Tablet Injection: A resource for anyone who is injecting tablet medications (pills) and would like to do so more safely"
[ff] See the BCCSU's "Safer Tablet Injection: A Resource for Clinicians Providing Care to Patients Who May Inject Oral Formulations"

10.0 Delivery Support

The prescriber should identify pharmacies that have delivery services and have the capacity to transport medication to the client's place of residence. Prescriptions will be sent to those pharmacies. Medications will be delivered directly to patients by the pharmacy under their appropriate regulations. Process of delivery:

- Medications will be delivered directly to patients under appropriate regulations. Client identity will be confirmed prior to provision of medication, while maintaining at least 2 metres distance.
- 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 in their unit or home.
- If pharmacists do not have capacity, consider other delivery options. See CPBC website for more information on delivery options.
- In circumstances in which capacity is severely limited, consider the capacity of providing weekly delivery rather than daily, which would require prescribing carries (see substance-specific sections above).
- Please refer to the latest updates from the BCCSU or appropriate regulatory colleges regarding transportation of controlled substances, as there have been changes in the context of the COVID-19 public health emergency. Information can be found here.

For homeless or precariously housed patients in shared living spaces, patients with suspected or confirmed COVID-19 may be referred for isolation at specified shelters or other locations. Delivery of medication could be arranged for these locations.

In the context of the pandemic, Health Canada has issued additional temporary exemptions under the Controlled Drugs and Substances Act (CDSA) for prescriptions of controlled medications, including OAT, effective March 19, 2020. The exemptions:

- Permit pharmacists to extend prescriptions[kk]
- Permit pharmacists to transfer prescriptions to other pharmacists
- Permit prescribers to verbally prescribe prescriptions with controlled substances (note that the original duplicates must still be sent to the pharmacy)
- Permit pharmacy employees to deliver prescriptions of controlled substances to patients' homes or other locations where they may be staying
- Allow an individual to deliver controlled substances to patients (at their homes or an alternate location)
- Are in effect until September 30, 2026, the date that they are replaced by another exemption, or the date on which they are revoked.

[kk] Although CDSA exemptions allow pharmacists to extend prescriptions, it is not currently within pharmacists' scope of practice in BC; however, pharmacists in BC are able to exercise their professional judgment in order to provide an emergency supply for continuity of care under Professional Practice Policy-31.

This regulation enabled changes to Professional Practice Policy-71 by the College of Pharmacists of BC, which permits another regulated health professional to deliver OAT to a patient, ensuring that they have the appropriate scope and competence to assess a patient and witness the ingestion of OAT.

11.0 Outreach Support

Consider ongoing assessment by phone to ensure that dosing is adequate. It is also important to consider food, fresh air, and entertainment for those in self-isolation or quarantine due to presumed or confirmed COVID-19. The approach should be flexible in keeping with the pandemic and in the best interest of the client and community.

In regions where overdose outreach teams exist, they may support patients with the following:

- Pharmacy delivery issues
- Prescription changes
- Identification of clinical needs and linkage to care
- Navigating other supportive services during self-isolation or quarantine period
- Harm reduction education and supplies

12.0 Peer Navigators and Advocacy

Clinical experience from the past year indicates that the inclusion of peer navigators and patient advocates on the care team can help support engagement in care, including both continued engagement with *Risk Mitigation* prescribing and with substance use disorder treatment. Peer navigators and advocates can support engagement in care in the following ways:

- Outreach
- Explaining interventions and treatment options and what to expect
- Completing intake forms in a setting that is comfortable for the patient
- Supporting patients to attend appointments (including reminders, providing rides)
- Accompanying patients to appointments, if requested
- Facilitating access to treatment, harm reduction, primary care services (e.g., vaccination), and social services
- Helping patients to navigate challenges accessing treatments or interventions
- Providing insight and expertise related to the patient experience to prescribers and other health care team members

13.0 Rural and Remote Considerations

There are unique barriers to both accessing and providing substance use care in rural and remote areas. Rural and remote communities may have limited health services (e.g., clinics or pharmacies), requiring patients to travel to neighbouring communities to access substance use care.

In the context of the COVID-19 pandemic, unique barriers may exist in rural and remote settings. These include:

- Limited ability to monitor patients, due to geography and access
- Limited access to outreach resources
- Limited access to pharmacy and limited delivery capacity
- Limited access to prescribers

One strategy to mitigate these barriers is the use of telemedicine, which enables family physicians, nurse practitioners, and addiction specialists to consult with patients from a distance; however, telemedicine supports may be limited in some communities, with barriers to access (including limited access to internet or smartphones for patients) and limited reach.[ll] The Canadian Research Initiative in Substance Misuse has developed guidance to support healthcare providers to deliver telemedicine for addiction services during the COVID-19 pandemic, *COVID-19 Pandemic—National Rapid Guidance*. Other strategies include adaptation in prescribing and dispensing practices; medication and formulation changes; connecting with local resources; referral to online psychosocial supports such as Alcoholics Anonymous, Self-Management and Recovery Training, Narcotics Anonymous, and mental health hotlines; and ensuring ongoing communication with the treatment team and between prescriber and pharmacist. Prescribers should use their clinical judgment when care planning and develop plans based on the specific needs, circumstances, and barriers faced by individual patients. Providers can consult the 24/7 Line (778-945-7619) for additional guidance and support.

[ll] Prescribers should follow their regulatory college's practice standards concerning telemedicine, including limitations on prescribing opioids.

14.0 Billing

Where there is no telehealth fee, non-procedural interventions provided by video or telephone should be billed under the equivalent face-to-face fee with a claim note record stating service was provided via telehealth. Some relevant examples include:

- Assessment for induction of OAT: 13013
- Management of OAT induction: 13014
- Methadone or buprenorphine/naloxone treatment only: 00039
    - Note: The required once-every-90 day follow ups for this billing code can be met by providing a telehealth visit (see billing codes below)
- For visits that normally would be billed as 0100 or 0120 series when provided in person, use the billing codes for telehealth visits instead:
    - Telehealth GP in-office visit: age appropriate 13437 series
    - Telehealth GP in-office individual counselling: age appropriate 13238 series
- To support COVID-19 risk mitigation, the Ministry of Health has approved temporary changes to fee code 00039 (Management of Maintenance OAT for OUD). These changes will allow physicians to bill an appropriate visit fee in addition to fee code 00039 for visits related to substance use risk mitigation during the pandemic
- With this change, fee code 00039 is not the only fee payable for any medically necessary service associated with OAT for OUD. This includes, but is not limited to the following:
    - At least one visit (in-person, telephone, or video conference) per month with the patient after induction/stabilization on OAT is complete
    - At least one in-person visit with the patient every 90 days. Exceptions to this criterion will be considered on an individual basis
    - Supervised urine drug testing and interpretation of results
    - Simple advice/communication with other allied care providers involved in the patients OAT

Claims for treatment of co-morbid medical conditions, including psychiatric diagnoses other than substance use disorder, remain billable using the applicable visit of service fees. Counselling and visit fees related only to substance use disorder remain not payable in addition, with the exception of visits required to support Substance Use Risk Mitigation in the context of COVID-19. Visits to support *Risk Mitigation* must include a claim note that indicates “COVID-19 risk mitigation.”

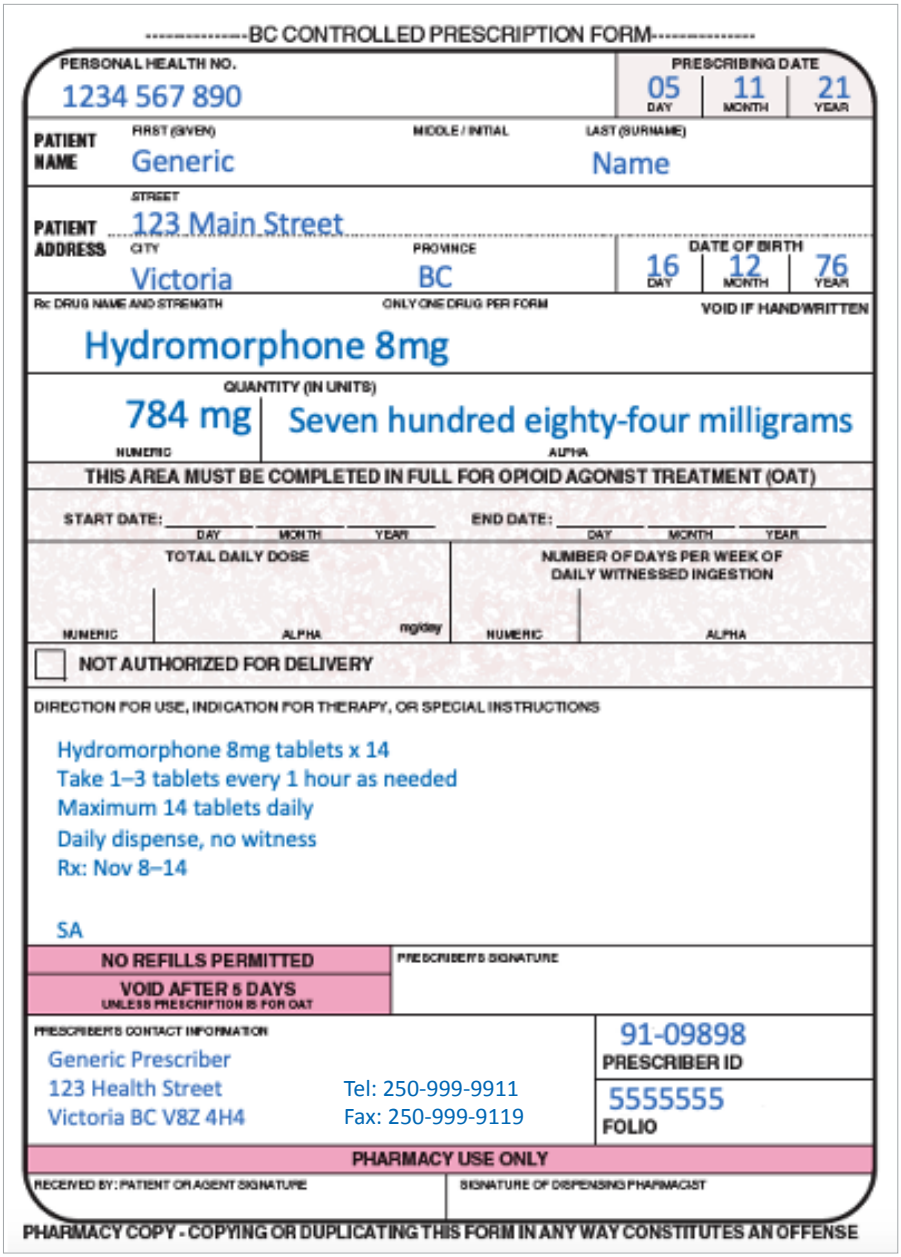
Pandemic prescribing should be billed as telehealth or in-office visits. If OAT is being prescribed or managed concurrently, OAT billing codes can also be used. If multiple visits on the same day are required, multiple codes can be billed, with a claim note stating the reason for the additional visit.

COVID-19 billing codes are not applicable for *Risk Mitigation* prescribing, as these are meant to be used for in-office visits by patients with suspected or active COVID-19 symptoms.

Appendix 1: Example Prescriptions

Note: These prescriptions assume that the patient is to not have take-home doses. The instructions would need to be adjusted should there be a need for take-home doses as per usual written requirements.

Hydromorphone:



----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.: 1234 567 890

PRESCRIBING DATE: 05 (DAY) 11 (MONTH) 21 (YEAR)

PATIENT NAME — FIRST (GIVEN): Generic — MIDDLE / INITIAL — LAST (SURNAME): Name

PATIENT ADDRESS — STREET: 123 Main Street — CITY: Victoria — PROVINCE: BC

DATE OF BIRTH: 16 (DAY) 12 (MONTH) 76 (YEAR)

Rx DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — VOID IF HANDWRITTEN

Hydromorphone 8mg

QUANTITY (IN UNITS)

784 mg (NUMERIC) | Seven hundred eighty-four milligrams (ALPHA)

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: ____ (DAY) ____ (MONTH) ____ (YEAR) END DATE: ____ (DAY) ____ (MONTH) ____ (YEAR)

TOTAL DAILY DOSE — NUMERIC — ALPHA — mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION — NUMERIC — ALPHA

☐ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Hydromorphone 8mg tablets x 14
Take 1–3 tablets every 1 hour as needed
Maximum 14 tablets daily
Daily dispense, no witness
Rx: Nov 8–14

SA

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898
PRESCRIBER ID

5555555
FOLIO

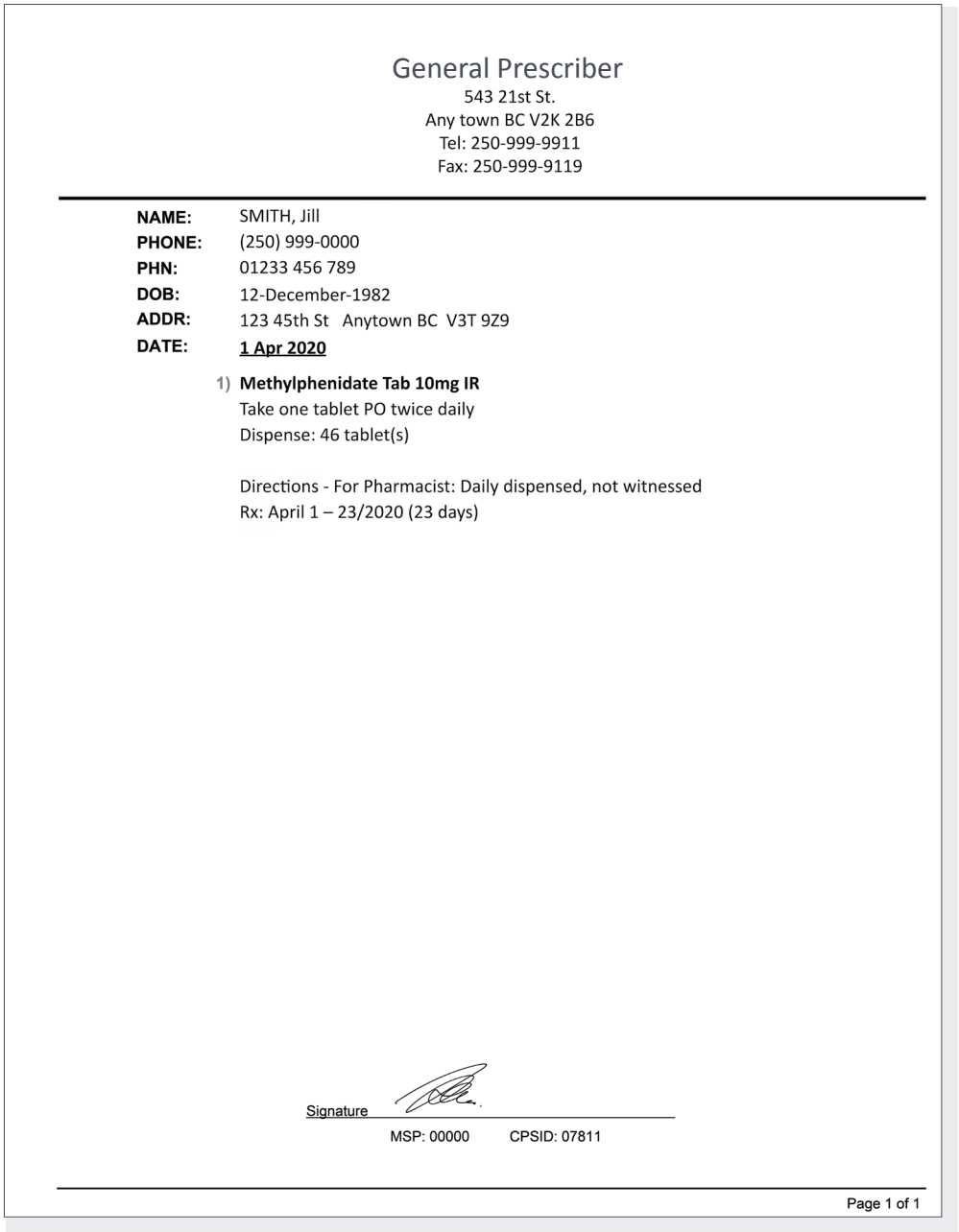
PHARMACY USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE

SIGNATURE OF DISPENSING PHARMACIST

PHARMACY COPY - COPYING OR DUPLICATING THIS FORM IN ANY WAY CONSTITUTES AN OFFENSE

Methylphenidate[mm]:



General Prescriber
543 21st St.
Any town BC V2K 2B6
Tel: 250-999-9911
Fax: 250-999-9119

NAME: SMITH, Jill
PHONE: (250) 999-0000
PHN: 01233 456 789
DOB: 12-December-1982
ADDR: 123 45th St Anytown BC V3T 9Z9
DATE: **1 Apr 2020**

1) **Methylphenidate Tab 10mg IR**
Take one tablet PO twice daily
Dispense: 46 tablet(s)

Directions - For Pharmacist: Daily dispensed, not witnessed
Rx: April 1 – 23/2020 (23 days)

Signature

MSP: 00000 CPSID: 07811

Page 1 of 1

[ii] This is an example prescription from the Plexia EMR system.

Appendix 2: Informed Consent

Seeking informed consent to trial an intervention requires disclosing the relevant information that will allow the patient to make a voluntary choice to accept and consent or decline the intervention. More information on informed consent is available through the Canadian Medical Protective Association's *Consent: A Guide for Canadian Physicians* and The Canadian Nurses Protective Society's *Consent to Treatment: The Role of the Nurse*. In addition, nurse practitioners must meet the BC College of Nurses and Midwives' Consent Practice Standard. This appendix provides a brief overview of the informed consent process, and a template that may be used to guide and document the process.

The informed consent process should include a description of the proposed intervention, including potential risks and benefits; a description of eligibility; a description of engagement with care during the intervention; and a description of what indicators would indicate that the patient is benefitting from the intervention and should continue to receive it, as well as what indications would indicate that the patient is not benefitting from the intervention and alternative harm reduction, treatment, and recovery options should be explored instead. This conversation should be thoroughly documented in the patient's medical record.

Informed Consent Template

1. Provide a description of the intervention

   The specific intervention (e.g., co-prescription of hydromorphone to support OAT initiation, prescription of hydromorphone to reduce reliance on toxic drug supply and overdose risk) should be described, including the limited evidence base supporting it, and potential benefits (e.g., reduced reliance on toxic drug supply, reduced overdose risk, increased OAT retention) and risks (e.g., known risks associated with opioid prescribing, injection-related risks if applicable).

2. Describe eligibility

   Eligibility considerations for this intervention include:
   - Ongoing active opioid use
     AND
   - At high risk of overdose or other harms related to illicit opioid use

3. Describe engagement with care during intervention

   Specific follow-up will depend on clinical judgment and the individual patient.

Items for discussion should include:

a. Frequency of follow-up
b. Frequency of dispensation of medications (e.g., daily dispensation vs. take-home doses)
c. Frequency of UDT
d. Expectation that patient will work together with prescriber on agreed upon plan for amount of engagement around care that would help ensure continuation of prescriptions, and what will happen if agreed upon plan is not met (e.g., consistently missed doses, and missed follow up appointments may result in prescription being cancelled)

4. Describe indications that patient is benefitting or not benefitting from intervention

   Clinical and psychosocial indications of benefit such as reduction or cessation of illicit substance use, reduced risk of overdose, and reduced need to engage in high-risk and criminalized activities should be described. Clinical and psychosocial indications of a lack of benefit such as no change or increased intensity of illicit substance use, no change or increased overdose risk, and no improvement in employment, volunteering, or housing should also be described.

   Indications of benefit should be tailored to the individual patient; the patient should be invited to describe ways that they would know they are benefitting from the intervention (e.g., less engagement in marginalized income-generating activities, experiencing less withdrawal), which should be documented in the patient's medical record and revisited on follow up.

5. Describe options if patient does not benefit from intervention

   If thorough assessment of patient-identified goals and indicators of clinical and psychosocial stability indicate that the patient is not benefitting from the intervention despite attempts at optimizing dosing and psychosocial supports, it may be appropriate to discontinue the intervention and explore alternative harm reduction, treatment, and recovery options.

   Alternative options may include initiating OAT, increasing existing OAT dose, tapering hydromorphone dose, referral to an existing pharmaceutical alternative or safe supply program, or a combination.

6. Ensure patient understands the above information and is capable giving informed consent. If patient is temporarily unable to provide informed consent (e.g., due to impairment), the conversation should be revisited when the patient is capable of providing informed consent. Document consent or refusal of care.

Appendix 3: Example Clinical Scenarios

These clinical scenarios are intended to provide examples of how this interim clinical guidance can be utilized. These examples represent one approach and should not supersede clinical judgment. If prescribing multiple sedating agents (e.g., opioids, benzodiazepines, alcohol), discuss the compounded risk of respiratory depression and overdose, and ensure patient has a take-home naloxone kit and has been trained on how to administer naloxone.

1. Concurrent Opioid and Benzodiazepine Use

Sandra, a 42-year-old female, has a visit through telehealth and reports mild upper respiratory tract infection symptoms. Sandra uses opioids daily and benzodiazepines when she can get them. Your assessment of Sandra shows:

- Stable housing—Sandra lives in supportive housing
- Using 250mg fentanyl IV per day (injects 2–3 times per day)
- On average, uses street-obtained Xanax PO 4mg tabs 3 times per day
- Not on OAT x 6 months, previously on methadone but found side effects intolerable
- No history of complicated withdrawal from benzodiazepines (no seizures/delirium tremens, has skipped days without benzodiazepines) but feels she'll need them to be able to stay in her room
- Declined OAT

Plan
Inform Sandra she must stay at home, away from other people, and to seek emergency help if she has trouble breathing. Encourage her to get tested for COVID-19, and provide information on local testing sites.

Opioids:

- Offer a restart on methadone or start on another OAT medication, which she declines today, but will consider
- M-Eslon 150mg PO BID
- Hydromorphone 16–24mg BID–TID (max 9 tabs per day of 8mg)
- Delivered; daily dispense, not witnessed

Benzodiazepines:

- If confirmed COVID-19, and you or Sandra have concerns that initiating a taper while self-isolating will lead to significant destabilization, consider 2-week maintenance period to support self-isolation, followed by initiation of a taper[jj]
- Clonazepam 1mg PO BID

- Daily dispense, not witnessed
- Assess the patient daily for benzodiazepine withdrawal and adjust dose as needed
- If COVID-19 negative, initiate a taper,[36] and instruct Sandra to follow public health directives followed isolation following a negative test

When prescribing benzodiazepines, ensure telemedicine or in-person follow-up where possible. Doses may need to be adjusted as starting doses are 50% reported use. If concerns of complicated withdrawal, consider outreach team doing regular in-person follow-up (where available). The risks associated with mixing CNS depressants should be discussed with Sandra and she should be provided with a naloxone kit and education on how to use it, as well as advised to avoid using alone and COVID-safe strategies to avoid using alone (e.g., having someone on the phone while she uses, having a neighbour knock on the door, using the LifeGuard App). Discuss with Sandra that you will reassess the opioid prescribing following the quarantine period to determine if she is benefitting from it and would benefit from continued prescribing.

Note: If benzodiazepines and opioids (including OAT) are being co-prescribed to support self-isolation or quarantine, the prescription should indicate that both medications can be dispensed, to avoid delays. Otherwise, pharmacy will have to contact the prescriber to ensure both medications should be dispensed. This is especially important if the patient is provided with two separate prescription forms, one for each medication.

Note: If this patient was pregnant, the 24/7 Line (778-945-7619) could be consulted as needed, and the patient should be connected to pre-natal care as well as any necessary psychosocial supports.

2. Concurrent Opioid and Stimulant Use

Amaya, a 45-year-old trans woman has a visit through telehealth. She tells you that she was called by Public Health, who informed her that she was in contact with someone who has been diagnosed with COVID-19 and must quarantine for 14 days. Amaya is concerned that she will go into withdrawal during quarantine. Amaya has stable housing. Amaya reports no symptoms of upper respiratory tract infection. Amaya uses both opioids and crystal methamphetamine daily. Your assessment of Amaya shows:

- Using 1 point/day IV (100mg) of "down" (injects 3 times/day)
- Using 1 point/day IV (100mg) of crystal methamphetamine IV (injects 2–3 times/day)
- Not on OAT and has never trialled OAT
- Reports 3 previous overdoses in the past year
- Declines OAT today
- No history of severe psychiatric co-morbidities or stimulant-induced psychosis

Plan

Opioids:

- Hydromorphone 16mg PO TID (max 6 tabs per day of 8mg)
- M-Eslon 100mg PO BID (for long-acting coverage)
- Daily dispense, not witnessed

Stimulants:

- Dexedrine 10mg SR PO BID
  OR
- Dexedrine 10mg IR BID–TID
- Delivered; daily dispense, not witnessed

Follow up with telehealth visits, and encourage her to call in to discuss how she is feeling and if the doses are adequate. Discuss with Amaya that you will reassess the prescribing following the quarantine period to determine if she is benefitting from it and would benefit from continued prescribing.

Note: If this patient was a youth, the 24/7 Line (778-945-7619) could be consulted as needed, and the patient should be connected to any necessary psychosocial supports.

3. Opioid Use with Discontinued Opioid Agonist Treatment

Aroon, a 39-year-old man, comes to see you. He tells you that he used to take SROM but started using illicit opioids again in the summer after losing his job due to COVID-19 closures. He is concerned about overdose risk and is interested in hydromorphone. Your assessment of Aroon shows:

- Patient reports no signs of respiratory infection and has had no known exposure to SARS-CoV-19
- Has fixed, safe, housing with his partner
- Has ability to safely store medication; no children live in the house
- Uses 1gram fentanyl IV per day
- No alcohol or benzodiazepine use
- Last on SROM 8 months ago, confirmed on PharmaNet. Has not been on OAT since
- Goal is to stop using illicit opioids

Plan

Using motivational interviewing to guide a discussion of patient goals, motivation, and collaborative planning, you and Aroon decide to reinitiate SROM with a goal of stopping illicit opioid use. In order to support initiation and support Aroon to stop accessing the illicit drug supply, you co-prescribe oral hydromorphone.

Opioids:

- Slow-release oral morphine titration following the *Opioid Use Disorder Practice Update*
- Hydromorphone 24mg PO TID–QID (max 12 tabs per day of 8mg)
- Delivered; daily dispense, not witnessed

Discuss that this plan is to support him to stop illicit opioid use, and that you will collaboratively assess whether he has been benefitting from prescription of hydromorphone following titration and stabilization on SROM and determine whether hydromorphone prescribing should continue or be discontinued once he is no longer self-isolating.

Arrange regular in-person follow-up with local outreach team, if available, as well as telemedicine visits with the prescriber to discuss how he is doing.

4. Assessing Continued Prescribing Following Isolation

Simon, a 59-year-old man who just completed self-isolation for confirmed COVID-19, comes to see you to assess whether continued *Risk Mitigation* prescribing is indicated. Your assessment of Simon shows:

- Diagnosed with OUD 5 years ago
- Has trialled buprenorphine/naloxone and methadone in the past, but continued to use illicit opioids. His last time on OAT (buprenorphine/naloxone) was 2 years ago. He is not interested in OAT at this time but would like to stop using illicit opioids as he has survived 2 overdoses in the past year
- Was using 1 point (100mg) fentanyl per day (inhalation)
- Prescribed M-Eslon 100mg PO BID and hydromorphone 16mg PO TID to support self-isolation
- Simon reports he was able to self-isolate with the help of the prescribed M-Eslon and hydromorphone. He reports he used fentanyl a “few times” during the isolation period, but was able to significantly reduce his use
- Improved sleep and reduced cravings and withdrawal symptoms
- Simon would like to start working part-time again, if he continues to feel well

Plan

As Simon has clearly benefitted from this prescribing, you decide to continue prescribing, with frequent follow up.

- M-Eslon 100mg PO BID and hydromorphone 16mg PO TID
- Daily dispense
- You discuss that the option to restart OAT is always available
- You offer referral to an organization that supports individuals to gain employment

Your documentation includes the following elements:

- Opioid use disorder diagnosis
- Overdose and treatment history
- Your decision to continue prescribing and rationale
    - Documentation of benefits from medications prescribed to support self-isolation
        - Significantly reduced fentanyl use
        - Significantly reduced risk of overdose
        - Improved sleep
        - Reduced cravings and withdrawal symptoms
        - Desire to start working part-time
- Medication prescribed, dose, and length of prescription
- Follow-up plan
- Any consultation (e.g., 24/7 Line (778-945-7619))
- Referral to community organization to support employment

5. Rural Setting

Walter is a 38-year-old man who lives 45 minutes outside of a small town in Northern BC. Walter has a visit with you through telehealth, as he has developed mild upper respiratory tract infection symptoms. Walter has been using opioids for over 10 years and stimulants for 5 years. Your assessment of Walter shows:

- Stable housing 45 mins away from pharmacy and clinic; lives with his partner and child
- Has access to a phone and computer
- Does not own a car
- Hitchhikes into town several times per week to procure illicit opioids and stimulants
- Currently using 500mg fentanyl and 200–300mg of crystal methamphetamine per day
- Has trialled methadone and buprenorphine/naloxone in the past, but has struggled to make appointments regularly and pharmacy pickups due to travel. Last trial on methadone was 8 months ago
- Has the ability to safely store medications at home (in a personal safe that only he has access to)
- No history of psychosis or bipolar disorder

Plan

Opioids

- Offer to restart methadone with hydromorphone prescribing to support titration, Walter agrees to this approach
- Methadone 30mg daily (following titration instructions in *Guideline for the Clinical Management of Opioid Use Disorder*) plus hydromorphone 8mg, 2 tabs TID
- Twice-weekly dispense

Stimulants

- Dextroamphetamine SR 20mg BID
- Twice-weekly dispense

Discuss that this plan is to support him to self-isolate, and that you will collaboratively assess whether he has been benefitting from prescription of these medications following the quarantine period and determine whether prescribing should continue or be discontinued once he is no longer self-isolating.

Notes specific to rural and remote settings:
There is little delivery or outreach capacity in many rural settings. However, this should not be an absolute contraindication to providing medications to support self-isolation. Clinical judgement is required to weigh patient/community benefit vs. risk if providing or withholding this intervention. For this reason, you decide on twice-weekly dispensation and twice-weekly telehealth follow-up during the self-isolation period.

Appendix 4: Resources

Harm Reduction Guidance for COVID-19

BCCDC:

- Priority Populations: People Who Use Substances
- Responding to Overdoses in Overdose Prevention Services (OPS) and Supervised Consumption Sites (SCS)
- "Safer Tablet Injection: A resource for anyone who is injecting tablet medications (pills) and would like to do so more safely"
- COVID-19 Provincial Episodic Overdose Prevention Service (e-OPS) Protocol

BCCSU:

- "Safer Tablet Injection: A Resource for Clinicians Providing Care to Patients Who May Inject Oral Formulations"

Prescribing Resources

BCCSU:

- Opioid Use Disorder
  - Guideline for the Clinical Management of Opioid Use Disorder
  - Opioid Use Disorder—Diagnosis and Management in Primary Care (BCCSU/GPAC)
  - Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder
  - Treatment of Opioid Use Disorder During Pregnancy
  - Treatment of Opioid Use Disorder for Youth
- Alcohol Use Disorder
  - Provincial Guideline for the Clinical Management of High-risk Drinking and Alcohol Use Disorder
  - Pregnancy Supplement: Provincial Guideline for the Clinical Management of High-risk Drinking and Alcohol Use Disorder
- Opioid Use Disorder Practice Update
- Stimulant Use Disorder Practice Update

COVID-19 resources:

- BCCSU: COVID-19 Bulletin: Information for Opioid Agonist Treatment Prescribers and Pharmacists
- BCCSU: COVID-19 Bulletin: Information for Health Care Providers Regarding Alcohol Use Disorder and Withdrawal Management
- CRISM: Guidance Supporting People Who Use Substances in Emergency Shelter Settings
- FNHA: Staying Connected During the Pandemic

If patients are self-isolating, they may be candidates for **home induction of buprenorphine/naloxone**. GPAC and the BCCSU co-developed a patient handout for home induction, available here. Fraser Health and Island Health have also developed patient handouts for home inductions.

Expert Support:

24/7 Addiction Medicine Clinician Support Line (778-945-7619) provides telephone consultation with an addiction medicine specialist to physicians, nurse practitioners, nurses, and pharmacists on screening, assessment, treatment, and management of substance use and substance use disorders.

Rapid Access to Consultative Expertise (RACE) for Addiction Medicine is available for physicians and nurse practitioners Monday–Friday, 8:00 a.m–5:00p.m. for consultation and support
Download the RACE app: www.raceconnect.ca/race-app

Some **rapid access addiction clinics (RAACs)** are equipped to provide telehealth support, both consultation for prescribers and patient assessment.
Victoria: 250-381-3222
Vancouver: 604-806-8867
Surrey: 604-587-3755

OAT Clinics Accepting New Patients: This list may be consulted for referral, for physicians and nurse practitioners who do not have extensive experience providing addiction medicine whose patients are at risk of withdrawal.

BC Centre on Substance Use COVID-19 resources: The BCCSU continues to release relevant guidance and information for health care providers and people who use drugs, including information for OAT prescribers and pharmacists, information for health care providers treating individuals with alcohol use disorder and high-risk drinking, and patient resources.

Patient Resources

Patients may benefit from the following 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 a.m–8:30p.m. every day provides information about physical distancing and what kinds of support, resources, and assistance are available from the provincial and federal governments.

The BCCDC has advice specifically for harm reduction and overdose prevention—available at: http://www.bccdc.ca/Health-Info-Site/Documents/COVID19-harm-reduction.pdf

The BCCSU has patient-facing materials available at: www.bccsu.ca/covid-19.

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