

Interim guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: a national response

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Disclaimer: The Coronavirus (COVID-19) pandemic is an evolving situation. Health professionals should refer to the advice provided by the Australian Government Department of Health in the first instance.

Foreword

The COVID-19 pandemic is having disastrous effects upon individuals, health care systems and societies in Australia and elsewhere. Health services are having to adapt rapidly to the changing conditions for patients and health workers to prevent the spread of COVID-19, and to respond to individuals with (suspected) infection.

One part of the health care system that is greatly affected is the opioid treatment system – with over 50,000 patients receiving the opioid agonist medications methadone or buprenorphine for the treatment of opioid dependence in Australia. A national framework to the provision of opioid treatment is described in the National Guidelines for Medication Assisted Treatment of Opioid Dependence⁴, implemented through regulations and local guidance at jurisdictional (state and territory) levels, and delivered by thousands of medical, nursing, pharmacy, allied health and consumer workers across the nation, in public and private health settings.

This document aims to provide guidance to clinicians in how to adapt treatment during this major transition. It should be read alongside state and territory guidance issued in response to COVID-19, recognising that many jurisdictions are at different stages of response, and also that many of the communications from government authorities relate to regulatory or guideline changes, rather than focussing on aspects of clinical care. To the extent of any inconsistency, directions from Health departments in local jurisdictions take precedence over recommendations in this document.

The document has been developed rapidly, and brings together the experiences of clinicians (including addiction medicine specialists, addiction psychiatrists, nurses, pharmacists, general practitioners) with input from consumer groups from across the country. We expect that conditions related to the pandemic will change in coming weeks and months, and this guidance may need to be updated or enhanced as events unfold.



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⁴ Gowing, L., Ali, R., Dunlop, A, Farrell, M., and Lintzeris, N. 2014. *National Guidelines for Medication-Assisted Treatment of Opioid Dependence*. <https://www.health.gov.au/sites/default/files/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence.pdf>

A. Background

In 2019 over 50,000 Australians were in medication-assisted treatment of opioid dependence (MATOD) with methadone, buprenorphine (BPN) or buprenorphine-naloxone (BNX), prescribed by approximately 3000 prescribers and dispensed from some 3,000 dosing points around the country (NOPSAD 2019).

The emergence of COVID-19 raises considerable challenges in the delivery of opioid agonist treatment (OAT), including:

- The need for effective social distancing and social isolation to protect patients, the treatment workforce, and people in contact with patients and health workers.
- The increased vulnerability of our patient population, with an ageing patient population, over-representation of Aboriginal and/or Torres Strait Islander people, and high rates of underlying respiratory and cardiac disease, and conditions that may cause immunosuppression.
- An ageing workforce, particularly amongst prescribing medical practitioners
- In many parts of the nation, limited public sector supports are available to respond to reduced services in the private sector (e.g. closure of community pharmacies or general practice).
- Increased demand for opioid treatment arising through reductions in access to other alcohol and other drugs (AoD) treatment services (e.g. hospital admissions, residential rehabilitation programs, self-help groups), and increased release of patients into the community from prison.
- The incompatibility of a model of care predicated on daily supervised dosing of methadone and sublingual buprenorphine, with the principles of social distancing and social isolation
- The requirement to perform a higher proportion of consults by telehealth, with limited use of clinical information available from physical examination and investigations such as urine drug screens.
- The potential increase in demand for treatment arising from disruption of drug distribution networks and street opioid drug availability

The key principle underlying these guidelines is to reduce the spread of COVID-19 amongst OAT patients and treatment providers by reducing social exposure and attendance of OAT patients to health services.

Some jurisdictional authorities have released statements that suspend routine clinical guidance regarding the provision of take-away doses and related clinical procedures (see Resources section for details). This document is to be read alongside state jurisdictional guidance provided on the delivery of OAT and to support clinicians to continue to provide this essential service.

Whilst this document focusses on issues specific to OAT, all clinical services should ensure they are adhering to recommendations regarding safe clinical service delivery – including routine screening, social distancing (e.g. seating in waiting rooms), hand hygiene (e.g. providing hand sanitiser stations for patients), use of PPE and infection control procedures for COVID-19 as per Department of Health requirements (see <https://www.safetyandquality.gov.au/coronavirus-COVID-19>).

It is also important to maintain effective communication with patients and other service providers to ensure that they are kept abreast of possible changes to service provision. Consider ways of linking patients to reliable sources of information such as state and federal government websites.

B. Initiating Opioid Agonist Treatment in Patients entering Treatment

General principles of assessing and initiating OAT are described in national and state guidelines. For patients initiating OAT – either from illicit or pharmaceutical opioids, consideration needs to be given to patient choice and usual informed consent procedures, and to practical considerations in delivering treatment.

Additional factors may need to be considered when planning treatment under COVID19 conditions. Initiating treatment with sublingual buprenorphine requires less daily monitoring and a shorter period of supervised dosing than methadone. Patients can generally stabilise on effective doses of sublingual buprenorphine within 3 to 5 days, enabling alternate day dosing and/or take away doses (TADs) to be provided within several days of commencing treatment – if using sublingual buprenorphine, or transfer to depot buprenorphine (with either Buvidal® or Sublocade®) after one week. In contrast, patients commencing methadone generally require closer clinical monitoring and a longer period of supervised dosing. Most methadone patients optimise outcomes on doses of between 60 to 80mg, which routinely takes several weeks to achieve, potentially delaying their eligibility for TADs.

Consideration should also be given to initiating patients directly onto depot buprenorphine using Buvidal Weekly® for patients using opioids other than methadone, obviating the need for supervised dosing immediately.

Under COVID-19 pandemic conditions, it is recognised that some services may not be able to initiate methadone treatment for some patients due to their inability to regularly monitor the patient and/or provide supervised doses, and if this is the case clinicians should consider referring the patient to a specialist service with greater capacity for regular monitoring.

Some patients may drop out of OAT during the course of the pandemic, and all efforts should be made to re-engage patients into care. Re-initiation of treatment may provide opportunities for some patients and clinicians to reconsider the current range of OAT options.

C. Reduce supervised dosing and increase availability of Take Away Doses (TADs)

C.1 How many TADs should we be providing to contain the spread of COVID-19?

Mathematical modelling of the spread of COVID-19 allows us to estimate the level of reduced social exposure required to contain the spread of COVID-19 amongst our patient population.

- Reduced social exposure by at least 75% (compatible with the average patient attending 1.75 days per week for dosing) suggests 1 infected patient will result in 2.5 infected people after 30 days
- Reduced social exposure by at 50% (compatible with the average patient attending for dosing 3 or 4 days per week) suggests 1 infected patient will result in 15 infected people after 30 days
- No reductions in social exposure (compatible with 6 or 7 days a week attendance for dosing) suggests 1 infected patient will result in 406 infected people after 30 days

Australian COVID-19 projections⁵ suggest that COVID-19 spread in the community cannot be contained without effective case isolation, requiring at least 70% of people practice effective social distancing – compatible with twice a week attendance for dosing on average).

The containment of COVID-19 in the OAT population requires that most patients attend dosing sites such as community pharmacies and clinics on no more than one or two occasions per week, and to receive five or six take-away doses (TADs) each week. Reduced attendance for dosing reduces the risk of possible exposure of patients to COVID-19 and increases the patients' ability to be able to self-isolate as per the recommendations from the Australian government.

In order to assist clinicians in determining TAD provision, Table 1 provides recommendations for categorising patients into high, moderate or low risk groups. These recommendations provide general guidance, and for more specific guidance please see state/territory specific guidelines where available.

Particular consideration needs to be given to enhancing the safety of patients (and those in contact with them) who have conditions that make them particularly vulnerable to severe illness associated

⁵ Chang SL, Harding N, Zachreson C, Cliff OM, Prokopenko M. Modelling transmission and control of the COVID-19 pandemic in Australia. arXiv:2003.10218 [q-bio.PE]. Downloaded <https://arxiv.org/pdf/2003.10218.pdf>. Accessed 2nd April

with SARS-CoV-2 infection, and who should be considered a high priority for enhanced social isolation, including:

- Age >60 years (>50 years if Aboriginal)
- Chronic pulmonary disease
- Hypertension, ischaemic heart disease, renal disease, cirrhosis
- Diabetes, immunosuppressed (e.g. chemotherapy for malignancy), HIV

A risk benefit analysis should occur for all patients considering their individual risks of COVID-19 and the need for supervised dosing of methadone / SL buprenorphine.

There may be circumstances where higher numbers of TADs are clinically indicated. For example, a patient in isolation (quarantine conditions) assessed as low risk with few active risk factors, may be suitable for more extended (e.g. 14 days) methadone TADs to accommodate the period of isolation. Prescribers are recommended to seek a second opinion and clearly document their decision making, including risk mitigation strategies.

Table 1. Guide to supervised and unsupervised dosing conditions for OAT during COVID-19 pandemic

Category	Risk factors for unsupervised dosing of OAT medications	Examples of dosing regimens
High	<ul style="list-style-type: none"> ▪ <u>Patients commencing methadone or SL buprenorphine treatment</u> (from illicit opioids, heroin or prescription opioids) 	Supervised dosing for at least 14 days methadone, 3-7 days SL BNX. Consider direct induction to depot buprenorphine without need for SL dosing.
	<ul style="list-style-type: none"> ▪ <u>High risk use of other sedative drugs</u>, including regular intravenous opioids, heavy and regular alcohol use; binge use of high dose benzodiazepines (BZDs) (stable daily low dose is not a barrier to TADs) or other sedatives ▪ <u>Recent overdose (e.g. past month)</u> ▪ <u>Recent history unstable dosing</u>: including multiple 'no dose due to intoxication' and/or multiple missed doses in past month ▪ <u>No safe storage of TADs</u> (e.g. homeless, domestic violence concerns, severe cognitive impairment) ▪ <u>Other high risk factors</u> (e.g. suicidal ideation, severe cognitive impairment, recent history of aberrant use of TADs, child safety issues) 	Continue supervised dosing with no TADs, unless pharmacy closed and/or no other dosing options available.
Moderate	<ul style="list-style-type: none"> ▪ <u>Regular use</u> (e.g. more than 1-2 times per week on average) <u>in past month of sedative drugs</u> (e.g. BZDs, alcohol, other opioids) ▪ <u>History of frequent missed doses or intoxicated presentations</u> (in past 3 months, but not in last 4 weeks) ▪ <u>Concerns regarding storage and use of TADs</u>: (e.g. mild-moderate cognitive impairment, living with other people who use drugs) 	<p>Methadone: intermittent TAD frequency (e.g. 2+3 or 2+2 per week).</p> <p>SL BNX 1+ 6TAD per week</p>

	<ul style="list-style-type: none"> ▪ <u>Concerns regarding mental and/or physical health</u> (cognitive impairment, severe liver disease, use of other sedating medications) ▪ <u>Other risk factors</u>: specify 	
Low	<ul style="list-style-type: none"> ▪ no significant use of sedative drugs, no recent injecting ▪ no significant physical, cognitive or mental health concerns ▪ no significant social concerns (housing, child safety, DV) re: safety of TADs ▪ good attendance for dosing with no recent history of aberrant use of medication (diversion, injecting TADs) 	<p><i>Methadone</i>: 1 supervised dose & 6 TADs per week;</p> <p><i>SL BNX</i>: 13 TADs per fortnight, or 27 TADs per 4 weeks.</p>

In regard to mono-buprenorphine products (e.g. Subutex®), given its greater propensity for injecting than buprenorphine-naloxone products by people not in buprenorphine treatment, it is recommended that TAD of Subutex be provided as per the guidance for methadone.

C.2 Conducting risk assessments for supervised and unsupervised dosing conditions

The provision of TADs as part of OAT involves an assessment of risks and implementation of risk mitigation strategies, and is described in the National Medication Assisted Treatment for Opioid Dependence (MATOD) Guidance (2014) – with more details provided in NSW Guidelines for Opioid Treatment Programs. Whilst the number of TADs recommended in the present context is outside historical approaches to supervised and unsupervised dosing conditions in Australia, the general principles of risk assessment and mitigation strategies remain.

Clinicians should conduct a risk assessment for TAD provision and examine risk mitigation strategies (see below). In summary, a risk assessment examines:

- recent patient substance use, with an emphasis upon high risk use of sedatives, injecting practices, and recent overdoses
- health (including mental health, mobility issues)
- social conditions (including child protection, domestic violence, housing stability)
- recent dosing history (e.g. missed doses, intoxicated presentations).

One approach to conducting risk assessment is to use checklists, or structured instruments such as the Australian Treatment Outcomes Profile (ATOP, which is also validated for telephone administration), and to review the patient's recent dosing history (consult with pharmacist or dosing point). The ATOP can be administered by members of a multidisciplinary team (MDT), reducing

burden on prescribers, is validated for administration by telephone and provides documentation of the risk assessment in medical records.

C.3 Mitigate risks associated with increased access to unsupervised doses.

The use of TADs in ways other than prescribed can be associated with overdose and death, particularly if TADs are used by people without significant opioid tolerance – such as children and other people not enrolled in OAT. The risks are particularly great with methadone, where even use of a single low dose of methadone (e.g. 10 or 20mg) can cause death.

To mitigate these risks:

- **Patient and carer education:** All patients receiving TADs are to be counselled regarding the need for safe use of TADs (including risks of using of TADs in ways other than prescribed), and the need for safe storage of TADs (particularly where children are involved). Patients should not disclose their access to TADs with others who may pressure the patient to give up (or sell) their TADs. Patients should be aware that misplaced or misused TADs will not be replaced under any circumstances. Vomited doses will not be replaced unless there are special circumstances such as pregnancy. Patients should confirm that they have received this information. Standardised written agreements can be of assistance.
- **Access to Take Home Naloxone:** All patients receiving TADs should have supplies of take home naloxone in the event of a suspected opioid overdose. Naloxone supplies are available across Australia, with Nyxoid (intranasal naloxone, 2 doses of 1.8mg) and Prenoxad (intramuscular naloxone 5 doses of 0.4mg) available as PBS subsidised prescriptions (see Lintzeris and Wilson. Take home naloxone to prevent opioid overdose. *Medicine Today* 2020; 21(4):400-4).
- **Engage carers in overseeing use of medications where possible.** Where there may be concerns regarding the safe storage and use of TADs, engage suitable carers where appropriate to assist in overseeing the use of medications, under conditions of patient consent. This may include partners, parents, carers, or institutional workers (e.g. boarding houses). Consideration should be given to the potential risk to the patient of engaging some carers, such as in domestic violence situations, substance use in carers, and ‘co-dependent’ relationships.
- **Regularly review patient conditions and use of medications.** Patients receiving an increased number of TADs should be reviewed by telephone within the first 14 days and regularly (e.g. monthly) thereafter. Review should include assessment of substance use, current physical and psychological health, and changes to social situation; all of which can be completed through use of an ATOP. Safe storage and use of TADs, recent overdose or use of take home naloxone should also be assessed and the need for resupply of naloxone established. There should be regular

communication with carers and dosing sites (e.g. pharmacists). Pharmacists and other dosing staff play an important role in reviewing and assessing patients (e.g. assessing for signs of intoxication, regular attendance, missed doses) and providing relevant information to the prescriber. Services should be prepared to upgrade or downgrade access to TADs according to patient progress.

- **Document decision making regarding TADs and risk mitigation strategies.** Ensure risk assessments (e.g. using ATOPs), and communications with patients, carers and other service providers (e.g. pharmacists, multidisciplinary teams) are documented, and can be readily accessed by other clinicians in the event that the treating prescriber is not available (e.g. due to illness).
- **Communicate with staff at dosing point.** Dosing staff (nurses or pharmacists) should receive communication about the need for increased TADs, including forwarding these guidelines to support provision of doses that might be outside current state/territory policies or guidelines, where these documents have not yet been updated to reflect the changing needs with the COVID-19 pandemic
- **Confer with a colleague if in doubt.** Whilst treatment decisions will often be clear for many patients, do not hesitate to consult a colleague or specialist if you are uncertain regarding appropriate course of management. This may be members of a multidisciplinary team, other prescribers in your practice, local specialists in your area, or state based advisory services (see Appendices for details).
- **Inform other key service providers of changes in treatment conditions, including the number of TADs in writing.** This may include the patient's general practitioner (when different to the OAT prescriber), pain, mental health or other specialist. Consider appropriate communication with housing workers for patients in supported accommodation and requiring storage of TADs.

C.4 Ensuring continuity of treatment for patients in quarantine or isolation.

Over coming weeks and months, some patients on OAT may be required to self-isolate or enter quarantine. This will prevent them leaving their place of residence to attend clinics or pharmacies for dosing. The conditions which require people to self-isolate or enter quarantine change as the pandemic evolves. Refer to state/territory guidelines for the most up to date criteria, and liaise with local Public Health Units to confirm any quarantine conditions and test results for individual patients.

Alternative strategies for ensuring continuity of treatment are required. Two broad approaches are recommended:

Supply of TADs to a responsible carer from the dosing site

In many circumstances, a reliable carer can be authorised by the prescribing doctor to collect dispensed TADs from a clinic or pharmacy for a specific patient. The minimum number of TADs should be provided to maintain treatment continuity and comply with isolation requirements.

The principles for authorising collection by a carer include:

- Patient has independently nominated carer in a one-on-one consult without the nominee present
- Consent has been provided and documented in clinical notes and communicated with dosing points
- The nominated carer does not have a history of aberrant medication behaviours such as diverting medications; nor are there any concerns regarding domestic violence or interpersonal relationship issues
- Identification of the carer is required by the dosing point
- Instructions regarding the safe storage and use of TADs are provided to the carer, and the carer signs that they have understood these conditions, and signs for the collection of the TADs
- The carer should be trained in the use of and have access to take home naloxone

Delivery of TADs to place of residence of isolated patient.

Dispensed TADs can be safely supplied to an isolated patient where no responsible carer is able to collect medications. Each service needs to establish local procedures. In general,

- medications should ideally be supplied by at least two staff members – with at least one being a health professional such as a pharmacist, nurse or doctor who can also briefly clinically assess the patient. Community pharmacies may have existing mechanisms for home delivery of medications that can be utilised for this purpose, and routine procedures should be followed.
- medications should only be delivered to the nominated person (patient or authorised carer if patient unable to come to door)
- safe procedures for delivering medications are required, including safe distancing from patients, and documentation that does not require contact with the patient (e.g. photographs of patient accepting TADs rather than patient signatures)

Ceasing social isolation or quarantine

The criteria for ceasing isolation will change as the pandemic evolves. Refer to state/territory guidelines for the most up to date criteria, and liaise with local Public Health Units for individual patients.

D. Consider the use of depot buprenorphine treatment, minimising attendance for dosing

Recent months have seen the introduction of depot buprenorphine formulations in Australia, although there is considerable variation between services across the country regarding the capacity to deliver this treatment option for patients. Buvidal® Weekly or Monthly subcutaneous injections have been available on PBS since September 2019 (although only more recently in community settings), and Sublocade® has recently become available for routine clinical use. Each jurisdiction has conditions regarding which medical and nursing practitioners can prescribe depot buprenorphine formulations, and readers are directed to local health departments for details. Detailed guidance regarding the use of depot buprenorphine is available through local health departments.

There are potential advantages in using depot buprenorphine products in the COVID-19 context. These arise from the reduced need for regular attendance for dosing, with the majority of patients attending only once a month for dosing, reduced need for risk assessments and reduced staff and/or patient costs associated with preparation of TADs. Clinicians and patients should jointly consider the relative merits of this treatment approach within the current context. Recommendations regarding the use of depot buprenorphine in response to COVID-19 are described below.

D.1 Induction onto depot buprenorphine treatment

- Patients transferring from SL buprenorphine could transfer directly to Buvidal® Monthly or Sublocade® products rather than Buvidal® Weekly to minimise attendance requirements.
- Patients entering treatment (e.g. from heroin or prescription opioid use) can commence directly with Buvidal® Weekly for 1 (or 2) doses, and then transfer to Monthly injections. Whilst outside of the Australian product label, this approach is recommended in various state guidelines (e.g. NSW). Note 7 days of prior treatment with sublingual buprenorphine (at least 8mg daily) is required before initiating Sublocade treatment
- Consult with a medical addiction specialist for management of patients transferring from methadone.

D.2. Maintenance on depot buprenorphine treatment

Wherever possible, maintain patients on Buvidal® Monthly or Sublocade® to reduce attendances. Continued Buvidal® Weekly may be prioritised for patients with other medical or social concerns who require more frequent clinical reviews (e.g. high risk pregnancy with poor antenatal care).

D.3. Providing depot buprenorphine treatment to patients who are in quarantine or have strict isolation requirements.

Some patients may be due to receive their depot during a period of isolation or quarantine. Consideration should be given as to whether administration can be delayed until after isolation is

complete, as many patients will not experience withdrawal effects for 6 to 8 weeks after their last monthly depot injection. If this is not possible (e.g. withdrawal discomfort) then the patient should receive supplemental doses of Suboxone (as TADs) until they can resume depot treatment. See jurisdictional guidance on depot buprenorphine treatment regarding supplemental Suboxone doses for patients in depot buprenorphine treatment.

D.4. Administering subcutaneous injections in patients in depot buprenorphine treatment.

Whilst depot buprenorphine treatment enables infrequent dosing and contact with patients, it nevertheless requires contact with patients at monthly intervals. Depot injections should be able to be administered safely using appropriate infection control procedures. Ensure screening of the patient for any recent symptoms of fever, respiratory symptoms or contact with known COVID-19 cases, using recommended screening approaches.

Administration of depot injection should be implemented in a consultation room, with hand washing (or equivalent) facilities, with the aim of limiting the amount of contact with the patient to less than 15 minutes if possible. Under normal circumstances (where there are no indications that the patient is, or is suspected to be COVID-19 positive), standard infection control procedures should be adequate.

E. Increased use of telehealth approaches to clinical consultation with OAT patients

Many of the activities that are undertaken during routine clinical reviews and monitoring can be undertaken effectively through telephone and telehealth consultations that include visual contact with patients. Clinicians are encouraged to transition and utilise telehealth approaches for regular monitoring and reviews of patients whilst recognising the potential gaps in clinical assessment arising from lack of physical examination and/or investigation (urine drug screens). Telehealth can include standard telephone and special telehealth software with appropriate confidentiality protections.

F. Reduced biological monitoring during pandemic

OAT traditionally involves regular use of biological approaches to monitoring of substance use – including regular urine drug screens (UDS), breathalyser assessments at dosing for patients suspected of intoxication with alcohol. The risks of undertaking biological monitoring need to be considered, with clear indications for undertaking any UDS or breathalyser test at this time. Routine infection control procedures for collecting and handling UDS should be adequate to prevent possible COVID-19 transmission.

G. MATOD for COVID-19 positive hospitalised patients

In general, OAT should be continued according to current local procedures. Hospital staff are responsible for confirming the current dose and the timing of the most recent dose including the provision of any TADs, in writing by fax or email, before any OAT dose is administered in hospital. If this cannot occur (e.g. community dosing point closed after hours), then consultation with a suitable medical addiction specialist is required, as per local procedure. The medication should be prescribed promptly as there are often delays in obtaining stock into the ward. If there are concerns regarding the patient's presentation (e.g. patient appears sedated), the dose should be withheld until clinically reviewed and consultation undertaken with appropriate specialists.

In patients experiencing respiratory distress or failure related to COVID-19 (e.g. Acute Respiratory Distress Syndrome), consultation with an addiction medicine specialist is recommended prior to making any changes to OAT, where practicable. In general, opioid doses may need to be reduced – particularly with methadone (buprenorphine has less respiratory depressant effect). OAT should not be permanently ceased unless absolutely clinically necessary, even in the unconscious patient, as withdrawal can still occur. If the patient is on depot buprenorphine treatment and is due to have their depot during the admission, then administration should proceed as scheduled unless it is clinically contraindicated or unavailable. In this situation consider temporarily transferring the patient onto SL BNX until able to access the depot. Consultation with an addiction medicine specialist is recommended.

Discharge planning in conjunction with the patient's OAT prescriber should occur early in the admission to ensure ongoing provision of OAT in the community on discharge recognising that it may not be possible for the patient to be reviewed by their prescriber for a number of days, or attend for daily dosing. Hospital staff should liaise with community prescribers and dosing sites to ensure continuity of care for patients.

H. Other supports for OAT patients

Many patients in OAT may require additional supports during periods of social isolation, including for issues arising from mental health (loneliness, depression, anxiety), homelessness, under-employment, financial problems, domestic violence, and care of others, including children and the elderly. Many may struggle to access routine services or health care for other problems. Liaise with local and internet based services (e.g. online counselling, state/territory peer-based drug user groups) to assist clients during this time (see Resources).

Access to sterile injecting equipment during this time may be limited and people who are required to remain in isolation or quarantine should not leave their place of residence to access injecting

equipment. Liaise with local Needle Syringe Programs who may provide access to sterile injecting equipment for those who are unable to access it.

I. Management of disruption of community dosing point or prescriber due to COVID-19

If a community prescriber is temporarily unable to continue to provide OAT services, then they should endeavour to appoint a locum prescriber until such time that they are able to return to work. They should discuss this with their regulatory prescribing body and ensure that the patients are informed of the alternative arrangements as a matter of priority. If prescribers are unable to identify a suitable locum then further advice can be sought through the National Hotline on 1800 250 015 or through state specific AoD information services. (See Resources).

If a community pharmacy is unable to continue to dispense OAT (e.g. due to illness in pharmacy staff) then alternative dosing points should be identified by the prescriber, in consultation with the patient. Community pharmacies should proactively identify contingency plans if this prospect arises, with clear communication to patients, prescribers and state/territory Health Departments.

J. Resources

1. *State and territory guidelines for opioid treatment during COVID-19*
2. *State and territory government services*
3. *Harm reduction information during COVID-19*
4. *Mental health supports for clients during COVID-19*

1. State and territory guidelines for opioid treatment during COVID-19

At the time of publication, the following states and territories have published guidance on opioid treatment during COVID-19.

New South Wales

- Notification of temporary changes in policy – Opioid Treatment Program
- Guidance for AOD Services about COVID-19
<https://www.health.nsw.gov.au/aod/Pages/COVID-19-aod-services-response.aspx>
- Suggested action plan for Community Pharmacy OTP dosing points
<https://www.health.nsw.gov.au/aod/Pages/COVID-19-action-plan-pharmacies.aspx>

Victoria

- Changed medicine regulatory requirements for health practitioners during COVID-19 pandemic
<https://www2.health.vic.gov.au/public-health/drugs-and-poisons>

2. State and territory Government Services

New South Wales

- NSW Health Guidance for AOD services about COVID-19
<https://www.health.nsw.gov.au/aod/Pages/covid19-aod-services-response.aspx>
- Alcohol and Drug Information Service
02 9361 8000 Metro; 1800 422 599 Rural
- Methadone Advice and Conciliation Service (MACS)
1800 642 428 (9:30am-5pm Monday to Friday)
- Authorisation of prescribing and dispensing
NSW: Pharmaceutical Services Branch, NSW
Phone (02) 9859 5165, E-mail pharmserv@doh.health.nsw.gov.au
Web: <http://www0.health.nsw.gov.au/csqq/ps/index.asp>

Victoria

- Directline
1800 888 236 Metro; 1800 858 584 Rural
- Drugs & Poisons Controls in Victoria including links to Victorian policy on maintenance pharmacotherapy for opioid dependence and training programs for prescribers and dispensers

<http://www.health.vic.gov.au/dpcs/pharm.htm>

For health practitioners: 1300 364 545

- Drug and Alcohol Clinical Advisory Service
1800 812 804; <http://www.dacas.org.au/>
- Victorian Pharmacotherapy Area-based Networks - COVID-19 Response
<https://www.pabn.org.au/COVID-19/>
- Victorian Alcohol and Drug Association (VAADA) webpage on COVID-19 (coronavirus) sector updates includes information and links about MATOD Service Continuity:
<https://www.vaada.org.au/covid-19-sector-updates/#1586223520625-39f309e3-8ccd>
- PAMS – Pharmacotherapy Advocacy, Mediation, Support – for consumers and their direct service providers: 1800 443 844 and <https://www.hrvic.org.au/pams>

Queensland

- Alcohol and Drug Information Service
07 3236 2414 Brisbane; 1800 177 833 Statewide
- Drugs of Dependence Unit
(07) 3328 9890; <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/drugs-of-dependence>

Western Australia

- Alcohol and Drug Information Service
08 9442 5000 Metro; 1800 198 024 Rural
- Parent Drug Information Service
08 9442 5050 Metropolitan; 1800 653 203 Rural
- Clinical Advisory Service
08 9442 5042 Metro; 1800 688 847 Rural
- WA Health Opioid Substitution Treatment: https://ww2.health.wa.gov.au/Articles/N_R/Opioid-substitution-treatment

South Australia

- Alcohol and Drug Information Service
08 8363 8618 Metro; 1300 131 340 Statewide
- Information on prescribing drugs of dependence
<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/medicines+and+drugs/prescribing+medicines+regulations+and+requirements/prescribing+drugs+of+dependence>
- Drugs of Dependence Unit
1300 652 584; email drugsofdependenceunit@health.sa.gov.au
- Drug and Alcohol Services South Australia
www.dassa.sa.gov.au (Note: Website is in the process of being migrated to www.sahealth.sa.gov.au)
Clinical Advisory Service (08) 8363 8633

Tasmania

- Alcohol and Drug Information Service
03 6233 6722 Metro; 1800 811 994 Statewide

- Department of Health and Human Services, Pharmaceutical Branch
Licence Application Forms (03) 6233 2064;
http://www.dhhs.tas.gov.au/psbtas/licence_application_forms

Northern Territory

- Alcohol and Drug Information Service
08 8922 8399 Darwin; 08 8951 7580 Alice Springs; 1800 131 350 Statewide

Australian Capital Territory

- Alcohol and Drug Information Service
02 6207 9977
- Authorisation of prescribing and dispensing
<http://health.act.gov.au/health-services/population-health/health-protection-service/pharmaceutical-services/controlled-medicines>
Phone (02) 6205 0998
- Canberra Alliance for Harm Minimisation (CAHMA) (02) 6253 3643 and
<https://www.cahma.org.au/dosing.html>

3. Harm reduction information during COVID-19

- NUAA
 - <https://www.nuaa.org.au/COVID-19-resources>
- Harm Reduction Victoria
 - Some Helpful Tips for People on Pharmacotherapy
 - <https://www.hrvic.org.au/COVID-19-methadone-suboxone-treatmen>
- Penington Institute
 - <https://www.penington.org.au/frontline-support/resources/COVID-19/>

4. Mental health supports for clients during COVID-19

- Head to Health
 - <https://headtohealth.gov.au/COVID-19-support/COVID-19>
- Beyond Blue
 - <https://www.beyondblue.org.au/the-facts/looking-after-your-mental-health-during-the-coronavirus-outbreak>
- SA Health
 - <https://www.sahealth.sa.gov.au/wps/wcm/connect/f584ac43-db54-44d5-a5df-82c6415f18d7/Mental+Health+and+COVID-19+Fact+Sheet+-+Information+for+the+community.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f584ac43-db54-44d5-a5df-82c6415f18d7-n4VnH0>
- Phoenix Australia
 - <https://www.phoenixaustralia.org/coronavirus-COVID-19/>