Responding to COVID-19: Emerging Practices in Addiction Medicine in 17 Countries

Florian Scheibein1, M. J. Stowe2, Sidharth Arya3, Nirvana Morgan4, Tomohiro Shirasaka5, Paolo Grandinetti6, Noha Ahmed Saad7, Abhishek Ghosh8, Ramyadarshni Vadivel9, Woraphat Ratta-apha10, Sagun Ballav Pant11, Ramdas Ransing12, Rodrigo Ramalho13, Angelo Bruschi14, Tanay Maiti15, Anne Yee HA16, Mirjana Delic17, Shobhit Jain18, Eric Peyron19, Kristiana Siste20, Joy Onoria21, Saïd Boujraf22, Lisa Dannati23, Arnt Schellekens24 and Tanya Calvey25*

1 School of Health Sciences, Waterford Institute of Technology, Waterford, Ireland, 2 Department of Family Medicine, School of Medicine, Faculty of Health Sciences, University of Pretoria, Pretoria, South Africa, 3 State Drug Dependence Treatment Centre, Institute of Mental Health, Pt Bhagwat Dayal Sharma University of Health Sciences, Rohtak, India, 4 University of the Witwatersrand, Johannesburg, South Africa, 5 Department of Psychiatry, Teine Keijinkai Medical Center, Sapporo, Japan, 6 Addiction Services (SeRo), Department of Territorial Services, ASL Teramo, Teramo, Italy, 7 Department of Psychiatry, Ain Shams University, Cairo, Egypt, 8 Drug Deaddiction and Treatment Centre, Postgraduate Institute of Medical Education and Research, Chandigarh, India, 9 Waikato District Health Board, Waikato, New Zealand, 10 Faculty of Medicine Siriraj Hospital, Mahidol University, Salaya, Thailand, 11 Department of Psychiatry and Mental Health, Institute of Medicine, Tribhuvan University, Kathmandu, Nepal, 12 Department of Psychiatry, BKL Walawalkar Rural Medical College, Ratnagiri, India, 13 Department of Social and Community Health, School of Population Health, The University of Auckland, Auckland, New Zealand, 14 Department of Mental Health, ASL Viterbo, Viterbo, Italy, 15 Department of Psychiatry, All India Institute of Medical Sciences (AIIMS), New Delhi, India, 16 Department of Psychological Medicine, University Malaya Centre of Addiction Sciences (UMCAS), Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia, 17 Center for Treatment of Drug Addiction, University Psychiatric Clinic Ljubljana, Ljubljana, Slovenia, 18 Department of Psychiatry, Heritage Institute of Medical Sciences (HIMS), Varanasi, India, 19 AddiPsy, Lyon, France, 20 Department of Psychiatry, Faculty of Medicine Universitas Indonesia-Ciptomangunkusumo Hospital, Jakarta, Indonesia, 21 Department of Psychiatry, College of Health Sciences, Makerere University, Kampala, Uganda, 22 Faculty of Medicine and Pharmacy, Sidi Mohamed Ben Abdellah University of Fez, Fes, Morocco, 23 Department of Psychiatry and Mental Health, Faculty of Health Sciences, University of Cape Town, Cape Town, South Africa, 24 Radboud University Medical Centre, Nijmegen, Netherlands, 25 Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

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INTRODUCTION

Following the classification of the Coronavirus disease (COVID-19) as a pandemic by the World Health Organization (WHO), countries were encouraged to implement urgent and aggressive actions to change the course of the disease spread while also protecting the physical and mental health and well-being of all people. The challenges and solutions of providing prevention, treatment, and care for those affected with issues related to substance use and addictive behaviors are still being discussed by the global community. Several international documents have been developed for service providers and public health professionals working in the field of addiction medicine in the context of the pandemic (1–3), however, less is known about country-level responses. In the current paper we, as individual members of the Network of Early Career Professionals working in Addiction Medicine (NECPAM), discuss emerging country-level guidelines developed in the 6 months following the outbreak.

We identified a number of pertinent, country-level documents in the 17 countries represented here and we summarized country-level briefing notes, practice documents, guidelines, discussion
papers and other documents containing recommendations on prevention, harm reduction, treatment, and care for people who use drugs (PWUD). Documents were identified in 12 out of the 17 countries. These documents are summarized and charted in Table 1. Additionally, several documents were under development at the time of our exercise in the Netherlands, Slovenia, and Paraguay and have not been included in this work. No specific documents or intentions to develop any were identified in Egypt, Uganda, or South Africa. Below we provide a summary of the identified documents.

Documents developed in Indonesia (4), Italy (5), and Nepal (6) discuss the use of personal and protective equipment (PPE). Malaysian (7), Moroccan (8), New Zealand (9–11), and Australian (12) organizations published documents which outlined risk assessment and mitigation practices. Documents in India (13), Malaysia (7), and Thailand (14, 15) discussed reducing admission of patients. Documents in India (16), Indonesia (17), and Japan (18) outlined strategies for maintaining physical distance in clinics and Standard Operating Procedures (SOP) were developed for isolation units in Ireland (19).

Italian (20) and Thai (15) documents discussed reducing addiction services and limiting group meetings. Documents in France (21), India (13), Italy (20), Ireland (19), Japan (22), Malaysia (7), New Zealand (11), and Thailand (15) advocated for the increased use of telemedicine to address the reduction in services.

Documents published in India (23) and Thailand (24) addressed substance withdrawal. The Thai document included strategies for the management of alcohol withdrawal that may have occurred due to local restrictions on alcohol sales. In Japan (22), there were discussions regarding the potential increase in the use of the internet, gambling, gaming, and higher prevalence of drinking at home during the COVID-19 pandemic.

Documents in France (21), Japan (25), and Ireland (26) described emerging practices of expedited access to opioid agonist maintenance treatment (OAMT). Documents in Indonesia (26), India (23), Italy (20), Japan (25), Malaysia (7), Morocco (8), Nepal (6), and New Zealand (11) advocated for increased take-home doses (TADs) of OAMT. SOPs for buprenorphine-naloxone TADs in a hospital context have been developed in India (27) and documents in Indonesia (17), Nepal (6), Malaysia (7), and Italy (5) advocated for increased TADs of OAMT to 7 days, 14 days and 1 month, respectively. An Irish document (26) advocated for prescriptions for naloxone for all new OAMT patients and changes in the naloxone administration procedure (move toward intramuscular injection and chest compression in the absence of specialized equipment during opioid overdose interventions).

Guidelines, SOPs and recommendations in Nepal (6), Ireland (28, 29), and France (21), respectively, have also advocated for increased access to harm reduction services. In New Zealand, guidelines addressed practices of adopting a health equity/social determinant lens, developing culturally and trauma informed approaches, awareness, and education efforts, development of self-help resources and the inclusion of people with lived experience of substance use and gambling into the evaluation of interventions (10, 11).

**DISCUSSION**

A range of practices have been suggested at the country-level to deal with the challenges brought about by the ongoing pandemic. These include those around mitigating the spread of the coronavirus, managing the risks associated with lockdown policies and changing trends in substance use and addictive behaviors.

In order to limit the spread of COVID-19, guidance has been drawn up to limit in-person meetings, physical support meetings, and contact time with physicians. Guidance suggests that this be operationalised through shifting services online, increased availability of TADs of OAMT, increased duration of TADs and increased availability of naloxone and injecting equipment allocations. Protocols have also been drawn up for the operation of clinics and outreach services for patients in isolation.

Several potential negative effects associated with the pandemic and resulting lockdown procedures have been identified which may require service adaptions. These include increased risks of substance withdrawal (30), access to service issues and potential changes in trends related to gambling, gaming, and internet related disorders. Several guidance documents discuss meeting these challenges through increased access to TADs, expedited access to OAMT and increased availability of online-based self-help groups and other services (11, 17–30). The increased commitment to TADs, telemedicine and access to harm reduction supplies are likely to address several issues brought about by the pandemic for people who use opioids and/or inject drugs. However, few documents explicitly discuss the increased availability of harm reduction supplies (for example, naloxone and injecting equipment) and service adaptions for people who use non-opioid drugs and/or engage in addictive behaviors (such as gambling and gaming) continue to be neglected by most documents.

There are also concerns regarding the implementation of COVID-19-related policy documents as a recent global survey indicates that among 130 countries, 60% reported disruptions to mental health services for vulnerable people, 67% reported disruptions to counseling and psychotherapy, 35% reported disruptions to emergency interventions, and 30% reported disruptions to access for medications for mental, neurological, and substance use disorders (31). The combination of a reduction in the availability of services, increased reliance on telemedicine, physical distancing protocols, and travel restrictions may exacerbate underlying health inequities in terms of access to addiction services (31–34). This seems to disproportionately affect the most marginalized and socioeconomically disadvantaged patients (32) who may lack access to internet-enabled devices, sufficient internet, the necessary private spaces to engage in telemedicine and means of transport to services.

The lack of representation of country-level documents from the Americas, Eastern Europe, the Middle East, Africa, and other regions is a limitation of this paper. Future research should document emerging practices in additional regions and monitor and evaluate the implementation of country-level policies. Country-level documents may be useful as they may allow clinicians to adapt to their given local context. Such documents should consider best emerging practices as it relates.
## TABLE 1 | Country specific COVID-19 guidance documents for clinical practice in addiction medicine.

| Country          | Author                                                                 | Type                      | Topics                                                                                                                                                                                                                                                                                                                                 |
|------------------|------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| India            | AIIMS (All India institute of medical sciences, New Delhi)            | Guidelines                | • TADs of buprenorphine and methadone (bi weekly or alternate days)  
• Take home doses to be managed by “responsible adults”  
• Hospital SOP for buprenorphine-naloxone TADs  
• Warns of potentially increased incidence of AOD withdrawal and associated complications  
• Advocates for seven-day TADs  
• Advocates for physical distancing in OAMT clinic  
• Discusses supply/travel restrictions and human resource issues |
|                  | Basu D, Ghosh A, Subodh BN et al. Indian Psychiatric Society          | Position statement, guidelines | • Advocates for taking home doses to be managed by “responsible adults”  
• Warns of potentially increased incidence of AOD withdrawal and associated complications  
• Advocates for seven-day TADs  
• Advocates for physical distancing in OAMT clinic  
• Discusses supply/travel restrictions and human resource issues |
|                  | Indian Psychiatric Society and National Institute of Mental Health and NeuroSciences | Guidance document          | • Advocates for reducing admissions  
• Physical distancing guidelines  
• Tobacco use  
• Telemedicine for follow up  
• Discusses challenges associated with physical distancing in emergency case management |
| Indonesia        | Ministry of Health                                                     |                           | • Advocates for TADs  
• Increased use of telemedicine  
• Safety procedures including PPE |
| Ireland          | Health Service Executive                                               | Guidelines, guidance documents, SOPs | • Recommends expedited access to OAMT (using telemedicine where possible)  
• Increased TADs  
• Increased naloxone availability (all inducted patients to be offered prescription)  
• Changes in naloxone administration (preference for IM, chest compressions only unless specially trained and with special equipment)  
• Telemedicine for follow up  
• Details procedure for expedited emergency induction  
• Standard operating procedure for operating National Drug Treatment Center Pharmacy OAMT program  
• Outlines general procedures for operating NSPs  
• Supply management  
• Advocates for increased harm reduction  
• Discusses challenges associated with human resources  
• Recommendations for storage and handling of prescription medication  
• Recommendations for conducting addiction telemedicine consultations |
| Italy            | Federazione Italiana Operatori Dipartimenti e Servizi Dipendenze (FeDerSerD) | Guidance documents        | • Detailed hygiene practices  
• Reduction of services  
• Suspension of groups (unless physical distancing is possible)  
• Promotion of telehealth  
• TADs OAMT (1 month)  
• Reduction of urine testing  
• Care with breathalyzers  
• Guidelines for service delivery in prison  
• Increased availability of extended-release preparations |
| France           | Ministères des Solidarités et de la Santé                              | Recommendations            | • Advocates for easier access to OAMT and nicotine replacement therapies (NRTs)  
• Advocates for maintaining communication with patients using telemedicine and reserve in-person meetings for emergencies  
• Improved prescription renewal procedures |
| Japan            | Ministry of Health, Labor, and Welfare.                               | Policy                     | • Procedures for expedited emergency induction  
• Increased TADs  
• Physical distancing |
|                  | Japanese Medical Society of Alcohol and Addiction Studies             | Guidelines                 | • Warns of overuse of the internet, gambling, gaming and drinking at home |
|                  | The Japanese Society of Psychiatry and Neurology                      | Guideline                  | • Use of online-based self-help groups |
| Malaysia         | Ministry of Health                                                     | SOP Guidance document      | • Increased TADs  
• Mental health and psychosocial support in COVID-19:  
1) For general population  
2) For healthcare workers  
3) For team leaders in health facilities  
4) For care providers for children  
5) For older adults, care providers, people with underlying health conditions  
• COVID-19 Management Guideline for special settings, including prisons, lockup and detection camps |
to issues surrounding a wide range of substances, addictive behaviors, harm reduction, and health inequities exasperated by the pandemic and restrictions.

AUTHOR CONTRIBUTIONS

FS and TC developed the initial draft of the document. The commentary was then reviewed by MS and NM. All authors subsequently reviewed their sections and the overall document. All authors identified their own local documents or confirmed the lack of their existence.

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