

RISK MITIGATION

IN THE CONTEXT OF DUAL PUBLIC HEALTH EMERGENCIES

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LAND ACKNOWLEDGEMENT

The BC Centre on Substance Use 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 x^wmeθkwey'em (Musqueam), Skwxwú7mesh (Squamish), and sel'ílweta| (Tsleil-Waututh) Nations.

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BACKGROUND

On March 11, 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, 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 onward 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.

This protocol is intended to provide clinical guidance to health care providers to support patients to mitigate these competing priorities and compounded risks and enable social distancing and self-isolation measures, where possible, to reduce and prevent the spread of COVID-19. These guidelines are not intended for treatment of substance use disorders but rather to support individuals with substance use disorders to self-isolate or social distance and avoid risk to themselves or others.

DEVELOPMENT

This interim guidance document was developed rapidly to provide clinical guidance in the context of the COVID-19 pandemic. As such, it does not provide a review of the relevant literature, and relies on the clinical judgment of prescribers when utilizing this guidance.

ELIGIBILITY

Target Population

This guidance aims to support individuals who may be at increased risk of overdose, withdrawal, craving, and other harms related to their substance use. As the effects of the pandemic continue, the drug supply may become significantly more adulterated and toxic, based on limited importation and availability, and illicit substances may become significantly more difficult to procure. Individuals seeking illicit substances to prevent withdrawal risk both overdose and exposure to and transmission of COVID-19. Individuals with unstable housing (those who are homeless or living in a shelter, single room occupancy (SRO), or supported housing unit) may face additional challenges physical distancing or self-isolating, in order to reduce community spread of COVID-19.

Eligible clients must meet the criteria below:

- Those at risk of COVID-19 infection, those confirmed COVID-19 positive, or those with a suspected case (e.g., symptomatic and self-isolating)
- Those with a history of ongoing active substance use (opioids, stimulants, alcohol, benzodiazepines, tobacco, or cannabis)
- Those that are deemed at high risk of withdrawal, overdose, craving, or other harms related to drug 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 options (e.g., opioid agonist treatment).
- For youth and pregnant individuals, in collaboration with the patient, referral to health and social services and connection to appropriate resources should be offered.

Screening and Assessment

Assessment for eligibility should include the following:

- Active substance use assessment (i.e., type of substance, quantity used, frequency of use)
- Substance use 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)

MEASURES IN PLACE TO ENSURE CLINICAL ELIGIBILITY AND TO REDUCE SECONDARY HARMS SUCH AS DRUG DIVERSION

- For any new potential patients unknown to the prescriber, eligibility will include a detailed clinical assessment (see above)
- All patients will be offered referrals to available evidence-based treatment programs based on patient-identified goals (e.g., OAT, recovery-oriented services—where still operating)
- For the safety of all enrolled participants, all pharmaceuticals will be provided daily. This could be facilitated by the housing provider, pharmacy, or a clinical outreach team.
- 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.
- Regular follow-up with health care providers to assess clinical and psychosocial stability should be conducted.

ENROLMENT AND PRESCRIBING

Patients are encouraged to work with their existing or assigned GP/NP who can use the below protocols and pharmacy delivery as per their usual process. For patients who do not have a GP/NP or for whom the GP/NP declines the service, several resources are available:

- 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: <http://www.raceconnect.ca/>
Local calls: 604-696-2131
Toll free: 1-877-696-2131
- **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.
<https://www.bccsu.ca/wp-content/uploads/2020/01/OAT-Clinics-Accepting-New-Patients.pdf>
- **VCH:** Physician and pharmacist requests, referrals, and questions should be directed to the Overdose Outreach Team (OOT). The OOT phone line and specialist phone consultation is available 7 days per week, 8:00am to 8:00pm at 604-360-2874.

PANDEMIC PHARMACOTHERAPY PROTOCOLS

In order to reduce the risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply, replacing illicit (i.e., opioids, benzodiazepines, and stimulants) and licit (i.e., alcohol, tobacco products, cannabis) products with prescribed or regulated substances is recommended.¹ The 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, though the use of a [short form](#).

Other alternate pharmaceuticals not specifically listed here may be limited coverage benefits or non-benefits under BC PharmaCare. PharmaCare Special Authority is not available for alternate treatments. Please consider the cost to the patient before prescribing alternate treatments. Please confirm PharmaCare coverage status (available via the PharmaCare Formulary Search) before prescribing alternative medication.

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 (cigarettes, joints, vapes, crack pipes, etc).

Opioids

In the context of the COVID-19 pandemic, individuals who use opioids may be at greater risk of overdose, withdrawal, craving, and other harms, due to an increasingly limited and toxic illicit drug supply. For patients who use opioids:

- Offer opioid agonist therapy (OAT) according to BCCSU guidelines or if they are already on OAT, consider increasing their dose and provide carries and delivery as needed.
<https://www.bccsu.ca/opioid-use-disorder/>
- If patient is using street opioids in addition to their OAT or declines OAT, prescribe according to current use and use patient preference and clinical judgment to select appropriate medications. Suggestions include:
 - o Prescribe oral hydromorphone 8mg tablets (1-3 tabs q1h as needed up to 14 tablets), provided daily
AND/OR
 - o Prescribe M-Eslon 80-240mg PO BID provided daily (avoid sprinkling doses)
 - o Discuss safe storage and develop a plan (e.g., if living in an SRO or supportive housing, medication could be stored and dispensed by staff)
 - o Make initial prescription at least 23 days in length to support ongoing isolation and social distancing, extending length as necessary, but ensure it does not end on a weekend or statutory holiday²

¹ This document was developed rapidly to provide guidance in the context of COVID-19 pandemic, additional resources are available upon request from the BCCSU.

² Using a prime number will enable pharmacy tracking of prescriptions.

- **Note:** These doses can be up-titrated as needed based on patient requirements; witnessed ingestion is not required. It is helpful to prescribe a long-acting opioid in conjunction with a short-acting opioid for those not on OAT. In circumstances in which capacity for daily delivery is limited, consider prescribing a limited quantity of carries (i.e., up to 7 days), where clinically appropriate.

Stimulants

The generally good safety profile of prescribed stimulants^{3,4} suggests that replacement therapy with psychostimulants in order to support a reduced risk of withdrawal, exposure to COVID-19, and exposure to a limited and toxic drug supply is a reasonable clinical decision in these extraordinary circumstances. For patients with active stimulant use disorder:

- Prescribe Dexedrine SR (dextroamphetamine) 10-20mg PO BID provided daily with a maximum dose of 40mg BID per day
Note: In some clinical practices, doses of 60mg BID are being used; however, there is limited data to support this practice.
OR
- Prescribe methylphenidate IR 10-20mg PO BID daily to max of 100mg/24hrs or methylphenidate SR 20-40mg PO OD with maximum dose of 100mg/24hrs
- Discuss safe storage and develop a plan (e.g., if living in an SRO or supportive housing, medication could be stored and dispensed by staff)
- Make initial prescription at least 23 days in length to support ongoing isolation and social distancing, extending length as necessary, but ensure it does not end on a weekend or statutory holiday²

Illicit Benzodiazepines

Anecdotally, most individuals using illicit benzodiazepines in BC are using bars of adulterated or counterfeit Xanax (alprazolam) that are actually 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 therefore important to start with a relatively low dose and titrate up as needed.

For patients at risk of benzodiazepine withdrawal, enquire which benzodiazepine the patient is using and aim to prescribe according to current use. A taper protocol should be offered if an individual wishes to stop or a temporary maintenance protocol can be considered if an individual feels they cannot stop during isolation.

³ Bhatt M, Zielinski L, Baker-Beal L, et al. Efficacy and safety of psychostimulants for amphetamine and methamphetamine use disorders: A systematic review and meta-analysis. *Syst Rev.* 2016; 5(1):189. 10.1186/s13643-016-0370-x

⁴ Castells X, Cunill R, Pérez-Mañá C, Vidal X, Capellà D. Psychostimulant drugs for cocaine dependence. *Cochrane Database of Systematic Reviews.* 2016; (9). 10.1002/14651858.CD007380.pub4

- For example, if the patient describes buying diazepam 10mg x 3/day then consider starting at 5mg TID and increasing the dose as needed. If a patient describes using 1-4 “bars” of Xanax, start with clonazepam 0.5mg-1mg BID. Starting at a lower dose than what they regularly purchase and titrating up is important due to varying potencies of illicit benzodiazepines. Be cautious when prescribing benzodiazepines for patients who use opioids or on OAT 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
- Discuss safe storage and develop a plan (e.g., if living in an SRO or supportive housing, medication could be stored and dispensed by staff)
- Make initial prescription at least 23 days in length to support ongoing isolation and social distancing, extending length as necessary, but ensure it does not end on a weekend or statutory holiday⁵
- Due to the diverse range of benzodiazepines, confirming PharmaCare benefit status before prescribing a drug other than diazepam is recommended to avoid unintended out of pocket costs to the patient.

Tobacco and Alcohol

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)
- 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 prescription NRT, consider writing longer prescriptions, to reduce the number of clinic visits required and monthly dispense, where clinically appropriate.

For patients with alcohol use disorder:

- Assess and offer pharmacotherapies to manage alcohol withdrawal, where indicated:
 - If low risk of complicated withdrawal (i.e., PAWSS \leq 3) consider providing withdrawal management medications including gabapentin⁶ and/or clonidine or and/or carbamazepine See BCCSU Alcohol Guidelines: <https://www.bccsu.ca/wp-content/uploads/2020/03/AUD-Guideline.pdf>
- Offer relapse prevention pharmacotherapies and other treatments for alcohol use disorder
<https://www.bccsu.ca/wp-content/uploads/2020/03/AUD-Guideline.pdf>

For patients who use alcohol or tobacco chronically and whose cessation may put them at risk for withdrawal, prescribers are encouraged to consider unique solutions, where possible (e.g., managed alcohol or tobacco/nicotine). Prescribers should contact local programs, where they exist, for more information.

⁵ Using a prime number will enable pharmacy tracking of prescriptions.

⁶ 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).

Overdose Prevention and Naloxone

Despite being in isolation or practicing physical distancing, patients are encouraged to not use alone. If using with others, suggest maintaining at least 2 metres separation. Individuals are encouraged to use harm reduction best practices to prevent overdose, and be provided with take-home naloxone. Provide education on how patients can avoid using alone while remaining in isolation. Individuals may request a neighbour, loved one, or staff member (e.g., supportive housing) check-in by knocking on the door, may utilize a phone, video or instant messaging buddy system in which a friend or other support person stays on the line and calls 911 if they are unresponsive. Patients should be connected to overdose prevention services where available.

Current guidance from the BCCDC states that, in the case of overdose, 911 should be called, naloxone should be administered, and rescue breaths should be given using a face shield mask found in take-home naloxone kits. More information can be found [here](#).

When prescribing medications, consider how patients can access necessary harm reduction supplies (e.g., sterile syringes, vitamin C powder, sterile water).

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 the patients. Client identity will be confirmed prior to provision of medication, while maintaining at least 2 metre 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 on their unit.
- If pharmacists do not have capacity, consider other delivery options.⁷
- 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 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: www.bccsu.ca/covid-19

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

⁷ In the context of the pandemic, Health Canada has issued [additional exemptions](#) under the Controlled Drugs and Substances Act (CDSA) for prescriptions of controlled medications, including OAT, effective March 19, 2020, which permit pharmacy employees to deliver prescriptions of controlled substances to patient's homes or other locations where they may be staying. The College of Pharmacists of BC is working to change policy where required in order to operationalize these exemptions.

Outreach Support

Consider ongoing assessment by phone to ensure the dosing is adequate. It is also important to consider food, fresh air, and entertainment for those in self-isolation. 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 quarantine period
- Harm reduction education and supplies

Appendix 1: Oral Morphine Milligram Equivalents Table

A range of dosages is provided in the guidance for opioids. This oral morphine equivalent conversion table may help to convert between prescribed opioids but should not be used to estimate a target dose when converting from illicit opioids to oral hydromorphone or M-Eslon because potency of street-obtained opioids is very unreliable.

Oral Morphine Milligram Equivalents Conversion Table ^{8,9}		
	Oral Morphine Equivalent (OME) conversion factor (dose in mg x conversion factor = equivalent dose to oral morphine in mg)	Equivalence to 30mg oral morphine
Oral Preparations		
Morphine	1.0	30mg
Codeine	0.15	200mg
Oxycodone	1.5	20mg
Hydromorphone	5.0	6mg
Methadone	4.7	6.4mg
Hydrocodone	1.2	25mg
Buccal/Sublingual		
Buprenorphine	38.8	0.8mg
Fentanyl	0.1	300mg
Transdermal Preparations		
Buprenorphine	2.2	13.6mg
Fentanyl	2.7	11.1mg
Parenteral Preparations		
Codeine (SC, IV)	0.3	100mg
Buprenorphine (IM, IV)	75.0	0.4mg
Diacetylmorphine	3.3	9.1mg
Hydromorphone (SC, IV)	17.5	1.7mg
Fentanyl (IV, IM, SC)	0.2	150mg
Morphine (SC, IV)	3.0	10mg
Methadone (IV)	13.5	2.2mg
Oxycodone (SC, IV)	3.0	10mg
IM=intramuscular; IV=intravenous; SC=subcutaneous.		
The OME conversion factors reported here are a median number based on academic literature, however a range have been reported.		
Note: This table has been adapted to include opioids commonly used in BC.		

⁸ Nielsen S, Degenhardt L, Hoban B, Gisev N. A synthesis of oral morphine equivalents (OME) for opioid utilisation studies. *Pharmacoepidemiology and drug safety*. 2016 Jun;25(6):733-7.

⁹ Centre for Addiction and Mental Health. *Opioid Advice: Switching Opioids Safely to Prevent Overdose for Outpatients Prescribed Opioids for Chronic Pain*. 2012 Apr.

Appendix 2: Benzodiazepine Equivalence Table

This benzodiazepine equivalent doses table may help estimate a target dose when converting from illicit to prescribed benzodiazepines. In line with guidance given above, patients should be started at a lower dose than what they regularly purchase and titrated up.


Benzodiazepine Equivalent Doses ¹⁰	
	Equivalent to 5mg Diazepam (Valium)
Alprazolam (Xanax)	0.5mg
Bromazepam (Lectopam)	3-6mg
Chlordiazepoxide (Librium)	10-25mg
Clonazepam (Klonopin, Rivotril)	0.5-1mg
Clorazepate (Tranxene)	7.5mg
Flurazepam (Dalmane)	15mg
Loprazolam (Ativan)	0.5-1mg
Nitrazepam (Mogadon)	5-10mg
Oxazepam (Serax)	15mg
Temazepam (Restoril)	10-15mg
Triazolam (Halcion)	0.25mg
Note: These equivalences are approximate.	

¹⁰ National Pain Centre. 2017. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. McMaster University. http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_bo6.html

Appendix 3: Example Prescriptions

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

Hydromorphone:

B.C. CONTROLLED PRESCRIPTION FORM					
Take to pharmacy of choice.					
PLEASE PRINT					
PERSONAL HEALTH NO. 123456789			PRESCRIBING DATE 01 DAY 04 MONTH 20 YEAR		
PATIENT NAME	FIRST Jill	INITIAL X	LAST Smith		
ADDRESS 123 45th St.					
CITY Any town	PROV. BC		DATE OF BIRTH 26 DAY 12 MONTH 82 YEAR		
Rx - DRUG NAME AND STRENGTH Hydromorphone 8mg			ONLY ONE Rx PER FORM VOID if altered		
			tablets		
NUMERIC 2576mg	QUANTITY	ALPHA twenty-five hundred seventy-six mg			
DIRECTIONS FOR USE Hydromorphone 8mg, 1 to 3 tabs q1h PO as needed up to 14 x 8mg tablets/day Daily dispensed, not witnessed Rx: April 1 – 23/2020 (23 days)					
NO REFILLS PERMITTED VOID AFTER 5 DAYS UNLESS PRESCRIPTION FOR METHADONE MAINTENANCE			PRESCRIBER'S SIGNATURE 		
Dr. Wendy Osler 543 21st St. Any town BC V2K 2B6			COLLEGE I.D. # 12345 67		
			FOLIO 12345678		
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					
PRESS HARD YOU ARE MAKING 2 COPIES PRINTED IN B.C.					

Methylphenidate¹¹:

DR. WENDY OSLER

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

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¹¹ This is an example prescription from the Plexia EMR system.

Appendix 4: Resources

Harm Reduction Guidance for COVID-19:

<http://www.bccdc.ca/health-info/diseases-conditions/covid-19/vulnerable-populations/people-who-use-substances>

Prescribing resources:

BCCSU Guidelines:

- [Opioid Use Disorder](#)
 - o [Guideline for the Clinical Management of Opioid Use Disorder](#)
 - o [Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder](#)
 - o [Treatment of Opioid Use Disorder During Pregnancy](#)
 - o [Treatment of Opioid Use Disorder for Youth](#)
- [Alcohol Use Disorder](#)

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:

Rapid Access to Consultative Expertise (RACE) for Addictions is available M-F 8am-5pm for additional consultation and support <http://www.raceconnect.ca/>

Local calls: 604-696-2131

Toll free: 1-877-696-2131

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.

<https://www.bccsu.ca/wp-content/uploads/2020/01/OAT-Clinics-Accepting-New-Patients.pdf>

BC Centre on Substance Use COVID-19: Information for opioid agonist treatment prescribers and pharmacists, as well as information for people who use drugs is available at: www.bccsu.ca/covid-19 and <https://www.bccsu.ca/opioid-use-disorder/>

