



Medications and other clinical approaches to support physical distancing for people who use substances during the COVID-19 pandemic

NATIONAL RAPID GUIDANCE

VERSION 1 GUIDANCE DOCUMENT



CRISM-ICRAS

Canadian Research Initiative
in Substance Misuse

Initiative Canadienne de
Recherche en Abus de Substance



CIHR IRSC

Canadian Institutes of Health Research
Instituts de recherche en santé du Canada

Citation

To quote this document:

Brar, R., Bruneau, J., Butt, P., Goyer, ME., Lim, R., Poulin, G., Sereda, A., Robinson, S., Ross, J., Wood, E. *Medications and other clinical approaches to support physical distancing for people who use substances during the COVID-19 pandemic: National Rapid Guidance Document*. Vancouver, British Columbia: Canadian Research Initiative in Substance Misuse; June 22, 2020. 53 p. Version 1.

Version 1, June 22, 2020

This publication is available in English. A French version will be available on the Canadian Research Initiative in Substance Misuse (CRISM)'s website: <https://crism.ca>

Land Acknowledgement

We would like to respectfully acknowledge that much of the development of this document occurred on the unceded homelands of the Coast Salish Peoples, including the traditional territories of x^wməθkwəyəm (Musqueam), Skw̓wú7mesh (Squamish), and səliilwətaʔ (Tsleil-Waututh) Nations.

We would also like to acknowledge that the land on which authors gathered in Québec to support the development of this guidance document is the traditional and unceded territory of the Kanien'keha:ka (Mohawk), a place which has long served as a site of meeting and exchange amongst nations.

We recognize that the ongoing criminalization, institutionalization, and discrimination against people who use drugs disproportionately harm Indigenous Peoples, and that continuous efforts are needed to dismantle colonial systems of oppression. We are committed to the process of reconciliation with Indigenous Peoples, and recognize that it requires significant and ongoing changes to the health care system.

We hope that this guidance document helps to reduce the harms faced by people who use drugs in the COVID-19 pandemic.

About the Canadian Research Initiative in Substance Misuse

Funded by the Canadian Institutes of Health Research (CIHR), the Canadian Research Initiative in Substance Misuse (CRISM) is a national research consortium focused on substance use disorders, comprising four large interdisciplinary regional teams (nodes) representing British Columbia, the Prairie Provinces, Ontario, and Quebec/Atlantic. Each CRISM node is an expert network of research scientists, service providers, policy makers, community leaders, and people with lived experience of substance use disorders. CRISM's mission is to translate the best scientific evidence into clinical practice and policy change. More information about CRISM can be found at: <https://crism.ca>.

About this Document

This document is one in a series of six national guidance documents, developed rapidly by the CRISM network at the request of the Government of Canada. Collectively, the six documents address urgent needs of people who use substances, service providers, and decision makers in relation to the COVID-19 pandemic. The urgent nature of this work required rapid development and dissemination of this guidance. This, and the continuing evolution of the knowledge base regarding COVID-19, precluded CRISM from conducting a comprehensive review of the relevant literature. However, a significant number of works were consulted in drafting this guidance; a list of works consulted is provided in **Appendix 1: Works Consulted on page 31**.

The guidance provided in this document is subject to change as new information becomes available. Readers should note that the intent of this document is to provide general guidance rather than detailed procedural and logistical advice. Readers are advised to consult local public health and medical authorities for specific input on navigating their own unique regulatory and policy environments, as necessary.

The CRISM/COVID-19 guidance documents cover the following topics:

- Supporting People Who Use Substances in Shelter Settings During the COVID-19 Pandemic
- Telemedicine Support for Addiction Services
- Harm Reduction Worker Safety
- Recovery Environments
- Supporting People Who Use Substance in Acute Care Settings
- Medications and Other Clinical Approaches to Support Physical Distancing (this document)

Completed documents may be accessed at: <https://crism.ca/projects/covid/>. Each document was developed by a core CRISM regional authorship committee, drawing on expert knowledge, available scientific evidence, and a review of relevant documentation from public health authorities. Draft documents produced by each authorship committee were reviewed by pan-Canadian panels of content and clinical experts. People with lived and living experience of substance use, including Indigenous people with lived and living experience of substance use, have participated in the production of the CRISM COVID-19 guidance document series, either as part of review or authorship committees. A Directed Operating Grant provided funding for this work to CRISM from the Canadian Institutes of Health Research (CIHR).

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Acknowledgments

CRISM would like to acknowledge the authorship committee for guiding the development of the initial draft of this document and revisions to the content, and the reviewer committee for providing their expertise, knowledge, and support. In addition to the individuals listed above, we are grateful to the authors of “Prescriber Guidelines for Risk Mitigation in the Context of Dual Public Health Emergencies” from Vancouver Coastal Health Authority; “Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance” from the British Columbia Centre on Substance Use; and “La pharmacothérapie de remplacement des substances psychoactives dans le contexte de pandémie de COVID-19 au Québec: guide clinique à l'intention des prescripteurs” from Institut universitaire sur les dépendances du CIUSSS du Centre-Sud-de-l'Île-de-Montréal. These documents served as a foundation for the development of this document. We would like to acknowledge the CRISM Node managers (Denise Adams, Fariyah Ali, Nirupa Goel, and Aissata Sako) for their leadership; Maryam Babaei for research support; Rivka Kushner and Trish Emerson for administrative and communications support; Jessica Bright for editorial support; Valeria Saavedra and Kevin Hollett for graphic design support; and Marjolaine Thompson for facilitating the external review. CRISM also wishes to thank Gina Lepage of Traductions Lepage for her assistance with translating the guidance document into French. This work was funded by the Canadian Institutes of Health Research (CUG-171602).

Disclaimer for Health Care Providers

The recommendations in this guidance document represent the view of the Guidance Document Authorship Committee, arrived at after careful consideration of the available scientific evidence and external expert peer review. The application of the guidance contained in this document does not override the responsibility of health care providers to make decisions appropriate to the needs, preferences, and values of an individual patient, in consultation with that patient (and their guardian[s] or family members, when appropriate) and, when appropriate, external experts (e.g., specialty consultation). When exercising clinical judgment in considering strategies to support people who use drugs to self-isolate, health care professionals must uphold their duties to adhere to the fundamental principles and values of their relevant codes of ethics, while taking this guidance document into account. Nothing in this guidance document should be interpreted in a way that would be inconsistent with compliance with those duties.

Legal Disclaimer

While the individuals and groups involved in the production of this document have made every effort to ensure the accuracy of the information contained in this guidance document, please note that the information is provided “as is” and that CIHR and CRISM make no representation or warranty of any kind, either expressed or implied, as to the accuracy of the information or the fitness of the information for any particular use. To the fullest extent possible under applicable law, CIHR and CRISM disclaim and will not be bound by any express, implied, or statutory representation or warranty (including, without limitation, representations or warranties of title or non-infringement). This document is intended to provide a conceptual overview for prescribers (physicians and nurse practitioners) across Canada of strategies to support their patients with substance use disorders to self-isolate in order to reduce the spread of SARS-CoV-2, which causes COVID-19. This guidance document is not intended as a substitute for the advice or professional judgment of a health professional, nor is it intended to be the only approach to the management of a clinical problem. We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a local health care professional.

Management of Competing Interests

This guidance document was entirely funded through the CIHR-funded CRISM network and without pharmaceutical industry support. Conflicts of interest were assessed using the Guidelines International Network’s Principles for Disclosure of Interests and Management of Conflicts.¹ For this

¹ Schunemann HJ, Al-Ansary LA, Forland F, et al. Guidelines International Network: Principles for Disclosure of Interests and Management of Conflicts in Guidelines. *Ann Intern Med* 2015;163(7):54⁸-53.

document, all authorship and review committee members were required to disclose all sources and amounts of direct and indirect remuneration received in the past five years from private industry, for-profit enterprises, and other commercial entities (e.g., direct financial conflicts) that could introduce real, potential or perceived risk of bias. In addition, committee members were asked to disclose possible indirect conflicts of interest, such as academic advancement, clinical/professional revenue, and public standing that could potentially influence interpretation of evidence and formulation of the strategies contained in this guidance.

No current or ongoing direct conflicts of interest were disclosed by the 33 committee members. Three committee members disclosed direct financial conflicts in the form of paid consulting or advisory board participation (n=1; total remuneration \$3,500), and/or paid honoraria for lectures/training (n=2; total remuneration range \$2,000 - \$4,000) by Indivior Inc. in the past five years; none were active at the time of participation. One committee member disclosed receiving non-monetary support for their research program (i.e., paid travel to a meeting) by Indivior Inc. (n=1; total value \$1500); this was not active at the time of publication.

In terms of indirect sources of potential interest or bias, overall, 22 of 33 individuals disclosed special interests in relation to the content of this document. These pertained to expertise and/or clinical practice (e.g., addiction medicine clinician, clinic staff, academic addictions expert), advisory board or committee membership, expert testimony, public statements, or past or current research on treatment interventions or approaches reviewed in this document. One individual reported that their clinical revenue could potentially be influenced by the guidance in this document.

Upon review, of those who disclosed potential direct or indirect conflicts of interest or bias, none were deemed to be of sufficient relevance or weight to warrant exclusion from the committee. To mitigate any real, potential or perceived risk of bias, the four committee members who disclosed a potential direct conflict of interest were recused from the final review and approval of guideline. The remaining 29 members of the committee with no disclosed direct conflicts of interest reviewed and granted final approval of the strategies outlined in this guidance document.

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1.0 Key points of the guidance document

- This guidance document is intended to support individuals with a substance use disorder diagnosis who have a presumed (e.g., symptomatic and self-isolating) or confirmed case of COVID-19.

- Extraordinary measures are needed to support people who use drugs, including alcohol, to follow public health directives (e.g., to self-isolate, quarantine, or physical distance) and prevent ongoing community spread of SARS-CoV-2.

- 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.

- Where possible, prescribers should offer evidence-based treatment according to local or national guidelines. However, not all patients will accept or stabilize on evidence-based treatment options for their substance use disorders. When evidence-based treatment options are not effective, available, or are declined, prescribers may consider alternative strategies—such as prescribing pharmaceutical alternatives or providing other regulated substances—to reduce the risks associated with withdrawal and exposure to SARS-CoV-2.

- For individuals who need to self-isolate and who are at risk of withdrawal from illicit substances (i.e., opioids, benzodiazepines, stimulants), clinical judgment and patient preference should inform prescribing options. These may include initiating and optimizing evidence-based pharmacotherapy, prescribing pharmaceutical alternatives, or a combination of approaches.

- For individuals who need to self-isolate and who are at risk of withdrawal from licit substances (alcohol, tobacco, cannabis), health care providers should work with each individual to determine how best to reduce the risk of withdrawal and support self-isolation. Examples may include initiating or referring to evidence-based treatment, developing a modified managed alcohol plan or plan for at-home withdrawal management, or facilitating access to cannabis.

- For individuals with co-occurring substance use or substance use disorders, the increased risk of overdose associated with co-ingestion of CNS depressants must also be considered when weighing risks and benefits. For these individuals, clinical judgement should be used, with priority given to providing alternatives for the substances associated with the highest risk of severe withdrawal.
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- Health care providers should provide education on harm reduction strategies and access to harm reduction supplies.
-
- For clients initiating or continuing to be prescribed medication for substance use disorders, prescribers are encouraged to identify pharmacies that offer delivery and have the capacity to transport medication to the client's place of residence—especially for those in self-isolation due to a confirmed or suspected COVID-19 case.
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- This clinical guidance does not replace or nullify existing guidelines.

2.0 Purpose and Scope

On March 11, the World Health Organization declared COVID-19—caused by the novel coronavirus SARS-CoV-2—a pandemic, citing concern over alarming levels of spread and severity across the globe. This global pandemic threatens to compound the risks and harms of the overdose crisis in Canada. At the intersection of these dual crises are a number of risks, including the risk for overdose and other harms related to an increasingly toxic illicit drug supply; the risk of acquiring or spreading SARS-CoV-2 among individuals with underlying health conditions who also face social and structural marginalization; and risks due to withdrawal for those who must self-isolate² or quarantine³ to prevent the onward spread of SARS-CoV-2. Individuals seeking illicit substances to prevent withdrawal risk both overdose and exposure to and transmission of SARS-CoV-2. Individuals with unstable housing (e.g., those who are homeless or living in a shelter,⁴ marginal housing, or supported housing unit) face additional challenges physical distancing or self-isolating in order to reduce community spread of SARS-CoV-2.

Where possible, prescribers should offer evidence-based treatment according to local or national guidelines (e.g., [CRISM National Guideline for the Clinical Management of Opioid Use Disorder](#)). However, not all patients will accept or stabilize on evidence-based treatment options for their substance use disorders. Extraordinary measures are needed to support people who use drugs (PWUD), including alcohol, to follow public health directives (e.g., to self-isolate) and prevent ongoing community spread of SARS-CoV-2 among an already marginalized population. When evidence-based treatment options are not effective, available, or are declined, prescribers may consider alternative strategies to reduce the risks associated with both withdrawal and exposure to SARS-CoV-2. Prescribers should use their clinical judgment when considering such alternative strategies, which may be considered outside of established standards of care, including off-label uses.

Making safer alternatives available to reduce harms associated with substance use or to support discontinuing the use of substances has an established history and a substantial collective body of supporting evidence (see **Appendix 1: Works Consulted on page 31**). For example, certain opioid medications have been prescribed in Canada since the 1960s to reduce the harms associated with illicit opioid use, in the form of opioid agonist treatment. In addition, nicotine replacement therapy has commonly been prescribed to manage tobacco use disorder for nearly four decades, and managed alcohol programs increasingly operate in Canadian settings to support people to access

² Self-isolation refers to isolation of individuals confirmed to have COVID-19.

³ Quarantine refers to isolation of individuals who have been exposed to SARS-CoV-2 but have not developed symptoms and are in the disease incubation period.

⁴ See [Supporting People Who Use Substances in Shelter Settings During the COVID-19 Pandemic](#) for guidance on supporting people who use drugs living in shelter settings.

beverage alcohol (rather than use of potentially more toxic non-beverage alcohol). Building on a well-established approach that reduces the harms of some substances through the provision of safer alternatives, the thoughtful prescribing of pharmaceutical alternatives may reduce the risk of SARS-CoV-2 acquisition and transmission, by helping people who use drugs to self-isolate, quarantine, or physically distance.

The guidance contained in this document is intended to provide an overview of approaches to support individuals with a substance use disorder diagnosis who have a presumed (e.g., symptomatic and self-isolating) or confirmed case of COVID-19, and who are being served outside of a shelter setting,⁴ to follow public health measures such as self-isolation or quarantine. This guidance is intended to provide prescribers (physicians and nurse practitioners [NP]⁵) across Canada with strategies for prescribing pharmaceutical alternatives when evidence-based treatment is not sufficient to reduce risk (see **5.0 Pandemic Prescribing on page 21**).

While it is the view of the authors of this guidance document that the toxic drug supply is one consequence of drug prohibition and current drug policies, this document is not intended to offer guidance for the regulation of drugs and substances. Policy change at federal and provincial levels is urgently needed to address the ongoing harms associated with prohibition and current drug policies.

This document is not intended to provide guidance on the treatment of substance use disorders, beyond recommending the use of first-line, evidence-based treatments when possible. This document is national in scope, and does not supersede or replace local guidelines and regulations. Prescribers should use their clinical judgment when utilizing this guidance, taking into account their own knowledge, skills, and expertise with substance use care, while consulting their local regulatory colleges and following established standards of practice in their local jurisdictions.

Care plans should be patient-centred, individualized, and developed on a case-by-case basis, taking into account the unique circumstances, needs, and goals of each patient, and weighing the risks and benefits of each possible intervention. As with all substance use care, prescribers should strive to provide care that is patient-centred, trauma- and violence-informed, and grounded in principles of harm reduction, cultural safety and humility, mutual respect, and an understanding of the social determinants of health.

Provincial or regional health systems partners and employers may need to consider ways in which the implementation of this guidance could be supported. Those involved in supporting implementation of this guidance should take into consideration the unique needs of the populations they serve, the

⁴ See [Supporting People Who Use Substances in Shelter Settings During the COVID-19 Pandemic](#) for guidance on supporting people who use drugs living in shelter settings.

⁵ Where nurse practitioners are authorized to prescribe controlled substances, including OAT, by their regulatory body.

local COVID-19 pandemic and substance use landscapes, standards of practice set by regulatory bodies, and available resources and expertise, as well as medication coverage and supply.

2.1 INTENDED AUDIENCE

The target audience for this guidance document includes primary care providers, pharmacists, addiction specialists, and other clinical professionals. The guidance contained in this document may also be relevant for policymakers, public health authorities, advocates, and people with lived and living experience of substance use.

2.2 DEVELOPMENT

An independent committee of clinical experts was assembled to serve as the authorship committee. The authorship committee (n=10) developed the content for an initial draft based on the available evidence for various treatment modalities, expert consensus, and a guidance document published by Vancouver Coastal Health (VCH). The VCH document served as a foundation for subsequent guidance released by the British Columbia Centre on Substance Use and Institut universitaire sur les dépendances du CIUSSS du Centre-Sud-de-l'Île-de-Montréal. These documents were reviewed by the authorship committee to inform the contents of the present guidance. The draft was shared with the review committee (n=23), which was comprised of additional clinical experts, researchers, service managers, and people with lived and living experience. Feedback and consensus were sought through one round of review via email and teleconference (June 2020). Additional feedback was received from external reviewers who are members of the Health Canada Safe Supply Expert Advisory Group. Feedback was incorporated into version 1 of this guidance document, which was circulated for final approval by the authorship and reviewer committees.

3.0 General Principles for Care Planning

In addition to overarching principles of care—such as Indigenous cultural safety and humility and trauma-informed care (see [Philosophical Approach—Patient-Centred Care and Harm Reduction](#) for more on principles of care)—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., opioid agonist treatment [OAT], alcohol use disorder [AUD] pharmacotherapy). When possible, patients should also be offered 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.⁶

2. Support continuation of current substance use treatment

Prescribers should support patients to maintain current prescriptions, including strategies to support self-isolation and physical distancing. For example, some medications with IM or IV routes of administration can safely be transitioned to oral formulations and thereby decrease the number of clinic and pharmacy visits.

3. Care planning should be individualized

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

⁶ Many support groups have moved online, in order to improve accessibility and decrease risk of COVID-19. See [Appendix 3: Online Substance Use Resources Listing](#) for a list of resources.

When determining prescription interval, consider patient stability, the risk of missing signs of incorrect dosing, the risks of missed doses or treatment discontinuation, patient burden, and the risks of exposure to SARS-CoV-2. Some patients may need additional supports to self-isolate or quarantine, such as housing, food delivery, and hygiene supplies (e.g., soap, bleach). 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.

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

Providers should discuss and make plans for continuity of care, including in the case of hospitalization or incarceration, and potential transitions in treatments as the pandemic shifts and resolves.

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 pharmaceutical alternatives. Check-ins can be brief, when patients have attained significant stability, and may be facilitated by a Registered Nurse (RN) or other appropriate staff. If feasible, utilize phone, telehealth platforms, or outreach services for follow-up. Where these means are unavailable, or patient safety or stability require in-person care, patients should be encouraged to follow up in person and follow public health directives regarding masks and respiratory and hand hygiene.

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. 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. For patients who are given take-home medications, clinicians should discuss a safe medication storage plan. Take-home dosing should be re-evaluated in the event of decreased clinical stability, diversion, a change in ability to securely store medications, or other harms.

7. Consider alternative strategies for dispensation of medication

When carries are not clinically appropriate,⁷ consider alternative strategies for dispensation of medication, in order to support self-isolation or quarantine. This could be facilitated by a housing

⁷ Or the number of clinically appropriate carries are insufficient to support self-isolation or quarantine (e.g., 1 witnessed and 6 take-home doses per week).

provider storing medication or delivery by a pharmacy, support worker, clinical outreach team, or community-based organization.

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

Utilizing telemedicine is advised, where possible; however, capacity may vary based on location. Guidance on using telemedicine for addiction care during the COVID-19 pandemic is available in [CRISM National Rapid Guidance: Telemedicine Support for Addiction Services](#). Prescribers should also refer to any regional guidance and/or practice standards developed by regulatory bodies in their local jurisdiction.

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. Examples include providing access to harm reduction supplies, supporting delivery of medication (depending on province/territory and staff qualifications) or managed alcohol, and facilitating access to other supports and services, depending on capacity.

11. Follow established clinical guidance for the treatment and management of substance use disorders

This guidance document is intended to provide strategies to support people who use drugs to self-isolate, quarantine, and physically distance during the pandemic; it is not intended to provide guidance on treatment of substance use disorders and does not replace existing guidelines or standards of care.

4.0 Eligibility, Screening, and Assessment

This guidance is intended to support individuals with a substance use disorder diagnosis who have a presumed (e.g., symptomatic and self-isolating) or confirmed case of COVID-19, and who are being served outside of a shelter setting (see [Supporting People Who Use Substances in Shelter Settings During the COVID-19 Pandemic](#)).

Some individuals at high risk of acquiring or transmitting SARS-CoV-2 may also be eligible, on a case-by-case basis, for prescribed pharmaceutical alternatives or provision of other regulated substances (i.e., opioids, stimulants, benzodiazepines, tobacco or nicotine replacement therapy, pharmacotherapy for alcohol use disorder or managed alcohol, cannabis) to support self-isolation. Individuals may be considered at high risk of acquiring or transmitting SARS-CoV-2 if they reside in a shelter or have limited access to health care or pharmacy services. More broadly, individuals who are at risk of COVID-19, use illicit substances to manage cravings and withdrawal, are at risk of drug-related harms, and decline or cannot access substance use disorder treatment should be assessed for eligibility on a case-by-case basis, utilizing clinical judgment.

Screening and assessment for eligibility should include the following:

- Active substance use assessment (i.e., type of substance, quantity and frequency used, and route 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 physically distance and avoid the illicit market
- Substance use history, including treatment interventions and periods of remission
- History of overdose
- History of adverse withdrawal events
- Comorbid mental and physical conditions
- Prescribed medication(s) and medication coverage
- Patient-identified needs and goals

- Current access to a prescriber (i.e., GP, addiction medicine physician, NP)
- Living conditions and environment with respect to COVID-19 risks and availability of supports, including financial support such as the Canada Emergency Response Benefit (CERB)

Validated screening and diagnostic tools for substance use disorders are available and can aid the clinician in determining an appropriate care plan, including validated tools for assessing risk of severe withdrawal ([Prediction of Alcohol Withdrawal Severity Scale](#)) and severity of withdrawal ([Clinical Institute Withdrawal Assessment of Alcohol Scale](#); [Clinical Opiate Withdrawal Scale](#); [Cannabis Withdrawal Scale](#)).

5.0 Pandemic Prescribing

As noted above, prescribers are advised to offer evidence-based substance use treatments according to regional/provincial or [national guidelines](#). Not all patients 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.

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 “treatment” for substance use disorders, but rather temporary measures to support people to self-isolate, quarantine, or physically distance to reduce the risk of SARS-CoV-2 transmission, while also reducing risks of withdrawal, overdose, and other substance-related harms. Prescribing immediate-release medications, extended-release medications, or a combination may be necessary, depending on the unique circumstances and needs of each patient. Medication coverage in each province/territory and any cost to patient should be considered with any prescribing decision. Prescribers can refer to Health Canada’s [Formulary Coverage of Select Medications](#). As with all substance use care, each individual’s circumstances, needs, goals, and substance use and treatment history should continuously inform care planning. Whether providing evidence-based treatment or prescribing pharmaceutical alternatives, adjunct psychosocial supports (including virtual, where available) should be offered where possible.

For individuals who need to self-isolate and who are at risk of withdrawal from illicit substances (i.e., opioids, benzodiazepines, stimulants), clinical judgment and patient preference should inform prescribing options. These may include initiating and optimizing evidence-based pharmacotherapy, prescribing pharmaceutical alternatives (see sections 5.1–5.3, below), or a combination of the two (e.g., continuing opioid agonist treatment plus additional prescribed opioids if illicit use continues after optimizing OAT).

For individuals who need to self-isolate and who are at risk of withdrawal from licit substances (alcohol, tobacco, cannabis), health care providers should work with each individual to determine how best to reduce the risk of withdrawal and support self-isolation. Examples may include developing a plan for at-home withdrawal management, referring to or developing a modified managed alcohol program, prescribing nicotine replacement therapy or other tobacco cessation medications, or facilitating access to cannabis (see sections 5.4–5.6, below).

For individuals with co-occurring substance use or substance use disorders, the increased risk of overdose associated with co-ingestion of CNS depressants must also be considered when weighing risks and benefits. For these individuals, clinical judgement should be used, with priority given to providing alternatives for the substances associated with the highest risk of severe withdrawal.⁸

When considering prescribing pharmaceutical alternatives or other provision of regulated substances, prescribers should consider the evidence supporting the use of each substance considered,⁹ 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, in the case of hospitalization or incarceration—for example, continuing to receive prescribed opioids, managed alcohol, or medication to avoid withdrawal. In addition, health care providers should discuss how care may change or transition as the pandemic shifts and eventually resolves. Consider consulting an addiction medicine specialist for support when prescribing.

Given that opioid-related harms (including new cases of opioid addiction and overdose) continue to stem from prescription opioids,¹⁰ strategies to limit diversion (such as daily dispensation, frequent follow-up, and blister-packing of medication where appropriate) and continuous assessment of diversion risk are critical. Urine drug testing is a less useful strategy to monitor for diversion and should only be used if it will change clinical management. Clinical assessment of decreased use and/or increased clinical and social stability—such as fewer infections, greater engagement in care, less sex work, less crime, and patient report of improvement—indicate that the patient is using the medications prescribed and benefitting from the intervention.

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 functioning¹¹ and people who smoke tobacco face a higher risk of COVID-19 progression¹²). 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.

The following sections describe, in brief, evidence-based treatment approaches for substance-specific use disorders as well as alternative strategies that may be considered.

⁸ For example, for an individual at high risk of severe alcohol withdrawal who also uses opioids occasionally, managing alcohol withdrawal should be prioritized, given the risks associated with severe alcohol withdrawal.

⁹ See **Appendix 1: Works Consulted** for a list of works consulted in developing this guidance.

¹⁰ Gomes T, Khuu W, Craiovan D, et al. Comparing the contribution of prescribed opioids to opioid-related hospitalizations across Canada: A multi-jurisdictional cross-sectional study. *Drug and Alcohol Dependence*. 2018; 191:86-90. <https://doi.org/10.1016/j.drugalcdep.2018.06.028>

¹¹ Szabo G, Saha B. Alcohol's Effect on Host Defense. *Alcohol Res*. 2015;37(2):159-170.

¹² Patanavanich R, Glantz SA. Smoking is associated with covid-19 progression: A meta-analysis. *Nicotine & Tobacco Research*. 2020. 10.1093/ntr/ntaa082

5.1 OPIOIDS

Treatment for opioid use disorder typically includes opioid agonist treatment (OAT) with buprenorphine/naloxone, methadone, slow-release oral morphine (SROM), or injectable opioid agonist treatment (iOAT) with hydromorphone or diacetylmorphine (where available), often with adjunct psychosocial treatments and supports. Guidance on treating opioid use disorder is available in CRISM's [National Guideline for the Clinical Management of Opioid Use Disorder](#) and [National Injectable Opioid Agonist Treatment Guideline](#).

If a patient is using illicit opioids in addition to their OAT, consider optimizing their OAT, which may include increased dosage, transitioning to a different OAT medication, or prescribing additional opioids. If strategies to optimize OAT have been tried and a patient continues to use illicit opioids, or declines OAT, consider prescribing opioids according to current use, and use patient preference and clinical judgment to select appropriate medications and dosage. See **6.0 Harm Reduction, Overdose Prevention, and Naloxone on page 27** for guidance on reducing the risks associated with injection of oral formulations.

For individuals with co-occurring substance use or substance use disorders, the increased risk of overdose associated with co-ingestion of CNS depressants (e.g., concurrent opioid and benzodiazepine or alcohol use) must also be considered when weighing risks and benefits. For these individuals, clinical judgement should be used, with priority given to providing alternatives for the substances associated with the highest risk of severe withdrawal.

5.2 STIMULANTS

There are currently no approved pharmacotherapy options for the treatment of stimulant use disorder. Where possible, effective psychosocial treatments for stimulant use disorder should be offered, including contingency management programs. Stimulant intoxication or withdrawal should be managed symptomatically (prescribing medications to address specific symptoms, like agitation).

Studies on psychostimulant replacement therapy, to date, have not shown consistent benefit in reducing illicit stimulant use; however, given the lack of available alternatives, replacement with psychostimulants could be a reasonable clinical decision in these extraordinary circumstances. A careful risk/benefit analysis must be conducted and discussed with the patient, including a thorough assessment of contraindications, including ischemic heart disease and certain mental health conditions (e.g., psychosis).

5.3 BENZODIAZEPINES

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

In the context of the COVID-19 pandemic, benzodiazepine use disorder may be managed through gradual benzodiazepine tapering or a brief period of benzodiazepine maintenance therapy. Given the significant harm associated with benzodiazepine maintenance (e.g., risk of fatal overdose, falls, worsening of mental health symptoms), this should be considered an extraordinary response requiring ongoing follow-up. 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.

For individuals with co-occurring substance use or substance use disorders, the increased risk of overdose associated with co-ingestion of CNS depressants (e.g., concurrent opioid or alcohol and benzodiazepine use) must also be considered when weighing risks and benefits. For these individuals, clinical judgement should be used, with priority given to providing alternatives for the substances associated with the highest risk of severe withdrawal.

5.4 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.

Individuals who have alcohol use disorder or regularly drink large amounts of alcohol should be assessed for risk of developing severe complications of withdrawal (i.e., seizures and delirium tremens) using the [PAWSS](#) tool. Patients with PAWSS<4 can, generally, depending upon age and co-morbidities, safely undergo alcohol withdrawal at home. All patients should be offered pharmacotherapy for withdrawal management (e.g., gabapentin¹³ for PAWSS<4); however, patients with mild-to-moderate AUD may experience negligible withdrawal symptoms and may decline medication for withdrawal management. In this case, AUD pharmacotherapy (naltrexone¹⁴ or acamprosate, first and second-line

¹³ While benzodiazepines are generally not required for mild to moderate withdrawal, they can be considered on a case-by-case basis, based on patient preference and clinical discretion.

¹⁴ Naltrexone is contraindicated in individuals who concurrently use opioids.

treatments, respectively¹⁵) may be offered and initiated, for individuals interested in abstinence or reduced consumption.

For patients at high risk of severe withdrawal symptoms (PAWSS \geq 4), refer to inpatient withdrawal management if space can be confirmed. If inpatient withdrawal management is not available, consider patient risks, available supports, and whether an outpatient withdrawal is clinically appropriate. Individuals with a history of delirium tremens or severe complicated withdrawal requiring hospitalization are not appropriate candidates for undergoing withdrawal management at home. For patients whose goals include decreased alcohol consumption, provide advice on how to safely reduce their drinking (e.g., tapering by one drink per day) in order to avoid withdrawal. For patients who do not want to undergo withdrawal, are not interested in abstinence, or who are not good candidates for withdrawal management, and who remain at high risk of severe withdrawal symptoms, offer managed alcohol services, where available.

Managed alcohol programs provide measured quantities of beverage alcohol to people with severe alcohol use disorder as a harm reduction strategy, and are offered in a growing number of settings in Canada, including both residential and community settings (e.g., drinkers' lounges). Eligible participants should be assessed for the amount and frequency of alcohol required, based on an individual's established drinking patterns, in an effort to reduce harms and reduce/prevent withdrawal symptoms. A list of managed alcohol programs is available [here](#); some jurisdictions may develop their own managed alcohol services in response to the COVID-19 pandemic.

For individuals with co-occurring substance use or substance use disorders, the increased risk of overdose associated with co-ingestion of CNS depressants (e.g., concurrent opioid or benzodiazepine and alcohol use) must also be considered when weighing risks and benefits. For these individuals, clinical judgement should be used, with priority given to providing alternatives for the substances associated with the highest risk of severe withdrawal.

5.5 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.¹⁶ This increased risk may serve as motivation for cessation for some individuals who smoke. People who consume tobacco on a daily basis can be prescribed nicotine replacement therapy (NRT) to avoid withdrawal if wishing to

¹⁵ More information on the clinical management of alcohol use disorder can be found in the BC Centre on Substance Use's [Provincial Guideline for the Clinical Management of high-Risk Drinking and Alcohol Use Disorder](#).

¹⁶ Patanavanich R, Glantz SA. Smoking is associated with covid-19 progression: A meta-analysis. *Nicotine & Tobacco Research*. 2020. 10.1093/ntr/ntaa082

abstain from or reduce tobacco use. There is a low risk of adverse effects with NRT and other tobacco cessation medications (i.e., varenicline, bupropion). Nicotine replacement therapy in the form of gum, lozenges, or transdermal patches can be obtained without a prescription in some provinces. Combination NRT (i.e., two different forms of NRT such as oral and patch) is more effective than a single form of NRT.¹⁷

Consider providing tobacco products to individuals who are not ready or willing to participate in NRT (or as a supplement to NRT) as a risk reduction measure to prevent sharing of cigarettes and to support self-isolation during the COVID-19 pandemic.

5.6 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, 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.

Consider facilitating access to cannabis products to individuals who are not able or willing to participate in psychosocial treatment for cannabis use disorder as a risk reduction measure to prevent sharing of joints or other consumption equipment and to support self-isolation during the COVID-19 pandemic.

¹⁷ Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: an overview and network meta-analysis. *Cochrane Database Syst Rev.* 2013;(5):CD009329.

6.0 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.¹⁸ 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), when possible, or refer patient to nearest pharmacy or harm reduction organization. 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.¹⁹ Patients may need support in determining how to avoid using alone while remaining in isolation. 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 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.²⁰ 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 [here](#) and [here](#). Additional guidance can be found 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](#).

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

¹⁸ See [Non-Medical Masks and Face Coverings: About](#) from the Public Health Agency of Canada.

¹⁹ Canadian Research Initiative in Substance Misuse (CRISM). *National guideline for the clinical management of opioid use disorder*. 2018. <https://crism.ca/projects/opioid-guideline/>.

²⁰ [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.

local and systemic infections, skin or soft tissue infections, and pulmonary, cardiac, or vascular conditions.^{21,22,23} Health care providers should provide education 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 ([see Appendix 8 here](#)). Prescribing practices should be used to reduce harm, when possible (for example, prescribing injectable formulations, where possible, or immediate-release hydromorphone over controlled-release hydromorphone²⁴). 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).

²¹ Roux P, Keijzer L, Carrieri MP, Dasgupta N. Reducing harm from injecting pharmaceutical tablet or capsule material by injecting drug users. *Drug and alcohol review*. 2011;30(3):287-90.

²² Nguyen, VT, Chan ES, Chou SS, et al. Pulmonary effects of IV injection of crushed oral tablets: “Excipient lung disease”. *AMJ Am J Roentgenol*. 2014;203(5):W506-15.

²³ Griffith, CC, Raval JS, Nichols L. Intravascular talcosis due to intravenous drug use is an under recognized cause of pulmonary hypertension. *Pulmonary medicine*. 2012;ID 617531.

²⁴ Silverman M, Slater J, Jandoc R, Koivu S, Garg AX, Weir MA. Hydromorphone and the risk of infective endocarditis among people who inject drugs: a population-based, retrospective cohort study. *Lancet Infect Dis*. 2020;20(4):487-497.

7.0 Delivery Support

For clients initiating or continuing to receive medication, prescribers are encouraged to identify pharmacies that offer delivery and have the capacity to transport medication to the client's place of residence—especially for those in self-isolation due to a confirmed or suspected COVID-19 case.

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 19th, 2020.²⁵ The exemptions:

- Permit pharmacists to extend prescriptions
- Permit pharmacists to transfer prescriptions to other pharmacists
- Permit prescribers to issue verbal orders (i.e., over the phone) to extend or refill a prescription
- Permit pharmacy employees to deliver prescriptions of controlled substances to patients' homes or other locations where they may be staying

While these exemptions are in place at the federal level, barriers to implementation in individual provinces and territories may still exist. Prescribers are encouraged to consult their local regulatory college for information and guidance. Any changes made to care (e.g., extending or transferring prescriptions) should be communicated to the prescriber, using standard communication best practices.

²⁵ Note, these exemptions expire September 30, 2020, unless replaced by another exemption or revoked before that date.

8.0 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 and limited reach. CRISM has developed guidance to support healthcare providers to deliver telemedicine for addiction services during the COVID-19 pandemic, available [here](#). Other strategies include adaptation in prescribing and dispensing practices; medication and formulation changes; referral to inpatient services (e.g., withdrawal management, supportive recovery), where available; connecting with local resources; referral to online psychosocial supports such as AA, SMART, NA, and mental health hotlines (see **Appendix 3: Online Substance Use Resources Listing on page 49**); 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.

Appendix 1: Works Consulted

This list provides an overview of the significant findings of works consulted in drafting this guidance document. Due to the urgent nature of the COVID-19 pandemic, a systematic review of the literature was not conducted. However, the following peer reviewed articles and resources informed the development of this guidance.

COVID-19

Government of Canada. Coronavirus disease (COVID-19): Outbreak update. Available at: <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html#a1>

As of June 15, 2020, the total number of cases of COVID-19 across Canada was almost 100,000, with more than 8,100 resulting deaths were reported. New cases continue to be reported across the country. The majority of cases and deaths have occurred in Quebec and Ontario.

Volkow ND. Collision of the COVID-19 and addiction epidemics. *Annals of internal medicine*. 2020.

Individuals with substance use disorders face a range of elevated health risks during the COVID-19 pandemic. For example, underlying cardiac and respiratory diseases (associated with smoking and vaping) and unstable housing (associated with SUDs in general) increase the risk of COVID-19 and its severe complications. Compromised lung function resulting from COVID-19 also increases the risk of overdose among people with opioid and stimulant use disorders. Additionally, physical distancing measures to minimize the spread of COVID-19 have posed challenges to accessing medication or harm reduction for OUD, which may lead to an increase in fatal overdoses. The healthcare system, policymakers, and researchers must accelerate new ways of meeting the treatment and recovery needs of this population without exposing them to pandemic-related risks.

Karamouzian, M., et al. (2020). Public health messaging and harm reduction in the time of COVID-19. *The Lancet Psychiatry*. 7(5): 390-391.

Marginalized and street entrenched individuals who use drugs are particularly vulnerable to COVID-19. Some necessary measures to address the needs of these individuals include increasing access to supplies for safe drug use; providing alternatives to non-beverage alcohol; and including sanitizing supplies and educational materials in harm reduction packages. The need for treatment continuity plans (e.g., for online visits, phone-based refills, extended prescriptions, take-home doses, transfer of prescriptions between pharmacies, and outreach and delivery options) is also emphasized.

European Monitoring Centre for Drugs and Drug Addiction. EMCDDA update on the implications of COVID-19 for people who use drugs (PWUD) and drug service providers. 2020. <https://www.emcdda.europa.eu/system/files/publications/12879/emcdda-covid-update-1-25.03.2020v2.pdf>

This briefing highlights emerging risks linked to the COVID-19 pandemic for people who use drugs and discusses considerations including infection prevention and control and strategies for ensuring continuity of care.

Green TC, Bratberg J, Finnell DS. Opioid use disorder and the COVID 19 pandemic: a call to sustain regulatory easements and further expand access to treatment. *Subst Abus.* 2020;41(2):147-149.

The COVID-19 pandemic has exacerbated the existing barriers to care faced by people with substance use disorders. One specific challenge that may lead to elevated rates of withdrawal and overdose across the United States is the difficulty of providing daily dispensed and witnessed opioid use disorder medications while observing physical distancing directives. Prescription of take-home OAT medications and the expansion of virtual and pharmacy-based services are emphasized among necessary measures to mitigate these risks.

Alexander GC, Stoller KB, Haffajee RL, Saloner B. An epidemic in the midst of a pandemic: opioid use disorder and COVID-19. *Annals of internal medicine.* 2020.

A number of new changes in US guidelines and policies can address barriers to OAT provision during the COVID-19 pandemic. For example, new guidance by the Substance Abuse and Mental Health Services Administration (SAMHSA) has increased the ability of opioid treatment programs to transfer patients to take-home methadone protocols. In addition, Medicaid and Medicare waivers expand options for the remote assessment and prescription of controlled substances. The need for further innovative steps to avoid excessive disruption of addiction care can be addressed through new partnerships, unprecedented use of technology, and reassessment of “antiquated regulations.”

Overdose Risk

Special Advisory Committee on the Epidemic of Opioid Overdoses. Opioid-related Harms in Canada. Ottawa: Public Health Agency of Canada; March 2020. <https://health-infobase.canada.ca/substance-related-harms/opioids>.

More than 14,700 Canadians died from opioid-related causes between 2016 and September 2019. While Western Canada continues to be the most severely impacted region, overdose death rates have also increased in other regions including Ontario. Among the nearly 3000 apparent opioid-related deaths that occurred between January and September 2019 across Canada, 78% involved fentanyl or fentanyl analogues, 72% involved non-opioid adulterants,

and 76% involved non-pharmaceutical drugs (67% were only non-pharmaceutical drugs and 9% were a mixture of pharmaceutical and non-pharmaceutical).

Ye X, Sutherland J, Henry B, Tyndall M, Kendall PRW. At-a-glance—impact of drug overdose-related deaths on life expectancy at birth in British Columbia. *Health Promot Chronic Dis Prev Can.* 2018;38(6):248-251.

BC's life expectancy at birth, which had steadily increased by almost 13 years from 2000 to 2013 (80.27 to 83.02 years of age), declined by 0.38 years from 2014 to 2016 as a direct consequence of the overdose crisis.

Strang J, McCambridge J, Best D, et al. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. *BMJ.* 2003;326(7396):959–960.

Patients who completed inpatient detoxification were more likely to have died from overdose than patients who did not complete withdrawal or left the program prematurely. The increased mortality is attributed to loss of tolerance in the course of withdrawal management. These results suggest that withdrawal management alone is not an effective treatment for opioid use disorder, and offering this as a standalone option to patients without transition to long-term treatment is neither sufficient nor appropriate.

Harm Reduction and Overdose Prevention

Chimbar L, Moleta Y. Naloxone effectiveness: a systematic review. *J Addict Nurs.* 2018;29(3):167-171.

On the basis of the most current evidence, there is overwhelming support for take-home naloxone programs as a means of decreasing mortality among those who use opioids. Take-home naloxone programs should be more widely implemented throughout communities as a method of decreasing mortality associated with opioid overdoses.

Potier C, Laprevote V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: what has been demonstrated? A systematic literature review. *Drug Alcohol Depend.* 2014;145:48-68.

Supervised injection services were efficacious in attracting the most marginalized people who use injection drugs, promoting safer injection conditions, enhancing access to primary health care, and reducing the overdose frequency. These services were not found to increase drug injecting, drug trafficking, or crime in the surrounding environments. Supervised injection services were found to be associated with reduced levels of public drug injections and dropped syringes.

Turner KME, Hutchinson S, Vickerman P, et al. The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: pooling of UK evidence. *Addiction*. 2011;106(11):1978-1988.

Needle and syringe distribution were significantly associated with a substantial reduction in self-reported needle sharing and hepatitis C transmission among people who inject drugs.

Injection-Related Harm

Nguyen VT, Chan ES, Chou SH, et al. Pulmonary effects of I.V. injection of crushed oral tablets: "excipient lung disease". *AJR Am J Roentgenol*. 2014;203(5):W506-515

When oral tablets are crushed and injected, their filler material (excipient) can induce a potentially fatal foreign-body reaction in pulmonary arterioles, presenting as dyspnea and pulmonary hypertension with centrilobular nodules on CT. This article describes the imaging and pathologic features of "excipient lung disease."

Griffith CC, Raval JS, Nichols L. Intravascular Talcosis due to intravenous drug use is an underrecognized cause of pulmonary hypertension. *Pulm Med*. 2012;2012:617531.

Intravenous injection of oral formulations can cause granulomatous disease of the lung, which results in pulmonary fibrosis and pulmonary hypertension. This case series describes the features of this condition and concludes that intravascular talcosis is an underdiagnosed cause of pulmonary hypertension in people who inject drugs.

Roux P, Carrieri MP, Keijzer L, Dasgupta N. Reducing harm from injecting pharmaceutical tablet or capsule material by injecting drug users. *Drug and alcohol review*. 2011;30(3):287-290.

Many pharmaceutical drug preparations not intended for intravenous use are commonly diverted and injected by people who use drugs. The introduction of fillers, such as talc or starch, in the blood stream may cause complications at the injection site and pulmonary emboli. Preliminary lab results support the effectiveness of injection drug user syringe filters (IDUSF) in filtering out large particles responsible for major harms like pulmonary emboli. Promoting the implementation of IDUSF in harm reduction programs, accompanied by appropriate training, may be a useful strategy for preventing harms associated with injecting tablets.

Silverman M, Slater J, Jandoc R, Koivu S, Garg AX, Weir MA. Hydromorphone and the risk of infective endocarditis among people who inject drugs: a population-based, retrospective cohort study. *Lancet Infect Dis*. 2020;20(4):487-497.

The frequency of infective endocarditis was higher among injection drug users who filled prescriptions for controlled-release hydromorphone than among those who filled prescriptions for non-hydromorphone opioids (2.8% [109 patients] vs. 1.1% [41 patients]). This association did not apply to immediate-release hydromorphone.

Opioids

Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *The Cochrane database of systematic reviews*. 2009;3.

Methadone was found to be significantly more effective than non-pharmacological approaches in retaining patients in treatment and in the suppression of heroin use as measured by self-report and urine/hair analysis. Differences in mortality and criminal activity were not statistically significant.

Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *The Cochrane database of systematic reviews*. 2014;2:CD002207.

While low doses (≤ 6 mg/day) of buprenorphine were less effective than methadone for treatment retention compared to low doses of methadone (≤ 40 mg/day), there was no difference in retention rates for medium (7–15mg/day) and high (≥ 16 mg/day) buprenorphine doses compared to approximately equivalent methadone doses (40–85mg/day and ≥ 85 mg/day). When adequately dosed, buprenorphine and methadone appear to be equally effective for reducing illicit opioid use.

Castells X, Kosten TR, Capellà D, Vidal X, Colom J, Casas M. Efficacy of opiate maintenance therapy and adjunctive interventions for opioid dependence with comorbid cocaine use disorders: a systematic review and meta-analysis of controlled clinical trials. *The American journal of drug and alcohol abuse*. 2009;35(5):339-349.

This systematic review found that dual opioid and cocaine use disorders can be effectively treated with opioid agonist therapy in combination with adjunctive interventions for cocaine use disorder (e.g., indirect dopaminergic agonists, contingency management). Higher opioid agonist doses were more effective than lower doses, and methadone appeared to be more effective than buprenorphine in supporting cocaine abstinence when paired with adjunctive treatments.

Klimas J, Gorfinkel L, Giacomuzzi SM, et al. Slow release oral morphine versus methadone for the treatment of opioid use disorder. *BMJ Open*. 2019;9(4):e025799.

This meta-analysis found no significant differences between slow-release oral morphine (SROM) and methadone for reduction in opioid use and retention in treatment. Results from two studies also suggest that SROM is superior to methadone in reducing opioid cravings. While gaps remain in the evidence base for SROM, this meta-analysis confirms the apparent non-inferiority of SROM with methadone.

Canadian Research Initiative in Substance Misuse (CRISM). National Guideline for the Clinical Management of Opioid Use Disorder. 2017.

Recommends OAT with buprenorphine-naloxone as the preferred first-line treatment. Opioid agonist treatment options should be offered within a harm reduction-oriented framework alongside appropriate psychosocial supports in accordance with patients' individual circumstances and preferences.

Ferri M, Davoli M, Perucci CA. Heroin maintenance for chronic heroin-dependent individuals. *Cochrane Database of Systematic Reviews*. 2011(12).

Findings demonstrated that supervised injection of diacetylmorphine, paired with flexible doses of methadone, were superior to oral methadone alone in retaining treatment refractory patients in treatment while helping reduce the use of illicit drugs. The authors concluded that treatment with diacetylmorphine should be considered for those who have not benefited from oral opioid agonist treatment, due to a higher risk of adverse events.

Strang J, Groshkova T, Uchtenhagen A, et al. Heroin on trial: systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. *The British Journal of Psychiatry*. 2015;207(1):5-14.

A comparison of supervised injectable diacetylmorphine and methadone found supervised injectable diacetylmorphine to be superior to methadone in terms of reducing illicit heroin use, among individuals with treatment refractory opioid use disorder.

Oviedo-Joekes E, Guh D, Brissette S, et al. Hydromorphone compared with diacetylmorphine for long-term opioid dependence: a randomized clinical trial. *JAMA Psychiatry*. 2016;73(5):447-455.

The Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) compared diacetylmorphine with injectable hydromorphone in patients with long-term, treatment-refractory opioid use disorder. Injectable hydromorphone was not inferior to injectable diacetylmorphine for people with long-term injection street opioid use, in terms of retention rates, reduction of any street opioid use, and illegal activities.

Canadian Research Initiative in Substance Misuse (CRISM). *National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline*. September 23, 2019 2019.

Recommends that iOAT (injectable hydromorphone or diacetylmorphine) be considered for individuals with severe, treatment-refractory opioid use disorder and ongoing illicit injection opioid use, as an open-ended treatment, with decisions to transition to oral OAT made collaboratively with the patient

Walton G, Nolan S, Sutherland C, Ahamad K. Sustained release oral morphine as an alternative to methadone for the treatment of opioid-use disorder post Torsades de Pointes cardiac arrest. *BMJ case reports*. 2015;2015. doi:10.1136/bcr-2015-210239.

Case study: A patient with OUD was maintained on sustained-release oral morphine (12-hour formulation) following an in-hospital episode of Torsades de Pointes associated with methadone administration. The change to sustained-release oral morphine reduced patient's measured QTc interval, prevented further arrhythmias, and supported abstinence from illicit opioid-use.

Stimulants

Canadian Centre on Substance use and addiction. Cocaine (Canadian Drug Summary). 2019. Available at: <https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Canadian-Drug-Summary-Cocaine-2019-en.pdf>

This report summarizes data on the use of cocaine, including the harms and effects, legal status, criminal justice implications, and access to treatment. While the percentage of cocaine use by Canadians remains low (about 2%), past-year use among 20 to 24-year olds is increasing.

Canadian Centre on Substance use and addiction. Methamphetamine (Canadian Drug Summary). 2018. Available at: <https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Canadian-Drug-Summary-Methamphetamine-2018-en.pdf>

This report summarizes data on the use of methamphetamine, including the harms and effects, legal status, and access to treatment. Although the overall prevalence of use by Canadians remains low (about 0.2%), the availability of methamphetamine has been increased in recent years.

Castells X, Cunill R, Perez-Mana C, Vidal X, Capella D. Psychostimulant drugs for cocaine dependence. *Cochrane Database Syst Rev*. 2016;9:Cd007380.

Low-quality evidence suggests that psychostimulants helped sustain cocaine abstinence but did not have a significant impact on treatment retention or frequency of cocaine use among

participants who continued to use it. No increased adverse events among patients treated with psychostimulants were observed.

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.

Findings indicate no significant difference between psychostimulant treatment and placebo groups in terms of end-of-study abstinence or treatment retention. The incidence of serious adverse events did not differ between intervention and placebo groups.

Nuijten M, Blanken P, van de Wetering B, Nuijen B, van den Brink W, Hendriks VM. Sustained-release dexamfetamine in the treatment of chronic cocaine-dependent patients on heroin-assisted treatment: a randomised, double-blind, placebo-controlled trial. *The Lancet*. 2016;387(10034):2226-2234.

At 12 weeks, the sustained-release dexamphetamine treatment group experienced significantly fewer days of cocaine use than the placebo group (mean 44.9 days vs. 60.6 days, respectively). Adverse events were mostly transient and well-tolerated.

Blanken P, Nuijten M, van den Brink W, Hendriks VM. Clinical effects beyond cocaine use of sustained-release dexamphetamine for the treatment of cocaine dependent patients with comorbid opioid dependence: secondary analysis of a double-blind, placebo-controlled randomized trial. *Addiction*. 2019.

Sustained-release dexamphetamine resulted in significant increases in the number of cocaine-abstinent days among patients with co-occurring cocaine and opioid use disorders who were engaged in treatment in heroin-assisted treatment. This outcome was associated with improved overall health among patients who were in poor health at the start of treatment.

Sangroula D, Motiwala F, Wagle B, Shah VC, Hagi K, Lippmann S. Modafinil Treatment of Cocaine Dependence: A Systematic Review and Meta-Analysis. *Substance use & misuse*. 2017;52(10):1292-1306.

Results indicated that modafinil was not superior to placebo in improving treatment retention. Similarly, data from seven studies did not demonstrate the superiority of modafinil in achieving cocaine abstinence; however, subgroup analysis of six studies did suggest that modafinil was more effective than placebo in improving cocaine abstinence rates. No excess adverse events or dropouts were observed compared to placebo.

De Crescenzo F, Ciabattini M, D'Alò GL, et al. Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: a systematic review and network meta-analysis. *PLoS Med.* 2018;15(12):e1002715.

Contingency management, paired with a community reinforcement approach, was the only intervention that increased the number of abstinent patients at the end of treatment compared to treatment as usual. At the end of treatment, contingency management with community reinforcement also had the highest number of statistically significant results in head-to-head comparisons, being more efficacious than cognitive behavioural therapy, non-contingent rewards, and 12-step programs. Contingency management with community reinforcement approach was also associated with fewer dropouts than treatment as usual.

Farronato N, Dürsteler-MacFarland KM, Wiesbeck GA, Petitjean SA. A systematic review comparing cognitive-behavioral therapy and contingency management for cocaine dependence. *J Addict Dis.* 2013;32(3):274-287.

Contingency management alone reliably reduced cocaine use during active treatment in all cited trials, whereas the positive effect of cognitive-behavioral therapy emerged after treatment in 3 of 5 trials.

Rawson RA, Marinelli-Casey P, Anglin MD, et al. A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction.* 2004;99(6):708-717.

The Matrix Model is a 16-week manualized intensive treatment protocol that combines cognitive behavioural therapy, family education, individual counselling, and 12-step fellowship participation. In comparison to treatment as usual, participants in the Matrix treatment group attended more clinical sessions, stayed in treatment longer, and provided more methamphetamine-free urine samples during the treatment period, and had longer periods of methamphetamine abstinence. Measures of drug use and functioning collected at treatment discharge and 6 months post-admission indicate significant improvement by study participants in all groups compared to baseline levels; however, the superiority of the Matrix approach did not persist at post-treatment follow-ups.

Benzodiazepines

Crowe SF, Stranks EK. The residual medium and long-term cognitive effects of benzodiazepine use: an updated meta-analysis. *Arch Clin Neuropsychol.* 2018;33(7):901-911.

The results of the analysis for people currently using benzodiazepines revealed statistically significant negative effects for the cognitive domains of working memory, processing speed, divided attention, visuo-construction, recent memory, and expressive language. For those who

had discontinued benzodiazepine use and successfully maintained abstinence, residual deficits were observed for the domains of recent memory, processing speed, visuo-construction, divided attention, working memory, and sustained attention.

Walton GR, Hayashi K, Bach P, et al. The impact of benzodiazepine use on mortality among polysubstance users in Vancouver, Canada. *Public Health Rep.* 2016;131(3):491-499.

The results of this prospective cohort study indicate that benzodiazepine use was more strongly associated with mortality than any other substances among people with co-occurring substance use. Authors call for greater recognition of the safety concerns related to benzodiazepines and strategies to prevent diversion to illicit use.

Ickowicz S, Hayashi K, Dong H, et al. Benzodiazepine use as an independent risk factor for HIV infection in a Canadian setting. *Drug Alcohol Depend.* 2015;155:190-194.

This prospective cohort study found benzodiazepine use to be independently associated with HIV seroconversion among people who inject drugs.

Bach P, Walton G, Hayashi K, et al. Benzodiazepine use and hepatitis C seroconversion in a cohort of persons who inject drugs. *Am J Public Health.* 2016;106(6):1067-1072.

The results of this prospective cohort study associated benzodiazepine use with increased rates of HCV seroconversion among people with co-occurring substance use.

Liebrenz M, Boesch L, Stohler R, Caflisch C. Agonist substitution—a treatment alternative for high-dose benzodiazepine-dependent patients? *Addiction.* 2010;105(11):1870-1874.

Regardless of intervention, most individuals dependent on high doses of benzodiazepines do not achieve long-term abstinence. Benzodiazepine replacement therapy has been used in such patients. Available literature suggests that maintenance treatment with a slow-onset, long-acting benzodiazepine may lead to less craving, reduced anxiety, fewer withdrawal complications, increased retention in treatment, and improved health and social functioning. Cognitive impairment could potentially be minimized through the use of an optimal agonist.

Nardi AE, Freire RC, Valença AM, et al. Tapering clonazepam in patients with panic disorder after at least 3 years of treatment. *J Clin Psychopharmacol.* 2010;30(3):290-293.

A gradual (4–7 month) protocol for tapering off of clonazepam was trialed in patients who had been receiving clonazepam as treatment for panic disorder for at least 3 years. The results indicated that clonazepam could be successfully discontinued without any major withdrawal symptoms if the dose is reduced gradually. Improvement in panic disorder and general well-being were maintained during both the taper and follow-up phases.

Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults. Canadian Coalition for Seniors' Mental Health, Toronto, Canada. 2019. Available at: https://ccsmh.ca/wp-content/uploads/2019/11/Benzodiazepine_Receptor_Agonist_Use_Disorder_ENG.pdf

For older adults (age \geq 65) diagnosed with benzodiazepine use disorder, this guideline strongly recommends against the abrupt discontinuation of benzodiazepine use. Referring to limited evidence, this document suggests that switching from a short-acting benzodiazepine to a long-acting option before beginning gradual dose reduction may be useful if reduction of the short half-life BZRA causes problematic withdrawal symptoms.

National Pain Centre. 2017. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: Appendix 6—Benzodiazepine Tapering. McMaster University. http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b06.html

This resource provides practical advice and sample dosing protocols and dose equivalence tables for slow benzodiazepine tapering.

Baandrup L, Ebdrup BH, Rasmussen JØ, Lindschou J, Gluud C, Glenthøj BY. Pharmacological interventions for benzodiazepine discontinuation in chronic benzodiazepine users. *Cochrane Database Syst Rev.* 2018;3(3):CD011481. Published 2018 Mar 15. doi:10.1002/14651858.CD011481.pub2

This systematic review compared pharmacological treatment versus placebo, no intervention, or another pharmacological treatment for individuals with benzodiazepine dependence. The low or very low quality of evidence and small number of trials prevent conclusions from being drawn on the efficacy of pharmacological interventions for benzodiazepine dependence.

Ashton CH. Benzodiazepines: How They Work and How to Withdraw. Rev. August 2002. <https://www.benzo.org.uk/manual/bzsched.htm>

The Ashton manual provides a comprehensive description of the impacts of long-term benzodiazepine use and benzodiazepine use disorder, as well as detailed guidance for slow withdrawal (\geq 6 months).

Tobacco/Nicotine

Apollonio D, Philipps R, Bero L. Interventions for tobacco use cessation in people in treatment for or recovery from substance use disorders. *Cochrane Database Syst Rev.* 2016;11:CD010274.

This systematic review evaluated NRT, non-NRT, and combination approaches for supporting tobacco cessation in people receiving concurrent treatment for other SUDs. Pharmacotherapy appeared to significantly increase tobacco abstinence rates, as did combined counselling

and pharmacotherapy (12 studies, 2229 participants, low quality evidence). Counselling interventions alone did not significantly increase tobacco abstinence. Data on adverse effects of the interventions were limited at the time of the study.

Hartmann-Boyce J, Chepkin SC, Ye W, Bullen C, Lancaster T. Nicotine replacement therapy versus control for smoking cessation. *Cochrane Database Syst Rev*. 2018;5(5):Cd000146.

High-quality evidence supports the use of all licensed forms of NRT to increase individuals' chances of successful discontinuation of smoking. Nicotine replacement therapy increases the rate of quitting by 50%– 60%. Additional supports provided to individuals attempting smoking cessation does not seem to impact the relative effectiveness of NRT. Side effects of NRT include minor irritation of the site through which it is administered, and, rarely, non-ischaemic chest pain and palpitations.

Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: an overview and network meta-analysis. *Cochrane Database Syst Rev*. 2013;(5):CD009329.

Results indicate that NRT, bupropion, and varenicline were all superior to placebo in supporting smoking cessation. Head-to-head comparisons between bupropion and NRT showed equal efficacy. Varenicline was superior to single forms of NRT and to bupropion, but was not more effective than combination NRT. Combination NRT and varenicline are equally effective as quitting aids. Combination NRT also outperformed single NRT formulations. The four categories of NRT performed similarly against each other and have a low risk of harms.

Alcohol

British Columbia Centre on Substance Use (BCCSU), B.C. Ministry of Health, and B.C. Ministry of Mental Health and Addictions. Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder. 2019. Vancouver, B.C.: BCCSU. Available at: <https://www.bccsu.ca/wp-content/uploads/2020/03/AUD-Guideline.pdf>

Provides a set of 13 clinical recommendations for the identification and clinical management of high-risk drinking and AUD, with a focus on primary care practice. Recommendations include assessing risk of severe complications of alcohol withdrawal and basing care planning off of assessment, as well as naltrexone or acamprosate as first-line pharmacotherapy.

Maldonado JR, Sher Y, Das S, et al. Prospective validation study of the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) in medically ill inpatients: a new scale for the prediction of complicated alcohol withdrawal syndrome. *Alcohol*. 2015;50(5):509-518.

The PAWSS was shown to have a high predictive value for identification of patients at high-risk of severe complications (positive predictive value=93.1; negative predictive value=99.5) and good inter-rater reliability (96.3%).

Amato L, Minozzi S, Vecchi S, Davoli M. Benzodiazepines for alcohol withdrawal. *Cochrane Database Syst Rev*. 2010(3)

Benzodiazepines showed a protective benefit against alcohol withdrawal symptoms, particularly seizures, when compared to placebo. There was also a trend in favour of benzodiazepines for avoiding treatment drop-out, seizures, and delirium, when compared with other drugs. A comparison among different benzodiazepines did not yield statistically significant results.

Leung JG, Hall-Flavin D, Nelson S, Schmidt KA, Schak KM. The role of gabapentin in the management of alcohol withdrawal and dependence. *Annals of Pharmacotherapy*. 2015;49(8):897-906.

The findings of this systematic review suggest that gabapentin can be effective in managing mild alcohol withdrawal syndrome. Sleep and mood/anxiety-related outcomes were reduced by gabapentin, which may result in long-term benefits if gabapentin is continued beyond the withdrawal period for the treatment of alcohol dependence. However, there were five reported or suspected seizures in gabapentin withdrawal studies, suggesting that this medication may not be safe for the treatment of severe withdrawal.

Jonas DE, Amick HR, Feltner C, et al. Pharmacotherapy for adults with alcohol use disorders in outpatient settings: a systematic review and meta-analysis. *JAMA*. 2014;311(18):1889–1900. doi:10.1001/jama.2014.3628

Both acamprosate and naltrexone were associated with reduction in return to drinking. When directly compared with one another, no significant differences were found between acamprosate and naltrexone for controlling alcohol consumption.

Maisel NC, Blodgett JC, Wilbourne PL, Humphreys K, Finney JW. Meta-analysis of naltrexone and acamprosate for treating alcohol use disorders: when are these medications most helpful? *Addiction*. 2013;108(2):275-293.

In treatment for alcohol use disorders, acamprosate was found to be slightly more effective than naltrexone in promoting abstinence, while naltrexone was slightly more effective than acamprosate in reducing heavy drinking and cravings. Detoxification before treatment and a longer period of required abstinence before treatment are associated with larger medication effects for acamprosate and naltrexone respectively.

Carvalho AF, Heilig M, Perez A, Probst C, Rehm J. Alcohol use disorders. *Lancet*. 2019;394(10200):781-792. doi:10.1016/S0140-6736(19)31775-1

This seminar article provides a comprehensive review of the epidemiology, risk factors, diagnosis, and treatment—both pharmacological and psychosocial—of alcohol use disorders.

The article also discusses the role of environment, culture, and policy in reducing alcohol-related harms.

van Amsterdam J, van den Brink W. Reduced-risk drinking as a viable treatment goal in problematic alcohol use and alcohol dependence. *J Psychopharmacol*. 2013;27(11):987-997. doi:10.1177/0269881113495320

Reviews the literature supporting reduced-risk drinking as a treatment option. Indications for reduced-risk drinking include individuals with out-of-control drinking with related harms who do not want to—or are unable to—abstain from alcohol. Contraindications include patient goals of abstinence, concurrent health conditions exacerbated by alcohol intake, drug-drug interactions, prior unsuccessful attempts at reduced-risk drinking, and a history of severe alcohol withdrawal symptoms.

Pauly BB, Vallance K, Wettlaufer A, et al. Community managed alcohol programs in Canada: overview of key dimensions and implementation. *Drug Alcohol Rev*. 2018;37 Suppl 1:S132-s139.

This paper describes existing MAPs in Canada, including key dimensions and implementation issues. Community-based MAPs have a common goal of preserving dignity and reducing harms of drinking while increasing access to housing, health, and social services. Managed alcohol programs are offered as both residential and day programs, with variations in eligibility assessment; alcohol dispensing and administration; funding; and provision of food, accommodation, primary care services, and clinical monitoring. Facilitating access to housing and re-establishing social and cultural connections are central to achieving MAP goals.

Brooks HL, Kassam S, Salvalaggio G, Hyshka E. Implementing managed alcohol programs in hospital settings: A review of academic and grey literature. *Drug and Alcohol Review*. 2018;37(S1):S145-S155.

Available articles examining alcohol provision in hospital settings (n=28 articles) report positive outcomes related to prevention or treatment of alcohol withdrawal. Fourteen studies examined MAPs in the community and reported that they help stabilise drinking patterns, reduce alcohol-related harms, and facilitate non-judgemental health and social care.

Podymow T, Turnbull J, Coyle D, Yetisir E, Wells G. Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*. 2006;174(1):45-49.

Seventeen adults with alcohol use disorder were enrolled in a shelter-based MAP for an average of 16 months. The monthly mean group total of emergency department visits decreased from 13.5 to 8 following enrollment, and police encounters decreased from 18.1 to 8.8. Changes in blood test findings were nonsignificant. All program participants reported less alcohol consumption while enrolled in the MAP, and subjects and staff alike reported

improved hygiene, adherence with medical care, and health.

Stockwell T, Pauly BB, Chow C, et al. Does managing the consumption of people with severe alcohol dependence reduce harm? A comparison of participants in six Canadian managed alcohol programs with locally recruited controls. *Drug Alcohol Rev.* 2018;37 Suppl 1:S159-s166.

Length of stay in a MAP was investigated as a predictor of drinking patterns, non-beverage alcohol consumption, and related harms. Recently admitted MAP participants (≤ 2 months) and controls were both high consumers of alcohol and had equal levels of alcohol dependency. Long-term MAP residents (> 2 months) drank significantly more days (+5.5) in the past 30 but consumed 7 standard drinks fewer per drinking day. Long-term MAP residents reported significantly fewer health, safety, legal, social, and withdrawal harms related to alcohol.

Vallance K, Stockwell T, Pauly B, et al. Do managed alcohol programs change patterns of alcohol consumption and reduce related harm? *A pilot study. Harm Reduct J.* 2016;13(1):13.

Participation in MAPs was associated with several positive outcomes including reduced withdrawal symptoms, hospital admissions, non-beverage alcohol consumption and police contacts leading to custody, in addition to self-reported decreases in some alcohol-related harms in the domains of home life, legal issues, and withdrawal seizures.

Cannabis

Fischer B, Russell C, Sabioni P, et al. Lower-risk cannabis use guidelines: a comprehensive update of evidence and recommendations. *American Journal of Public Health.* 2017;107(8):e1-e12.

Recommendations include avoiding early age initiation of cannabis use; choosing low-potency cannabis products; avoiding the use of synthetic cannabinoids; avoiding combusted cannabis inhalation and giving preference to non-smoking use methods; refraining from high-frequency (e.g., daily or near-daily) cannabis use; and avoiding cannabis-impaired driving.

Livne O, Shmulewitz D, Lev-Ran S, Hasin DS. DSM-5 cannabis withdrawal syndrome: demographic and clinical correlates in U.S. adults. *Drug and alcohol dependence.* 2018.

The prevalence of cannabis withdrawal syndrome was 12.1% among patients with frequent cannabis use (n=1527). The most common withdrawal symptoms were nervousness/anxiety (76.3%), hostility (71.9%), sleep difficulty (68.2%), and depressed mood (58.9%). Cannabis withdrawal syndrome was associated with anxiety, mood, and personality disorders; significant disability; and family history of depression; but not associated with a personal or family history of other substance use disorders.

Werneck MA, Kortas GT, de Andrade AG, Castaldelli-Maia JM. A systematic review of the efficacy of cannabinoid agonist replacement therapy for cannabis withdrawal symptoms. *CNS Drugs*. 2018;32(12):1113-1129.

Dronabinol, nabilone, or nabiximols, either alone or in combination with other drugs, may be useful in reducing cannabis withdrawal symptoms and the rate of relapse, probably with a dose-dependent effect. Good tolerability and few adverse effects were observed with this group of medications

Gates PJ, Sabioni P, Copeland J, Le Foll B, Gowing L. Psychosocial interventions for cannabis use disorder. *Cochrane Database Syst Rev*. 2016;2016(5):Cd005336.

Compared to minimal treatment controls, psychosocial intervention was shown to reduce the frequency of cannabis use and the severity of dependence. Intensive intervention (based on cognitive behavioural therapy and motivational enhancement therapy) provided over more than four sessions had the most support for treatment of cannabis use disorder.

Other

Eibl JK, Gauthier G, Pellegrini D, et al. The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. *Drug Alcohol Depend*. 2017;176:133-138.

Patients treated via telemedicine were significantly more likely to be retained in therapy than patients treated in person. Telemedicine patients demonstrated a retention rate of 50% at one year, whereas in-person patients were retained at a rate of 39%. Mixed remote and in-person OAT also led to higher retention rates (47%) than in-person OAT

Weintraub E, Greenblatt AD, Chang J, Himelhoch S, Welsh C. Expanding access to buprenorphine treatment in rural areas with the use of telemedicine. *Am J Addict*. 2018;27(8):612-617.

This report describes the results of a retrospective chart review of 177 patients in a rural drug treatment center who were treated with buprenorphine through telemedicine. Retention in treatment was 98% at 1 week, 91% at 1 month, and 57% at 3 months. Of patients still engaged in treatment at 3 months, 86% had opioid-negative urine toxicology. Findings suggest that treatment with buprenorphine can be effectively delivered by telemedicine to patients with opioid use disorders in a rural drug treatment program.

Appendix 2: Resources for Treatment and Care Planning

The following guidance documents may be useful in care planning for individuals with substance use disorders who need to self-isolate, quarantine, or physically distance.

Risk Mitigation and Harm Reduction Prescribing Clinical Guidance

- [Risk Mitigation in the Context of Dual Public Health Emergencies](#) (BC Centre on Substance Use)
- [Safer Opioid Supply Programs: A Harm Reduction Informed Guiding Document for Primary Care Teams](#) (Hales, et al)
- [La pharmacothérapie de remplacement des substances psychoactives en contexte de la COVID-19 au Québec: guide clinique à l'intention des prescripteurs](#) (Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal)

CRISM Guidance

- [CRISM National Rapid Guidance: Supporting People Who Use Substances in Shelter Settings During the COVID-19 Pandemic](#)
- [CRISM National Rapid Guidance: Telemedicine Support for Addiction Services](#)
- [CRISM National Guideline for the Clinical Management of Opioid Use Disorder](#)
- [CRISM National Injectable Opioid Agonist Treatment Guideline](#)

COVID-19 Clinical Guidance

- [CAMH/META-PHI/OMA: COVID-19 Opioid Agonist Treatment Guidance](#)
- [BCCSU: COVID-19 Bulletin: Information for Opioid Agonist Treatment Prescribers and Pharmacists](#)

- [BCCSU: Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder](#)
- [BCCSU: COVID-19 Bulletin: Information For Health Care Providers Regarding Alcohol Use Disorder and Withdrawal Management](#)

Overdose Response Bulletins

- [BCCDC Information Sheet: COVID-19 Harm Reduction and Overdose Response](#)
- [VCH: COVID-19: Community Members Responding to an Overdose](#)
- [Toronto Public Health: COVID-19 Guidelines for Harm Reduction Outreach and Community Overdose Response](#)
- [Alberta Health Services: Harm Reduction and COVID-19—Guidance Document for Community Services Providers](#)

Appendix 3: Online Substance Use Resources Listing

Below is a list of online resources on substance use. Please note that this is not an exhaustive list of resources

Resources for Patients

- [Anxiety Canada's free MindShift™ CBT app](#)
- [AA Online Intergroup](#)
- [NA Recovery](#)
- [SMART Recovery Program](#)
- [Community Addictions Peers Support Association \(CAPSA\)](#) and [Breaking Free Online](#)
- [Take Home Naloxone](#) and [Toward the Heart](#)
- [Canadian Addiction Counsellors Certification Federation](#)
- [CCSA Coping with Stress, Anxiety, and Substance Use](#)

Resources for Clinicians

- [CATIE – Canada's source for HIV and hepatitis C information](#)
- [British Columbia Centre on Substance Use: COVID-19](#)
- [Nova Scotia Health Authority \(NSHA\) Standard Operating Procedures for Opioid Use Disorder Treatment \(OUDT\) Programs](#)
- [Health Canada Subsection 56\(1\) Class Exemption FAQ](#)
- [Mental Health First Aid Canada](#)
- [Canadian Foundation for Healthcare Improvement \(CFHI\)](#)
- [CCSA Managing Stress, Anxiety, and Substance Use During COVID-19](#)

Guidance on oral and injectable OAT

- [Nova Scotia Department of Health and Wellness: Points to Guide Clinical Decision for OAT Prescribers](#)
- [College of Physicians and Surgeons of Newfoundland and Labrador - Opioid Agonist Treatment \(OAT\) Guidance during COVID-19](#)
- [Providence Health Care Nursing Practice Standard Dispensing Injectable Opioid Agonist Therapy to Client With or at Risk of COVID-19](#)
- [BCCSU Bulletin–COVID-19: Information for Opioid Agonist Treatment Prescribers and Pharmacists](#)
- [Draft Emergency Carry Agreement](#)
- [Lignes directrices, Le traitement du trouble lié à l'utilisation d'opioïde, version temporaire comprenant les mesures d'exception autorisées par santé Canada en lien avec la pandémie de la COVID-19.](#)

Harm Reduction Resources

- [Canadian Association of People Who Use Drugs \(CAPUD\)](#)
- [Canadian Drug Policy Coalition: COVID-19 Harm Reduction Resources](#)
- [International Network of People Who Used Drugs: COVID-19 Crisis: Harm Reduction Resources for People who Use Drugs](#)

Mental Health and Substance Use Resources

- [Centre for Addiction and Mental Health \(CAMH\): Mental Health and the COVID-19 Pandemic](#)
- [Narcotics Anonymous](#)
- [Taking Care of Your Mental Health \(COVID-19\)](#)
- [Wellness Together Canada: Mental Health and Substance Use Support](#)

Indigenous Communities

- [Assembly of First Nations: COVID-19](#)
- [First Nations Health Managers Association: COVID-19 Resources and Announcement](#)
- [First Peoples Wellness Circle: COVID-19 Resources page](#)
- [Thunderbird Partnership Foundation: Harm Reduction during COVID-19](#)

Appendix 4: Health Canada Safe Supply ToolKit

Health Canada has compiled a number of resources in an effort to provide clarity regarding the rules that apply for substance use disorder treatment or providing a pharmaceutical grade alternative to the toxic street supply in Canada, in the context of COVID-19. This includes:

- A regulatory pathways graphic;
- Frequently asked questions and answers related to the legislative and regulatory requirements for substance use disorder treatment/safer supply;
- A list of all relevant exemptions that have been issued under the Controlled Drugs and Substances Act;
- Formulary coverage under drug plans of medications used in substance use disorder treatment and as pharmaceutical grade alternatives to the illegal supply; and,
- Resources related to substance use disorder treatment and providing safer supply, both in general and during the COVID-19 pandemic.

The toolkit is available [here](#).

