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Guidance

COVID-19: guidance for commissioners and providers of services for people who use drugs or alcohol

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This guidance applies to England only. There is different advice for Scotland (https://www.gov.scot/publications/coronavirus-covid-19-stay-at-home-guidance/), Wales (https://gov.wales/covid-19-alert-levels) and Northern Ireland (https://www.nidirect.gov.uk/articles/coronavirus-covid-19-regulations-guidance-what-restrictions-mean-you).

Please note: this guidance is of a general nature and should be treated as a guide, and in the event of any conflict between any applicable legislation (including the health and safety legislation) and this guidance, the applicable legislation shall prevail.

This guidance will help commissioners, managers and staff to minimise risk from coronavirus (COVID-19) in drug and alcohol services in England, including services for young people.

Guidance for other UK nations is available from Scottish Drugs Forum (http://www.sdf.org.uk/covid-19-guidance/) and the Welsh Government (https://gov.wales/coronavirus-covid-19-guidance-for-substance-misuse-and-homelessness-services-html).

What you need to know

It is important that drug and alcohol services remain open and operating as they protect vulnerable people who are at greater risk from COVID-19 and help reduce the burden on other healthcare services. People who misuse or are dependent on drugs and alcohol may be at increased risk of becoming infected, and infecting others, with COVID-19. They may also be more vulnerable to poor health outcomes due to underlying physical and mental health conditions, which may have worsened due to the pandemic.

Where emergency response plans have been put in place for services during the pandemic they should be continuously reviewed to check that local and individual treatment needs are being met, that there are no unintended consequences and that opportunities are being taken to improve and to provide high quality treatment to service users.

Where interventions such as detoxification, supervised consumption, and blood-borne virus (BBV) testing and treatment were curtailed or reduced because of the initial impact of COVID-19, services should be reintroducing or expanding them in line with national clinical guidance and guidance on making services COVID-secure.

While services should continue to keep avoidable face-to-face contact to a minimum, they should not seek to limit interventions that require face-to-face contact (such as the above). Biological drug testing and breathalysers can be used with appropriate personal protective equipment (PPE) (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe) and following manufacturers' precautions and instructions for cleaning.

Services should follow up-to-date guidance for infection prevention and control (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control), including: hand-washing, surface-cleaning, appropriate use of PPE, isolation and sending symptomatic staff home.

Arrangements for prescribing and dispensing of medicines used in drug and alcohol treatment were previously changed to take account of service and pharmacy closures, staff unavailability, patients having to maintain social distance or self-isolate (including the clinically extremely vulnerable), and the need to reduce the spread of COVID-19. These arrangements should continue to be reviewed. Where

safe to do so they should comply with national drug (https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management) and alcohol (https://www.nice.org.uk/guidance/cg115) clinical guidance, and meet service user needs, while continuing to protect staff and service users.

Measures to reduce drug and alcohol-related harm, such as needle and syringe programmes (NSP), take-home naloxone, thiamine, e-cigarettes, and advice on gradual reduction of alcohol consumption, should all be increased where possible.

Usual expectations on services for local monitoring and reporting, contract and performance management and contract re-tendering can all be scaled back to enable services to focus on delivery.

People who are homeless or rough sleeping may be at particular risk of poorer outcomes of COVID-19 compared to the general population. Many in this population are dependent on drugs or alcohol or both. The Joint Committee on Vaccination and Immunisation (JCVI) advises that local vaccination teams prioritise people experiencing homelessness and rough sleeping, alongside delivery of the programme to priority group 6. Where local authorities are continuing to provide access to COVID-related emergency accommodation, the operational advice (https://www.local.gov.uk/sites/default/files/documents/Alcohol%20drugs%20and%20nicotine%20in%20emergency%20accommodation.pdf) shared with commissioners and providers of drug and alcohol treatment services remains relevant to support the response.

Symptoms

The most important symptoms of COVID-19 are recent onset of any of the following:

- a new continuous cough
- a high temperature
- a loss of, or change in, your normal sense of taste or smell (anosmia)

For most people, COVID-19 will be a mild illness. However, if someone has any of the symptoms above they should immediately self-isolate at home (https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection#ending-isolation), and should arrange to have a test to see if they have COVID-19. Visit NHS.UK (https://www.nhs.uk/conditions/coronavirus-covid-19/testing-for-coronavirus/) to arrange a test or contact NHS 119 via telephone if internet access is not available.

The symptoms of COVID-19 may be confused with withdrawal symptoms in a dependent drug or alcohol user. Anyone showing symptoms that could be COVID-19 should be tested and treated according to the results.

Protection against infection

Services should assess the risks (https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff) of COVID-19 to their staff and service users, and put appropriate measures in place to minimise the risks to them.

Everyone accessing services should wash their hands frequently, for 20 seconds with soap and water, and should have access to hand sanitising gels. Depending on their patient contact and activities, staff may need to be supplied with PPE and trained in how to use it. Services should regularly check the PPE guidance (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/new-nhs-england-operational-guidance) to ensure that they are following the latest advice.

Service considerations

Service managers should assess the risks (https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/supporting-staff-health-and-safety) of COVID-19 to their staff and service users, and put appropriate measures in place.

Face-to-face contact should be avoided where it would be unsafe or unnecessary; telephone or other remote or virtual support should be provided as an alternative. Where face-to-face contact is necessary (for example for vulnerable service users, those undergoing healthcare interventions, people starting treatment and community alcohol detoxification services), social distancing of 2 metres should be maintained where possible, with mitigations such as face coverings used in situations where it is not possible. Staff should wear personal protective equipment (PPE) (https://www.gov.uk/government/publications/covid-19-guidance-on-services-for-people-experiencing-rough-sleeping/covid-19-guidance-for-commissioners-and-providers-of-hostel-services-for-people-experiencing-homelessness-and-rough-sleeping#ppe) where social distancing would be inappropriate or difficult to maintain, and in line with a risk assessment.

There is further information available for people who are clinically extremely vulnerable (https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19).

Telephone one-to-one contacts should be maintained wherever possible with those not coming into services. Keeping in touch by phone generally will be important but especially for those without internet access.

Mutual aid and other support groups that can meet digitally should continue to do so.

Support groups that have to be delivered in person can continue with up to 15 participants where formally organised to provide mutual aid, therapy or any other form of support. Support groups must be organised by a business, charity or public body and must not take place in a private home. All participants should maintain social distancing.

Where a group includes someone covered by an exception (for example, someone who is working or volunteering), they are not generally counted as part of the gatherings limit.

Groups should continue to protect anyone who is clinically extremely vulnerable (https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19): if they need to attend, everyone present should be rigorous with distancing and other precautions. Anyone attending meetings will need to socially distance (https://www.gov.uk/government/publications/how-to-stop-the-spread-of-coronavirus-covid-19/how-to-stop-the-spread-of-coronavirus-covid-19) from anyone they do not live with or who is not in their support bubble.

Providers on CQC and NDTMS lists can have all their COVID-19 PPE needs met through the government portal (https://www.gov.uk/guidance/ppe-portal-how-to-order-covid-19-personal-protective-equipment). Urgent supplies can still be sought from the National Supply Disruption Response line on 0800 915 9964.

Advice on cleaning and waste is available for clinical settings and for non-clinical settings.

In advance of a face-to-face appointment, staff should contact the service user to check whether they have had symptoms (https://www.gov.uk/government/publications/covid-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol/covid-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol/#symptoms) of COVID-19 in the previous 10 days, or have been asked to self-isolate by NHS Test and Trace, or travelled abroad recently. If they have, they will need to remain in self-isolation for at least 10 days from when their symptoms started, or as directed by NHS Test and Trace. Service users who have travelled abroad should follow the guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-how-to-self-isolate-when-you-travel-to-the-uk/coronavirus-covid-19-how-to-self-isolate-when-you-travel-to-the-uk) on travelling to the UK. If a service user develops symptoms of COVID-19 in a residential drug or alcohol service, they should follow current advice (https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes).

People who have tested positive for COVID-19 will be asked to cooperate with NHS Test and Trace to identify their close contacts, who will usually then be asked to self-isolate.

Services should keep a temporary record of their staff shift patterns for 21 days and assist NHS Test and Trace with requests for that data if needed. This could help contain clusters or outbreaks.

Where staff are using the Test and Trace app (https://www.nhsprofessionals.nhs.uk/COVID-19/covid-19-app), they can use the ‘pause’ contact tracing function on the app when they are providing direct care within a COVID-secure environment and wearing appropriate PPE in line with existing guidance. The app can be paused during the donning of PPE at the start of work and restarted after the doffing of PPE.

Supporting compliance with recommended measures

Drug and alcohol users who are at higher risk of COVID-19 may need additional support to follow the recommended measures to protect themselves and others (https://www.gov.uk/government/publications/how-to-stop-the-spread-of-coronavirus-covid-19).

Commissioners, service managers and staff need to consider contingency plans for situations such as:

- reduced or interrupted supply of medicines, or access to medicines when pharmacies are closed
- reduced access to, or interrupted supply of, illicit drugs or alcohol
- resulting increased demand on services and a possible increase in crime and aggressive behaviour
- greater vulnerability to the effects of COVID-19 because of reduced immunity from poor health, drug and alcohol use, or medication for other conditions
- heightened risk of non-compliance with social distancing and other measures intended to mitigate the risk of transmission of COVID-19
- risk of exacerbation of breathing impairment from COVID-19 due to use of drugs such as opioids, benzodiazepines and pregabalin, and alcohol
- increased risk of domestic abuse and violence as people spend more time at home or self-isolate in the house and may be unable to obtain drugs and alcohol
- increased risk of harm to children whose parents or carers use drugs or alcohol, due to increased time together if children are not at school

Contingency plans should include ensuring that sufficient, rapid-access treatment capacity is available if people look for withdrawal support or substitute prescribing as an alternative to using illicit drugs or alcohol.

National guidance on clinical management of drug misuse and dependence (https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management) and NICE guidance on harmful drinking and alcohol dependence (https://www.nice.org.uk/guidance/cg115) should be used when developing these contingency plans.

Services should aim where possible to provide a full range of harm reduction, healthcare, treatment and recovery support for people who use (or have stopped using) drugs and alcohol. This support will be both digital and face-to-face. Alternative supply routes for NSP and naloxone may have been developed.

Service providers should consider a range of routes and mechanisms to provide equitable support, delivery of services and supplies to those who might be disadvantaged or exposed to inequalities, for example those without a phone, internet access or a stable postal address.

There may be an increased demand and need for detoxification, including inpatient, and for residential rehabilitation, and access to these services should be supported in line with clinical guidelines and where it is safe to do so.

Children and families

If staff discover a service user is living with children, or see that a service user with children is now struggling to cope, they should consider whether the family would benefit from further support from their local Early Help service, community food banks and other resources.

For children whose usual protective factors (such as attending school or being cared for by older relatives) have been removed, staff should consider whether a child meets any safeguarding criteria (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) and refer to children's social care services where necessary. There is guidance on how to support families in the home (https://ihv.org.uk/news-and-views/news/ihv%20-launches-covid-19-professional-advice-for-health-visiting/).

Children may be expected to take on inappropriate caring roles in the pandemic. A referral to children's social care services is then appropriate so that the child's needs can be properly assessed and appropriate emotional and practical support offered.

Schools should be able to identify staff who are available to listen to children and young people or who can signpost them to help. Staff could include the mental health lead, heads of years, school counsellors and school nurses. If children prefer to talk to someone outside the school or college they can be referred to organisations such as Childline (https://www.childline.org.uk/), The Mix (https://www.themix.org.uk/), the Youth Wellbeing Directory (https://www.annafreud.org/on-my-mind/youth-wellbeing/) the National Association for Children of Alcoholics (Nacoa) (https://www.nacoa.org.uk/), as well as local services.

Family coping mechanisms and situations can change. Practitioners should monitor potential safeguarding issues, including the wellbeing of children who are caring for vulnerable adults, through their usual contacts with service users. Staff supervision should include discussions about safeguarding and support from managers or safeguarding leads. Referrals to children's social care services or adult safeguarding services need to be made if a child or vulnerable adult is at risk of neglect or abuse. This includes parents being too sick to care for their children or children witnessing domestic abuse and violence.

Mental health and wellbeing

Service users struggling with their mental health should, if possible, be assessed and supported by their service in line with PHE guidance on people with co-occurring mental health, and alcohol and drug use conditions (https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services). Others struggling can be directed to the NHS mental health and wellbeing advice (https://www.nhs.uk/conditions/stress-anxiety-depression/) website for self-assessment, audio guides and tools that they can use. There are also digital offers for common mental illness (https://www.nhs.uk/apps-library/category/mental-health/).

If they are still struggling after being signposted to NHS mental health and wellbeing advice, they should contact NHS 111 online (https://111.nhs.uk/). If they have no internet access, they should call NHS 111.

Read the guidance for the public on the mental health and wellbeing aspects of COVID-19 (https://www.gov.uk/government/publications/covid-19-guidance-for-the-public-on-mental-health-and-wellbeing/guidance-for-the-public-on-the-mental-health-and-wellbeing-aspects-of-coronavirus-covid-19) for further information and support.

Opioid substitution treatment (OST)

After assessing and mitigating risks to patients and their households, drug treatment services should continue to review the actions below in consultation with their commissioners, community pharmacies and the Local Pharmaceutical Committee (LPC).

There is extensive guidance for pharmacists in relation to the COVID-19 pandemic (https://psnc.org.uk/the-healthcare-landscape/covid19/). Commissioners and providers should work in collaboration with pharmacies and LPCs to accommodate the requirements of people who need to access OST, bearing in mind that many pharmacies will be opening with more restricted hours and some may have to shut temporarily. Pharmacies have arranged to partner with other pharmacies to provide some cover.

Treatment providers, pharmacies, commissioners and LPCs should be as flexible as possible, within the legal framework and national clinical guidance (https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management), to support the safe delivery of OST. Pharmacies will need to work closely with their local drug and alcohol services, commissioners, and NHS England and NHS Improvement controlled drug accountable officers to support this.

Steps to consider

The following steps should be considered within the operational and clinical governance of the treatment service with clinical oversight and decision-making from lead clinicians, adjusted for local circumstances and individual needs.

1. Clinical decisions regarding pick-up and supervision requirements should be made in broadly the same manner as before the pandemic and in line with the clinical guidelines. Exceptions to this are when patients are self-isolating or shielding, or in areas where the availability of supervised consumption at pharmacies is severely limited. Prescribing arrangements for all patients on OST should be reviewed as normal, and future arrangements should be based on repeat individual assessments. For patients who were transferred off supervised consumption in the initial phase of the pandemic response, these assessments should include how they responded to any relaxation in

pick-up and supervision requirements, confirmation (not just self-report) that they are not using on top, and visual evidence that they are thriving.

2. It is possible that supervised consumption will not be available within a reasonable distance of some patients for whom it is clinically appropriate, due to pharmacy closure or restrictions on hours. Consideration should then be given to mitigations that reduce risk, such as hostel staff holding medicines, pharmacy delivery of medicines if available, or lock boxes. Commissioners should seek to address any issues with continuing lack of provision of supervised consumption.
3. People who have been advised to self-isolate should be asked to nominate an individual to collect the dispensed medicine on their behalf. The nominated individual will usually need the written instruction of the patient, but community pharmacies will have received guidance about acceptable alternatives during the pandemic. If the patient cannot nominate someone, a staff member may, with agreed authorisation, be able to collect and deliver the medicines. Delivery can also be requested from the pharmacy. These options will generally be subject to local capacity and agreements, though anyone who has been asked to self-isolate by NHS Test and Trace is eligible for free medicines delivery.
4. Consideration might be given to implementing a system whereby a small group of nominated individuals are authorised to collect medicines on patients' behalf, if it can be done safely.
5. Detoxifications and dose reductions that were deferred, and people encouraged to maintain stability during the initial period of uncertainty, should now be reviewed.
6. If unsupervised dosing is needed from the outset for people newly assessed for treatment, then there are safety advantages to buprenorphine compared to methadone. Patients with good support and stable circumstances can be provided with a multi-day supply of buprenorphine. Patients being initiated on to methadone treatment should generally collect their medicine daily from the pharmacy, followed by take-home doses when appropriate.
7. People restarting OST who were taking methadone in the recent past may be able to return to methadone after careful assessment but usually starting at a lower dose, titrated up again and with daily pick-up to start if available.
8. If only remote assessments are possible and drug testing is not possible, it may be possible to proceed with buprenorphine titration in known opioid-dependent patients as above, based on an adequate history.
9. The above approach is unlikely to be suitable for methadone, where drug testing will usually be needed unless there is a clear history of opioid use and tolerance in a known patient, with evidence that opioids have been used in the last 24 hours.
10. Inform GPs of the changes in prescribing and amounts of OST medicines stored in homes where there are children and inform local children's social care services if they are involved or if there are any concerns.
11. Work with health and justice to provide rapid access to treatment for released prisoners and other detainees, and to understand their treatment protocols to ensure safe continuity of care (https://www.england.nhs.uk/coronavirus/publication/advice-for-health-and-justice-healthcare-teams-on-medicines-and-pharmacy-services-continuity/).

12. Work with police to provide treatment for those taken into custody (https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr227.pdf), ensuring medicine supplies taken home are not duplicated.
13. Work with local services supporting isolation for people experiencing rough sleeping to ensure continuity of care.
14. Mitigation of risk should include:
    - provision of take-home naloxone (naloxone should be ordered only in quantities needed to support additional provision, and supplies should be rapidly distributed, not stockpiled)
    - safe storage boxes, especially if there are children in the home (but bearing in mind that boxes have limited capacity that may not be enough for liquid medicines if take-home doses have been increased)
    - information sharing with children's social care and other relevant professionals (see guidance list)
    - verbal and written harm reduction advice
    - regular communication between the patient and service, enabled by the provision of mobile phones or credit where required

Depot buprenorphine

Injectable depot buprenorphine is available as Buvidal, a one-week or one-month injection. NICE published an evidence summary (https://www.nice.org.uk/advice/es19/evidence) on Buvidal in 2019 and it is available for use by community or prison drug treatment services in England and Wales. However, only a few services in England are using it (often in pilot schemes) and English prisons are not recommending its use. Further independent implementation guidance from the NHS England Regional Medicines Optimisation Committee (RMOC) is awaited.

Depot buprenorphine generally requires less frequent face-to-face contact with patients than oral OST medicines as it does not require regular pick-up or supervised consumption. However, it does demand some hands-on contact for administering the weekly or monthly injection. The demands of depot buprenorphine made it unlikely to be a widely-used option in the early stages of responding to the pandemic. As restrictions are eased, services adapt to social distancing and have sufficient supplies of PPE, and the role of supervised consumption is reassessed, commissioners and providers in England will need to decide whether and how depot buprenorphine is used.

Continuity of care between UK nations

The Welsh Government has agreed to support the use of Buvidal in the community and in prisons during the COVID-19 pandemic. All-male Welsh prisons have introduced it as an option to be offered to prisoners in the last 2 months of their sentences and due to be released, with the expectation they will continue to receive it in the community. Advice for health and justice healthcare teams on medicines and pharmacy services continuity (https://www.england.nhs.uk/coronavirus/publication/advice-for-health-and-justice-healthcare-teams-on-medicines-and-pharmacy-services-continuity/) is available.

Scottish prisons (https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2020/05/coronavirus-covid-19-clinical-guidance-on-the-use-of-buvidal-in-prisons/documents/guidance-for-the-use-of-buvidal-for-opiate-substitution-treatment-in-prisons-during-the-covid-19-pandemic/guidance-for-the-use-of-buvidal-for-opiate-substitution-treatment-in-prisons-during-the-covid-19-

pandemic/govscot%3Adocument/Protocol%2Bfor%2Buse%2Bof%2Bbuvidal%2Bin%2Bprisons%2B2.pdf) are also using Buvidal, for serving prisoners as well as those coming up for release. As transfer between Scottish and English prisons, and Scottish prisoners being released to England, are not common, there is currently no continuity guidance.

Needle and syringe programmes (NSPs)

Ensuring there is an adequate supply of injecting equipment might involve:

- increasing the amount of stock held by NSPs
- allowing service users to take more equipment or providing packs with more equipment in them
- more outreach and peer-to-peer supply with appropriate social distancing
- allowing others to collect equipment for someone or for general peer-to-peer distribution
- considering other options such as posting supplies

Any changes in pharmacy-based NSPs will need to be agreed with the pharmacies involved.

It may also be necessary, as a last resort, to provide advice on cleaning injecting equipment. A short film (http://www.harmreductionworks.org.uk/2_films/cleaning_syringes.html) providing more information on syringe cleaning is available.

Drug detoxification

Given the pressures on the NHS and other services, especially acute beds and GPs, it may have been necessary to defer drug detoxifications, especially those that require in-patient treatment. In-patient facilities are returning in most areas, though possibly with reduced capacity or specific infection control conditions, so consideration should be given to supporting community detoxification.

Alcohol harm reduction

If services are temporarily unable to offer community, inpatient or residential detoxification, competent staff should give advice on alcohol harm reduction. This advice should cover the risks associated with stopping drinking suddenly, and – for people with mild or moderate dependence for whom reducing drinking is assessed as appropriate – the need for slow reduction of daily consumption.

PHE has published separate guidance (https://www.gov.uk/government/publications/covid-19-information-on-stopping-drinking-for-people-dependent-on-alcohol) to support dependent drinkers to cut down without medication. The advice is also relevant for family members and friends supporting the person.

There are risks in abruptly reducing or stopping drinking in people who are severely alcohol dependent. Those who are at particularly high risk of developing withdrawal complications, and are more likely to require emergency medical treatment if they reduce or stop drinking abruptly, include:

- service users drinking over 30 units of alcohol per day
- those who have pre-existing epilepsy
- those who have a history of seizures or delirium tremens during alcohol withdrawal

These groups, who will often have poor health, should be prioritised for support by specialist alcohol treatment services during the COVID-19 pandemic.

Following clinical assessment, it will usually be appropriate to advise that these high-risk groups continue drinking for the time being, preferably at a steady level with no large binges or days without any alcohol. This will help to avoid severe complications of withdrawal. They should do this until it is possible to arrange appropriate medically supervised detoxification.

It is important to monitor the ongoing physical and mental health of service users and arrange appropriate care where needed.

Subject to the availability of sufficient supplies, service users who are dependent on alcohol can be given a one-month supply of thiamine on their first presentation at a treatment service and the prescription can be repeated where clinically indicated.

Community alcohol detoxification

Where sufficient competent staff are available, services will want to deliver community alcohol detoxification in response to demand. They will need to follow current guidance on how to stop the spread of COVID-19 (https://www.gov.uk/government/publications/how-to-stop-the-spread-of-coronavirus-covid-19/how-to-stop-the-spread-of-coronavirus-covid-19), and use recommended PPE, and appropriate precautions when, for example, breathalysing patients, taking blood samples, or administering parenteral thiamine.

Decisions about the provision of community alcohol detoxification should be made on a case-by-case basis, following clinical assessment. Suitability for community detoxification and risk assessment should be based on severity of dependence and complexity of additional needs, in accordance with NICE guideline CG115 (https://www.nice.org.uk/guidance/cg115). If the exceptional circumstances of the pandemic make it impossible to adhere fully to this NICE guideline, it should be followed as closely as possible.

Service users with mild to moderate dependence

People with mild to moderate dependence, without additional needs or risk factors, will usually be suitable for community detoxification. Services should offer face-to-face assessment and face-to-face monitoring at least every 2 days during community detoxification wherever this can be carried out safely.

If the exceptional circumstances of the COVID-19 pandemic make it impossible to fully adhere to NICE guidelines when delivering community detox, and delaying detox could cause harm, it may be possible to make the following modifications. For those with mild to moderate dependence, based on a face-to-face assessment by a competent clinician, a suitable detoxification regimen using a prescription of a recommended benzodiazepine could be issued. The service user could then be monitored daily through telephone conversations or video calls. Remote monitoring is not recommended in NICE guidelines as normal clinical practice, but it may be the safest or only option to prevent severe complications in the exceptional circumstances posed by the pandemic.

The dose of benzodiazepine should be tailored to the level of severity of alcohol dependence as recommended by NICE guideline CG115 (https://www.nice.org.uk/guidance/cg115). Service users and carers should be warned of the signs of severe alcohol withdrawal and advised to seek urgent medical care should they occur. Wherever possible, medication should be dispensed and delivered (or collected) every 2 days in line with NICE guidance. For service users living alone, community detoxification should only be offered in exceptional circumstances, following an assessment of relative risks and benefits.

Due to the increased clinical risks associated with remote monitoring of community alcohol detoxification all providers need to satisfy themselves that the clinical protocols they use are safe and appropriate.

Service users with severe dependence or complex needs

Those with severe dependence or complex needs will usually require residential or inpatient detoxification and should generally be advised to continue drinking steadily until they can access this. If the exceptional circumstances of the pandemic make it impossible for a service user to access inpatient detoxification, and they urgently need to stop drinking, they should receive a face-to-face assessment and should be monitored by a competent clinical team with involvement of senior clinicians.

If a decision, based on assessment, is made to offer community detoxification, the service user is likely to need a high level of face-to-face observation and tailored medication. Service users and carers should be warned of the signs of severe alcohol withdrawal and advised to seek urgent medical care should they occur.

Community detoxification is not recommended in NICE guidelines as normal clinical practice for severe dependence (drinking over 30 units of alcohol a day) or complex needs, but in some cases, it may be the safest or only option to prevent severe complications in the exceptional circumstances posed by the pandemic.

Further information for all settings

Clinicians providing alcohol detoxification in any setting should be aware of the MHRA drug alert (https://www.gov.uk/drug-safety-update/benzodiazepines-and-opioids-reminder-of-risk-of-potentially-fatal-respiratory-depression) about the potentially fatal respiratory depression caused by benzodiazepines and opioids. They should consider how it might relate to infection with COVID-19. This caution in using benzodiazepines should be balanced against the risks of not adequately treating severe symptoms of acute alcohol withdrawal.

Services should be prepared for an increase in requests for advice and support from people who:

- are at risk of, or experiencing, alcohol withdrawal, and
- have been signposted from 111 or emergency departments, or
- have been discharged from hospital

Drug and alcohol services should work closely with the local services that are supporting isolation for people experiencing rough sleeping, to ensure continuity of care.

The Royal College of Psychiatrists has published guidance on managing people with alcohol problems (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/managing-individuals-with-alcohol-problems).

Those not in drug and alcohol treatment

People who use drugs and alcohol who are not in drug and alcohol treatment may also be at increased risk from COVID-19. They may also be more affected by changes in the supply of drugs and alcohol and the impact of COVID-19 safety measures.

If it can be supported, fast access to drug and alcohol treatment for these people will be important. It may also be necessary to consider the nature and requirements of drug and alcohol treatment for at least the duration of the COVID-19 pandemic; for example, reduced expectations of engagement and change, so that people are more willing to attend.

The supply of naloxone to those liable to use opioids, and of injecting equipment to those who inject drugs, should be a priority.

Additional considerations

Testing and treatment for hepatitis C

It may have been necessary for some providers to temporarily scale back testing for hepatitis C infection and referral to treatment for those testing positive. Patients already being treated for hepatitis C should have continued with treatment wherever possible. They should have been provided with a full, take-home course of medication if it could be managed without support.

Services should continue to review which service users have missed out on hepatitis C testing and these service users, as well as all new service users, should be offered testing and referral as soon as it can be done safely. Options for self and home testing, supported by peers, should be considered, and operational delivery networks (ODNs) will be able to advise.

Testing for HIV and vaccination for hepatitis B should also be resumed as soon as they can be done safely.

Liaise with local hospitals

Providers of drug and alcohol treatment services should liaise with their local hospitals to ensure they are aware that the symptoms of COVID-19 may be confused with withdrawal symptoms in a dependent drug or alcohol user. It is important that anyone taken to hospital and showing symptoms that could be either withdrawal or COVID-19 is managed as if they have COVID-19, unless and until test results show otherwise.

Introduce or increase e-cigarette or nicotine replacement therapy provision

Given the increased risks of respiratory harm in people who drink, use drugs and smoke tobacco (https://www.gov.uk/government/news/smokers-at-greater-risk-of-severe-respiratory-disease-from-covid-19), it may be appropriate to introduce or increase the provision of e-cigarettes or nicotine replacement therapy. This is especially important for those infected by COVID-19, but also generally to encourage service users to stop or cut down smoking. PHE has published advice for smokers and vapers (https://www.gov.uk/government/publications/covid-19-advice-for-smokers-and-vapers) on how to reduce the risk of contracting COVID-19, and how to access support to stop smoking and remain smoke-free.

Review contract management arrangements

In the initial response to the pandemic, to enable services to focus on delivering interventions to service users, commissioners may have scaled back their usual expectations on services for local monitoring and reporting, and contract management meetings. It will be for local agreement when and how regular management returns. Re-commissioning and re-tendering of standard services will likely need to be kept on hold for the duration of the COVID-19 pandemic. However, authorities may need to procure additional goods and services, and work with extreme urgency to respond to COVID-19. There is government advice on this in the procurement policy notes (https://www.gov.uk/government/collections/procurement-policy-notes#2020).

Sources of information for service users

Sources of information, advice and support for service users include:

- written and verbal advice on reducing harm
- telephone helplines including:
    - drinkline provides advice and support on 0300 123 1110. Call charges may apply
    - FRANK offers information and advice on drugs, and information on where to get help, on 0300 123 6600. Call charges may apply
    - the National Society for the Prevention of Cruelty to Children (NSPCC) helpline, if there are worries about a child or young person, on 0808 800 5000
    - the National Association for Children of Alcoholics (Nacoa), on 0800 358 3456
    - Childline, which provides advice for anyone under 19, on 0800 1111
- online help from websites including:
    - FRANK (https://www.talktofrank.com/), which offers information and advice on drugs and where to get help
    - Down Your Drink (https://www.downyourdrink.org.uk/), which provides interactive web-based support to help people to drink more safely
    - Nacoa (https://www.nacoa.org.uk/), which provides information, advice and support for anyone affected by a parent's drinking
    - Childline (https://www.childline.org.uk/)
- online access to mutual support including:
    - SMART Recovery (https://smartrecovery.org.uk/)
    - Alcoholics Anonymous (AA) (https://www.alcoholics-anonymous.org.uk/)
    - Narcotics Anonymous (NA) (https://online.ukna.org/)
    - Cocaine Anonymous (CA) (https://meetings.cocaineanonymous.org.uk/meetings/?tsml-type=ONLINE)
    - Marijuana Anonymous (http://www.marijuana-anonymous.org.uk/meetings.html)

There may be a need for additional information sharing during this time, and to protect information used by staff working from home. For advice on this, please consult the information governance guidance from NHSX (https://www.nhsx.nhs.uk/information-governance/guidance/).

Sector guidance

- Royal College of Psychiatrists – COVID-19: Working with vulnerable people (https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/covid-19-working-with-vulnerable-patients)
- European Monitoring Centre for Drugs and Drug Addiction (http://www.emcdda.europa.eu/publications/topic-overviews/covid-19-and-people-who-use-drugs)
- Drink and Drugs News (https://drinkanddrugsnews.com/coronavirus-advice/)
- Collective Voice (https://www.collectivevoice.org.uk/blog/treatment-and-recovery-services-and-covid-19/)
- Scottish Drugs Forum (http://www.sdf.org.uk/covid-19-guidance/)
- Society for the Study of Addiction (https://www.addiction-ssa.org/useful-coronavirus-covid-19-links-19-march-2020/)

- Homeless Link (https://www.homeless.org.uk/covid19-homelessness)
- Alcohol Change UK (https://alcoholchange.org.uk/help-and-support/get-help-now/coronavirus-information-and-advice-hub)

Guidance for pharmacists

- Pharmaceutical Services Negotiating Committee (https://psnc.org.uk/the-healthcare-landscape/covid19/)
- Royal Pharmaceutical Society (https://www.rpharms.com/coronavirus/)

Guidance for healthcare

- NHS guidance for people working in healthcare (https://www.england.nhs.uk/coronavirus/)
- GOV.UK collection of guidance for health professionals (https://www.gov.uk/government/collections/wuhan-novel-coronavirus)

Guidance for particular settings

- Adult social care guidance (https://www.gov.uk/government/collections/coronavirus-covid-19-social-care-guidance)
- Advice for health and justice healthcare teams on medicines and pharmacy services continuity (https://www.england.nhs.uk/coronavirus/publication/advice-for-health-and-justice-healthcare-teams-on-medicines-and-pharmacy-services-continuity/)

Guidance on children and young people

- The Children’s Commissioner (https://www.childrenscommissioner.gov.uk/coronavirus/)

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