Supporting people who use substances in shelter settings during the COVID-19 pandemic

NATIONAL RAPID GUIDANCE

VERSION 1 GUIDANCE DOCUMENT

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This publication is available in English. A French version will be available on the Canadian Research Initiative in Substance Misuse (CRISM)'s website on the week of June 22nd: https://crism.ca

Land Acknowledgement

We respectfully acknowledge that the work to complete this rapid guidance document was hosted on Treaty 6 territory, a traditional gathering place for diverse Indigenous peoples including the Cree, Blackfoot, Métis, Nakota Sioux, Iroquois, Dene, Ojibway/Saulteaux/Anishinaabe, Inuit, and many others.

About the Canadian Research Initiative in Substance Misuse

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

About this Document

This document is one of a series of six national guidance documents, rapidly developed by the CRISM network at the request of the Government of Canada. Collectively, the six documents address urgent needs of people who use substances, service providers, and decision makers in relation to the COVID-19 pandemic. The urgent nature of this work required rapid development and dissemination of this guidance. This, and the continuing evolution of the knowledge base regarding COVID-19, precluded CRISM from conducting a comprehensive review of the relevant literature. However, when available, scientific evidence is cited in support of the expert advice offered herein.

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

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

- Supporting People Who Use Substances in Shelter Settings During the COVID-19 Pandemic (this document)
- Telemedicine Support for Addiction Services

- Harm Reduction Worker Safety
- Recovery Environments
- Supporting People Who Use Substance in Acute Care Settings
- Strategies to Help Individuals Self-Isolate for People who use Drugs

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

Disclaimer for Health Care Providers

The recommendations in this guidance document represent the view of the National Operational Guidance Document Review Committee, arrived at after careful consideration of the available scientific evidence and external expert peer review. The application of the guidance contained in this document does not override the responsibility of health care professionals to make decisions appropriate to the needs, preferences, and values of an individual patient, in consultation with that patient (and their guardian[s] or family members, when appropriate), and, when appropriate, external experts (e.g., specialty consultation). When exercising clinical judgment in supervising drug consumption and caring for patients, health care professionals are expected to take this guidance document fully into account while upholding their duties to adhere to the fundamental principles and values of their relevant codes of ethics. Nothing in this guidance document should be interpreted in a way that would be inconsistent with compliance with those duties.

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care. This guidance document is not intended as a substitute for the advice or professional judgment of a health professional, nor is it intended to be the only approach to the management of a clinical problem. We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a local health care professional.

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Detailed Summary – Disclosure of Interests (DOI) for CRISM Rapid Response COVID-19 Shelter Guidance Document

In accordance with the Guidelines International Network's *Principles for Disclosure of Interests and Management of Conflicts* (1), authorship committee members and external reviewers were asked to disclose all sources and amounts of direct and indirect (i.e., research support) remuneration from industry, for-profit enterprises, and other entities that could potentially introduce real or perceived risk of bias. In addition, authorship committee members and external reviewers were asked to report indirect sources of bias, such as academic advancement, clinical revenue, and professional or public standing that could potentially influence interpretation of research evidence and formulation of recommendations.

1. Schünemann HJ, Al-Ansary LA, Forland F, et al. Guidelines international network: principles for disclosure of interests and management of conflicts in guidelines. Ann Intern Med. 2015;163(7):548-553.

Of 27 authorship committee members and external reviewers, 14 acknowledged potential direct conflicts of interest. Of the 14, only one (an external reviewer) provided paid consultation to private companies including Merck, Abbott, ViiV, Rickett-Benkiser, Gilead, BMS and Indivior. There were no authorship committee members or external reviewers with commercial interests. On review, potential conflicts of interest were not deemed to be of sufficient weight or relevance to warrant exclusion from the guidance committee.

Most (22, 81%) authorship committee members and external reviewers disclosed potential indirect sources of bias (e.g., specialization in addiction medicine, advisory board and committee membership, involvement with SCS programs, provincial substance use treatment programs, previous guideline development, research interests). Of these, 11 acknowledged that they have publicly stated support for SCS. In order to mitigate the risk of bias while maximizing the contributions of members in their respective areas of expertise, authorship committee members and external reviewers were reminded to consider any influential factors or sources of bias during the review process. Authors and reviewers contributed to review of sections related to their areas of expertise as well as the overarching guideline content to ensure that a broad range of clinical and academic specializations was adequately represented.

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ABBREVIATIONS

AED: Automated External Defibrillator

AGMP: Aerosol Generating Medical Procedure

AIDS: Acquired Immunodeficiency Syndrome

CBT: Cognitive-Behavioral Therapy

CIHR: Canadian Institutes of Health Research

COVID-19: Novel Coronavirus disease of 2019

CPR: Cardiopulmonary Resuscitation

CRISM: Canadian Research Institute in Substance Misuse

EMS: Emergency Medical Service

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

iOAT: Injectable Opioid Agonist Treatment

MAP: Managed Alcohol Programs

MET: Motivational Enhancement Therapy

NRT: Nicotine Replacement Therapy

OAT: Opioid Agonist Treatment

OPS: Overdose Prevention Sites

PPE: Personal Protective Equipment

PWLE: People With Lived and Living Experience

SCS: Supervised Consumption Services

SROM: Slow Release Oral Morphine

UPHNS: Urgent Public Health Need Site

1.0 Key points of the guidance document

- **The COVID-19 pandemic has compounded risks already posed by the overdose epidemic, and placed people who use substances and are experiencing homelessness or housing vulnerability at high risk of negative health outcomes including death.**
- **The purpose of this guidance document is to support organizations operating new or existing shelter settings to provide evidence-informed care for people who use substances during the COVID-19 pandemic in Canada.**
- **For shelters providing care to people who use substances during COVID-19, a pragmatic approach assumes that some level of drug and alcohol use will continue irrespective of formal or informal bans or criminal prohibitions.**
- **Under a harm reduction approach, modifying risks associated with unsafe substance use practices or settings takes precedence over enforcing abstinence, and residents are supported to access care based on self-determined needs and goals.**
- **Design and delivery of shelter services should incorporate perspectives of people with lived or living experience of substance use and homelessness or housing vulnerability.**
- **Integrating supervised illegal drug consumption services into shelter settings is feasible, and has the potential to reduce overdose-related mortality and other negative health outcomes.**
- **A variety of supervised consumption service models can be operated during COVID-19 through use of appropriate infection prevention and control measures and personal protective equipment.**
- **Supervised consumption services should regularly review infection prevention and control and personal protective equipment procedures to ensure they remain consistent with the latest public health guidance in their jurisdiction.**
- **Shelters should facilitate access to healthcare providers who are able to assist with substance use disorder treatment, withdrawal management, and substance use stabilization/risk mitigation.**

- **A variety of first- and second-line substance use disorder treatments are available to support shelter residents who wish to abstain from drugs and/or alcohol.**

- **Not all residents will accept or stabilize on evidence-based treatment options for their substance use disorders. In these cases, health care professionals should consider providing access to replacement medications for withdrawal and craving management, and to mitigate harms associated with ongoing procurement and use of substances from the illegal drug market.**

- **Managed alcohol programs (MAPs) are a promising option for supporting shelter residents whose pattern of alcohol consumption may place them at increased risk of harm during COVID-19.**

- **There are multiple possible avenues for shelter residents to receive their prescribed medications, including multi-day dispensing, pharmacy delivery, and on-site pharmacy services.**

- **Psychosocial interventions and supports should be routinely offered alone or in conjunction with prescribed medications or managed alcohol.**

- **Any resident receiving substance use disorder treatment, replacement pharmacotherapy, and/or managed alcohol should be assisted in achieving continuity of care following discharge from the shelter.**

2.0 Purpose and Scope

On March 11, 2020 the World Health Organization declared COVID-19, caused by a novel coronavirus, a pandemic, citing concern over alarming levels of spread and severity across the globe. People who are experiencing homelessness or housing vulnerability are particularly at risk of COVID-19 (1). In Canada, homelessness is defined as "the living situation of an individual or family who does not have stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it" (2), and incorporates people who do not have housing and those living in inadequate conditions. People experiencing homelessness often live in dense and overcrowded conditions and do not have access to the resources required to take protective measures against the virus, such as space to practice physical distancing and access to hygiene amenities, increasing their risk of infection (3). In addition to lacking housing that would facilitate adhering to infection prevention guidelines, people who are experiencing homelessness or housing vulnerability are also more likely to congregate with others to access essential services (e.g., drop-in services, government resources, pharmacies), use public transit, regularly travel long distances, and be subject to law enforcement and incarceration, further increasing their risk of exposure to COVID-19.

We know that lack of safe, stable housing increases the risk of a host of negative health outcomes, and COVID-19 is no exception. Populations experiencing homelessness or housing vulnerability have a higher prevalence of chronic disease and other comorbidities (e.g., respiratory problems and health conditions that compromise immunity) compared to the general population, making them more susceptible to severe outcomes associated with COVID-19 infection (4). Many jurisdictions are attempting to rapidly shelter people who are experiencing homelessness or housing vulnerability as part of a broader pandemic response, either by implementing new, or reconfiguring existing, shelter settings. These efforts should prioritize the health, safety, and human rights of people who are experiencing homelessness or housing vulnerability and support them in addressing their pre-existing health conditions when possible.

People who use substances and are experiencing homelessness or housing vulnerability represent a particularly at-risk subpopulation. Those reliant on a highly toxic illegal drug market are at high risk of overdose morbidity and mortality and other negative health outcomes (e.g., cellulitis, endocarditis, human immunodeficiency virus [HIV], hepatitis C virus [HCV]). Travel restrictions and border closures related to COVID-19 are causing new disruptions in the illegal drug supply (5). The health consequences of such disruptions are not fully known, but there is potential for increased risk of withdrawal or related complications (5). It is also possible that supply disruptions could lead to consumption of more dangerous substances or transition to riskier, but more efficient, routes of administration. A number of Canadian jurisdictions have reported spikes in overdose during COVID-19, however the extent to which these trends reflect changes to the illegal drug supply, versus the impacts of physical distancing,

isolation, stress and anxiety, or other underlying factors is not currently known (6–10). Disruptions in alcohol access for people with high risk drinking patterns and alcohol use disorders may also lead to serious medical complications, including alcohol withdrawal syndrome, seizures, and increased risk of significant harm or death.

The purpose of this guidance document is to support organizations operating new or existing shelter settings in providing evidence-informed care for people who use substances during the COVID-19 pandemic in Canada. Strategies discussed herein are intended to mitigate risks of overdose death, withdrawal, transmission of bloodborne infections, and other poor health outcomes while also supporting people to adhere to physical distancing and self-isolation requirements for preventing COVID-19 transmission. We define **shelter settings** to include existing day and overnight homeless shelters, as well as new temporary shelters implemented to support people experiencing homelessness or housing vulnerability during the COVID-19 pandemic. This document is thus intended to be relevant for shelters offering both congregate or separate accommodations for residents (e.g. hotel rooms, semi-private rooms) and incorporating varying degrees of medical support.

The guidance herein addresses the needs of two distinct subpopulations of people staying in shelters: [1] those accessing services who are asymptomatic, not under any public health directive to self-isolate and not undergoing any investigations related to COVID-19; and [2] those who are self-isolating after testing positive for COVID-19, having high-risk exposure to a contact with known COVID-19 infection, or are otherwise under a related investigation. Specifically, this document provides:

- An overview of the rationale for the need to support people who use substances and are experiencing homelessness or housing vulnerability during COVID-19.
- Guidance on how to obtain a legal exemption, implement, and operate a temporary supervised consumption service [also referred to as an Urgent Public Health Need Site (11)].
- Guidance on providing or facilitating access to a range of conventional first- and second-line substance use disorder treatments and recovery options.
- Guidance on risk mitigation strategies, such as replacement pharmacotherapy or managed alcohol programs, to support people with substance use disorders in emergency shelter settings when conventional treatments are not effective or appropriate.
- Advice for monitoring and evaluating the provision of these services.

Readers should note that this document does not address the provision of harm reduction supplies outside the context of a supervised consumption service. For more information on best practices for supply distribution, please see:

- Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Services to People who use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1; Working Group on Best Practice for Harm Reduction Programs in Canada (12).

- Best Practice Recommendations 2 for Canadian Harm Reduction Programs that Provide Service to People who use Drugs and are at Risk for HIV, HCV, and Other Harms; Working Group on Best Practice for Harm Reduction Programs in Canada (13).

2.1 DEVELOPMENT

This rapid guidance on supporting people who use substances in shelter settings was developed to provide urgent advice in the context of the COVID-19 pandemic. Members of the authorship committee developed this document based on expert knowledge, scientific evidence, and a review of documentation from public health authorities and other relevant organizations.

The urgent nature of this work required rapid development and dissemination of this guidance. This timeline and the continuing evolution of the knowledge base regarding COVID-19 precluded a comprehensive review of the relevant literature. However, where available, academic research is cited in support of the expert advice offered herein. The guidance provided in this document is subject to change as new information becomes available.

Readers should note that the intent of this document is to provide *general* guidance for supporting people who use substances in shelter settings across Canada rather than detailed procedural instructions for implementing supervised consumption services or prescribing pharmacotherapy. Implementation processes and regulations may vary by local, regional, or provincial/territorial jurisdiction. Readers should consult local public health and medical authorities for advice on navigating their own unique regulatory and policy environments, as necessary.

Note that a number of external organizations have produced relevant resources for supporting people who use substances in shelter settings. Where possible, we have linked to external documents or websites which may be useful for readers of this guidance; at the time of publication, all links were confirmed to be active.

2.2 INTENDED AUDIENCE

The target audience for this rapid guidance document includes both clinical and non-clinical staff organizing and delivering care to people accessing day, overnight, and/or medical isolation shelters during the COVID-19 pandemic. The guidance contained in this document may also be relevant for policymakers, public health authorities, groups representing people who use drugs and those in recovery, advocates, and other people working to prevent the spread of COVID-19, and protect the health and wellbeing of people who are experiencing homelessness or housing vulnerability.

2.3 GUIDING PRINCIPLES

This document is guided by the principles of harm reduction and engaging people with lived or living experience in the development and operation of services designed for people who use substances and are experiencing homelessness or housing vulnerability.

Harm reduction is an umbrella term for various policies and practices that aim to reduce harms associated with consuming substances without requiring a reduction in or abstinence from substance use. Substance use can occur along a continuum from beneficial to harmful, and people deserve non-judgmental care that supports their autonomy and dignity regardless of where they fall on that continuum. Under a harm reduction approach, modifying risks associated with unsafe drug use practices or settings takes precedence over enforcing abstinence (14,15), and people are supported to access health and social services (e.g. medical care, substance use treatment, counselling, housing, income support) based on self-determined needs and goals. Shelters or any organization adopting the interventions outlined in this document should endorse clear and well communicated harm reduction policies that embrace core international principles (16,17). Harm reduction training and education should be available to all staff and include a review of related principles and values, and opportunities to reflect on the broader social, legal, and policy context of substance use. If hiring new staff, look for applicants with values that align with harm reduction philosophy. This is essential to create a culture of harm reduction (18,19).

Engaging people with lived or living experience of substance use and homelessness or housing vulnerability in the design and delivery of services is essential to ensure that the services achieve their intended outcomes and meet the needs of their target population. While meaningfully engaging people with lived or living experience may be challenging in the context of the pandemic, operators should attempt to abide by the principle of 'nothing about us without us' as much as possible. Regional or national groups advocating for people who use substances can often facilitate contact with local people who use substances. When consulting or employing people with lived or living experience, it is important to ensure equitable compensation for expertise and labour (20). The following resources

provide more guidance on engaging people with lived or living experience:

- Having a Voice and Saving Lives; CRISM People with Lived Expertise of Drug Use (PWLE) National Working Group (21)
- Engaging People who use Drugs in Policy and Program Development: A Review of the Literature; Substance Abuse Treatment, Prevention, and Policy (22)
- "Nothing About Us Without Us" Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative; Canadian HIV/AIDS Legal Network (23)
- Peer Worker Involvement in Low-Threshold Supervised Consumption Facilities in the Context of an Overdose Epidemic in Vancouver, Canada; Social Science & Medicine (24)
- Peerology; Canadian AIDS Society (20)

2.4 BACKGROUND

Canada has a growing homelessness crisis. An estimated 35,000 people experienced homelessness each night in 2016 (25), and this number has likely increased since. People experiencing homelessness have a high prevalence of substance use disorders, but to date there have been only relatively small Canadian studies on the topic. Based on these, up to 82% of people who were experiencing homelessness qualified for a diagnosis of substance use disorder (26), defined as either drug use or alcohol use disorders. Other studies found lower prevalence, but in all studies, prevalence was multifold to that found in the general population (27,28). Amidst rising homelessness, Canada is also experiencing an overdose crisis.

Canada has seen an increase in overdose deaths since the 1990s (29), and the widespread contamination of the illegal drug supply has further intensified the crisis (30). The opioid-related overdose death rate reached 12.4 per 100,000 in 2018 (31,32). The most up-to-date national data suggests that the prevalence rate decreased to 10.3 per 100,000 in the first 9 months of 2019 (32). However, recent reports from a number of Canadian jurisdictions suggest that overdose deaths may be increasing during the pandemic (6–10). The ongoing overdose epidemic requires comprehensive public health and addiction treatment responses.

The outbreak of COVID-19 was declared a global pandemic by the World Health Organization on March 11, 2020 (33). The most common symptoms of this viral infection include fever and cough (34). In more severe cases, sepsis, respiratory failure, and heart failure can occur (34). COVID-19 is believed

to spread mainly through respiratory droplets from coughing or sneezing, prolonged personal contact, or contact with contaminated surfaces (35,36). Globally, there have been over 4 million confirmed cases and over 295,000 deaths (37), although this is likely underestimated. In Canada, as of May 13, 2020, there have been 72,278 confirmed cases and 5,304 deaths (38).

The COVID-19 pandemic has compounded risks already posed by the overdose epidemic, and these intersecting public health emergencies place people who use substances and are experiencing homelessness or housing vulnerability at extreme risk of negative outcomes. Physical distancing and self-isolation protocols further exacerbate the risk of overdose death, as these protocols may lead more people to use substances alone, limiting the presence of bystanders who could intervene in the event of an overdose. If an overdose occurs in public, intervening bystanders may inadvertently expose themselves or the person who has overdosed to COVID-19 when providing CPR or other interventions, if not equipped with appropriate PPE. In shelter settings where PPE may be in short supply, staff are less able to respond effectively without risking potential COVID-19 exposure or transmission. Alternatively, lifesaving interventions such as rescue breathing and/or CPR may be delayed until EMS arrives, increasing the risk of anoxia and brain damage. These situations may lead to adverse outcomes for the person experiencing an overdose, including death, and significant moral distress for staff.

The COVID-19 pandemic may intensify existing barriers to health care (39–42) and harm reduction services. Comorbid health conditions commonly experienced by people with substance use disorders (43–45) may also place them at an elevated risk for severe COVID-19-related complications and mortality (46). COVID-19 has also disrupted 'open air' drug markets due to public health orders forbidding public congregating. As a result, those reliant on these markets may need to travel longer distances to obtain substances potentially from unfamiliar sellers, and consume drugs in new surroundings, which could exacerbate risk of COVID-19 infection or transmission, overdose, arrest and incarceration, and violent victimization. Finally, people who are experiencing homelessness or housing vulnerability may lack basic resources to protect themselves from COVID-19 by adhering to physical distancing, self-isolation, and hygiene guidelines, further increasing risk of infection (35).

Shelter settings in Canada have adapted their service models in response to the pandemic. Many existing emergency shelters that house people overnight or provide daytime drop-in spaces are reducing the number of people allowed in at one time and/or modifying their spaces to try to align with physical distancing guidelines. These services may also be altering their hours or temporarily relocating to larger facilities in an attempt to reduce COVID-19 transmission risks. Many jurisdictions are also establishing medical isolation shelters, within existing or in new settings (e.g. convention centres or other large facilities), to support people who are experiencing homelessness or housing vulnerability to self-isolate if they have had a known high-risk exposure, are under COVID-19 investigation, or test positive for the virus. A number of jurisdictions are also supporting people to

either physically distance or isolate using hotels or similar kinds of temporary accommodations with integrated support services.

Although shelters are implementing various measures to reduce the risk of COVID-19, many continue to face challenges containing infection (47,48). Early studies from the United States have found case rates of 15-66% in some shelter settings (49–52). The COVID-19 pandemic dramatically illustrates a public health and human rights imperative to provide housing for all. Safe and stable housing is the first-line defense against COVID-19 (53,54). While shelters can help respond to the immediate need to mitigate public health risks of COVID-19, they are only a temporary and inadequate solution to pre-existing structures of marginalization and exclusion (55) and ultimately do not advance the human right to housing (54,56). While shelters may be acceptable interim measures, they should not replace work to ensure safe and adequate housing for all.

For shelters providing care to people who use substances during COVID-19, a pragmatic approach assumes that some level of drug and alcohol use will continue irrespective of formal or informal bans or criminal prohibitions (57,58). This means that people who use substances should not be excluded from shelter settings because of substance use policies that prohibit use on site or possession of alcohol or drugs. Beyond addiction, people use drugs for a variety of reasons including for stimulation, to reduce stress and anxiety, to manage pain and mental health conditions, and for pleasure (59–61). To reduce risk of substance-related harms and promote safety of both residents and staff, shelters should integrate harm reduction approaches and interventions into their service models.

Operators providing temporary housing or shelter during the COVID-19 pandemic should consider adding or bolstering strategies for accommodating active drug and alcohol use, and make concerted efforts to support people who use substances to stay as safe and healthy as possible. Promising strategies for achieving this are: [1] integration of supervised illegal drug consumption services into shelters, and [2] provision of substance use disorder treatment and related recovery supports, managed alcohol programs, and replacement pharmacotherapy to support those who use substances to mitigate their risk of COVID-19 transmission, overdose, and withdrawal. A recent systematic review of reviews illustrates the utility of these approaches (62). It found that supervised consumption services and pharmaceutical interventions (e.g., buprenorphine, methadone, and injectable diacetylmorphine or hydromorphone) reduced mortality and morbidity, and improved other outcomes amongst people experiencing homelessness, and that managed alcohol programs helped reduce or stabilize alcohol consumption (62). For some settings, integration of these strategies may be in addition to an already established culture and set of policies related to harm reduction. In other cases, specific attention may be needed to develop organizational harm reduction policies and ensure staff education in harm reduction.

3.0 Implementing Temporary Supervised Consumption Services in Response to COVID-19

Supervised consumption services provide monitored spaces where people consume illegal drugs without the risk of police intervention or criminal sanctions, in the presence of staff trained to respond in the event of an overdose or other adverse event. They also provide access to sterile drug consumption supplies and typically offer other health and social supports. Supervised consumption services are associated with reductions in overdose-related mortality and drug-related risks (e.g., syringe-sharing), increased access to social, health, and addiction-related services, and have not been shown to have a negative impact on public disorder or drug-related crime in the surrounding area (63,64).

3.1 SECURING AN EXEMPTION FOR AN URGENT PUBLIC HEALTH NEED SITE

In Canada, Health Canada grants exemptions to the *Controlled Drugs and Substances Act* to operate supervised consumption services. Applicants can apply to open either a supervised consumption site or an Urgent Public Health Need Site. Health Canada defines Urgent Public Health Need Sites (UPHNS) as spaces for people who use illegal substances to consume them and receive assistance in the event of an overdose (UPHNS are sometimes also referred to as overdose prevention sites (OPS) because, as OPS, they are meant to be temporary locations and low-threshold services which distinguish them from supervised consumption sites). Site staff monitor participants before, during, and after they consume drugs. Staff are prepared to give naloxone or other life-saving responses, as needed. Compared to supervised consumption sites that require going through a longer and more exhaustive exemption process (and possibly additional regulatory or policy processes at the provincial or territorial level), UPHNS can be established quickly as short-term responses to address urgent public health needs, such as the need for consumption spaces in an emergency or temporary shelter in the context of COVID-19.

UPHNS are intended to be short-term, targeted interventions. In the context of the current pandemic, the health of people who use substances is at risk due to concomitant threats of opioid-related overdose deaths and hazards related to illegal substances, as well as the spread of COVID-19. Often implemented rapidly to prevent the loss of life, UPHNS may have pared down service models compared

to longer term supervised consumption site models. While many supervised consumption sites offer a wider continuum of health and social services for people who use substances, UPHNS typically have less capacity to offer these ancillary supports.

Prospective operators of both UPHNS and supervised consumption sites require exemptions under either subsection 56(1) or section 56.1, respectively, to protect participants and staff from criminal sanctions under the *Controlled Drugs and Substances Act*. Health Canada has established two possible avenues for prospective operators to apply for exemptions to legally operate UPHNS.

First, in response to COVID-19, Health Canada issued temporary class exemptions to all Canadian provinces and territories in April 2020, enabling provincial or territorial Ministers of Health to approve UPHNS applications in their jurisdictions. Provinces and territories may have their own application process and criteria for prospective UPHNS operators. They are also able to further delegate UPHNS approval to municipalities. The class exemption enables a province or territory to allow their Ministry of Health, their Health Authorities, municipalities, or any other entity as the province or territory sees fit, to set up and administer the UPHNS on their behalf. The entity is authorized by the province or territory to set up and administer the UPHNS, however, the province or territory remains ultimately responsible for complying with the terms and conditions of the class exemption. Some provinces or territories may decide not to activate their class exemptions, and others may or may not grant other entities, such as municipalities, the permission to approve UPHNS applications. To obtain more information or to apply to operate UPHNS under a provincial or territorial class exemption, contact your provincial or territorial department of health.

Second, prospective UPHNS operators can apply directly to Health Canada. The first step in this process is to request an application form from the Office of Controlled Substances by emailing hc.exemption.sc@canada.ca. Applicants will receive instructions for completing the application and submit their completed information to the same email address. Health Canada prioritizes the review of these applications, and working closely with the applicant, aims to provide an authorization/response within 5 business days.

UPHNS applications submitted to the federal government typically include:

- Contact information of the applicant;
- Location of the proposed site;
- Details regarding the services to be provided (e.g., the routes of consumption that will be permitted, the hours of operation, etc.); and
- Information on why the site is required (i.e., describe the urgent public health need that the site is addressing).

Other information may be required by Health Canada in assessing temporary exemption applications. With regard to funding, Health Canada, has stated that at this time they will not fund supervised consumption sites or UPHNS, "however, due to the impacts of COVID-19 on communities and vulnerable populations, there may be other sources of funding available from community partners dealing with harm reduction, homelessness, community services and other donors. As examples, many cities and organizations have been provided federal funding for homelessness that could be potentially used to alleviate funding pressures for urgent public health need sites or supervised consumption sites" (65).

In addition to securing federal legal exemptions, shelter operators should be aware that other administrative requirements (updates to insurance or other policies, etc.) may be needed to protect against potential liability in the event of an adverse event involving supervised consumption service participants or staff. Finally, it should be noted that staff who belong to professional colleges may have to comply with specific regulatory requirements when providing care to supervised consumption service participants. Staff should contact their professional college for more information on their roles and responsibilities, as required.

See the following resource for more information about the revised application process for UPHNS:

- Questions and Answers - Provincial/Territorial Class Exemptions: For Supervised Consumption Site Operators (65)

3.2 SETTING UP SUPERVISED CONSUMPTION SERVICES WITHIN A SHELTER SETTING DURING COVID-19

There are many factors to consider when determining key attributes of supervised consumption services within shelter settings. Some considerations are outlined below.

Privacy. Where possible, supervised consumption services should be located in an area that protects privacy by limiting the visibility of participants entering and exiting the service by people in other areas of the shelter (66).

Lighting. Proper lighting in all areas of the supervised consumption service is required to ensure the safety of participants and staff.

Centralized models. Supervised consumption services can be adapted to a range of contexts; there are precedents for integrating these services into hospitals (67), hotels temporarily housing people who are experiencing homelessness or housing vulnerability (68), shelters (69), mobile units (70),

and housing facilities (24,71). For shelters seeking to implement one or more centralized spaces for supervised consumption (e.g. all residents attend one or more designated areas dedicated to supervised consumption only), a large, closed-in space is recommended to help manage entry and flow of participants while maintaining physical distancing requirements (e.g. participants and staff remain two metres apart as much as possible throughout all areas of the service). However, if participants use the service alone (e.g. staff observe from behind a window or door), space for physical distancing is not required. In facilities where sufficient space is not available for physical distancing, continuous masking of staff and participants could be another option. Any supervised consumption service area should be easily observed by staff and large enough to meet applicable accessibility requirements and safety codes, and ensure emergency medical services (EMS) can access it in the case of a medical emergency. A separate, designated area could be included for screening participants for COVID-19 prior to them entering the supervised consumption service, if required. Staff should inform participants that in the event of an overdose or other medical emergency, the space will need to be quickly cleared of all other participants and staff not responding to the emergency to ensure safety and reduce potential risk of COVID-19 transmission. The space should be sufficiently separate (ideally enclosed) from other areas of the shelter to minimize the potential spread of aerosolized droplets in the event that a supervised consumption service participant is COVID-19 positive and requires an intervention, including certain methods of respiratory support, that are considered to be an aerosol-generating medical procedure (AGMP; see section **3.3.5 Responding to Overdose within Supervised Consumption Services on page 36** for more information on AGMPs in supervised consumption services). All surfaces, including barriers separating patient areas and furniture, should be made of non-porous materials that can be easily cleaned (72).

Grouping participants depending on COVID-19 status. With centralized supervised consumption service models, when feasible, there should ideally be separate services (with waiting, consumption, and monitoring areas) for each of the three populations at varying degrees of COVID-19 risk: [1] those who are asymptomatic, not under any public health directive to self-isolate, and not undergoing any investigations related to COVID-19; [2] those who are suspected of COVID-19 infection (e.g., suspected to be COVID-19 positive but awaiting test results) or who have had close contact with someone who is confirmed positive for COVID-19; and [3] those who are confirmed to be positive for COVID-19. Specific cohorts or participant groups within each setting should be determined in consultation with local public health and infection prevention and control experts and account for local COVID-19 epidemiology. Grouping participants by their COVID-19 status aims to limit risk to other participants and shelter staff and conserve personal protective equipment (PPE) (73). See section **3.3.2 Screening Supervised Consumption Service Participants for COVID-19 on page 27** for information on screening participants for COVID-19.

Decentralized or dispersed model. Instead of one centralized area for supervising drug consumption episodes, shelter operators and medical teams may explore the possibility of providing a decentralized, 'bedside' or 'episodic' supervised consumption service model where a participant consumes drugs

within their own designated area or room and are supervised by a staff member maintaining physical distancing and wearing the appropriate PPE (see section **3.3.3 Staff PPE on page 28** for information on PPE for staff). If there are multiple people staying together (e.g. couples, family members) peer-witnessing and monitoring for overdose may be another practical option. Harm reduction supplies and sharps disposal containers could be distributed to participants to be stored with their personal belongings. This may be an especially useful option in medical isolation shelters with multiple separate areas for cohorting participants based on COVID-19 status. See *COVID-19 Provincial Episodic Overdose Prevention Service (e-OPS) Protocol* (74) from the British Columbia Centre for Disease Control for more information on implementing this kind of model.

Mode of administration. Ideally all common modes of drug administration (oral, intranasal, injection, and inhalation) should be accommodated. The majority of supervised consumption sites in Canada accommodate injection, oral, and intranasal routes. There are currently two supervised consumption sites (one in Lethbridge, Alberta and one in Saskatoon, Saskatchewan) that are federally-exempted to monitor drug consumption via inhalation/smoking. Both of these facilities have specially ventilated rooms that follow occupational health and safety protocols to protect staff and other participants from exposure to secondhand smoke. While this is unlikely to be practical in UPHNS scenarios, there is precedence for supervising inhalation activities in a designated outdoor area (75). Pop-up inhalation tents could be established in courtyards or adjacent outdoor areas within view of staff. However, operators should note that outdoor locations are not ideal because concrete or asphalt flooring does not facilitate thorough cleaning and disinfecting.

Hours of operation. Supervised consumption services operating 24 hours per day, seven days per week provide the most accessible service for residents. However, depending on the specific needs of the community, available resources and demand, this schedule may not be practical. Operators should have in place procedures for monitoring high-risk areas within and around the shelter premises for potential unobserved overdoses amongst residents consuming substances outside of supervised consumption service operating hours.

Hand hygiene. Supervised consumption service staff and participants need to have access to hand hygiene sinks and/or a Health Canada-approved hand sanitizer (with a minimum of 60% ethanol content) (76). Participants should perform hand hygiene, either by washing their hands with soap and water for 20 seconds, or applying hand sanitizer prior to entering the supervised consumption service, before and after drug consumption, and upon leaving the supervised consumption service. Staff should perform hand hygiene regularly, including before and after any physical contact with any participants or their belongings. Posters for HandRub and HandWash procedures (77,78) should be posted at all hand hygiene stations in the supervised consumption service.

Surface and environmental cleaning. The supervised consumption service should be implemented in an area of the shelter amenable to regular cleaning. A process should be developed for cleaning that

delineates roles and responsibilities, frequency, and tracking. The process should include cleaning and disinfecting (two-step process) all surfaces and reusable equipment contacted by participants regardless of their COVID-19 status, between each participant. Other high touch areas and shared spaces should be cleaned frequently throughout the day and this should be documented. A Health Canada approved disinfectant with activity against COVID-19 should be used (76,79).

Building trust with people who use drugs. Operators should be mindful that they are introducing a new service which, in some cases, could mean an organizational policy change from abstinence to embracing a wider range of harm reduction practices. It may take time to build trust amongst people who use substances who may be understandably wary of the supervised consumption service at first. One strategy to better understand the needs of the people who use the service is to implement a community advisory committee of people who access the service. Hiring people with lived and living experience also helps build trust. For more information on effectively engaging and employing people who use substances see section **2.3 Guiding Principles on page 17**.

Preventing overdose in adjacent shelter areas. Even with the implementation of supervised consumption services in shelter settings, bathrooms and other private or semi-private areas may still be used to consume substances to avoid the perceived or real threat of punitive measures from staff (e.g., eviction), when the supervised consumption service is closed or at capacity, or in an effort to conceal drug possession or use from peers (19,80,81). Drug use within bathrooms or other areas can result in unhygienic practices and increase the possibility of unwitnessed overdoses (82). Therefore, whether or not a supervised consumption service is operational, it is recommended to include regular monitoring and safety checks of bathrooms and other high-risk areas. Bathrooms should ideally have locks that can be opened from the outside and/or a door which unlocks after a fixed amount of time to allow staff to check on occupants while maintaining the individual's privacy and dignity as much as possible (83). Secured and tamper resistant sharps containers should be installed in bathrooms and other areas where substance use could occur, and overdose prevention information posted (84–86).

3.3 SUPERVISING CONSUMPTION IN SHELTERS DURING COVID-19

3.3.1 Screening Supervised Consumption Service Staff for COVID-19

Every supervised consumption service staff member should be screened for COVID-19 as they arrive at work according to the standard screening questionnaires and procedures recommended by local public health authorities. Staff who experience new symptoms or meet other high-risk criteria should be immediately placed on leave until it is deemed safe (according to local public health guidance) for

them to return. They should be referred for testing and advised of procedures for self-isolation and available financial benefits to offset lost income, as required. Operators should consider scheduling cohorts of staff together on the same rotations to help mitigate potential staff shortages if an outbreak occurs by potentially limiting the number of staff exposed.

3.3.2 Screening Supervised Consumption Service Participants for COVID-19

Staff should warmly greet each supervised consumption service participant in the intake area. Participant screening should be done either from behind a physical barrier (e.g., plexiglass or by a call-in from outside), with physical distancing, or with appropriate PPE (see section **3.3.3 Staff PPE on page 28** for information on PPE). Staff members should be knowledgeable about harm reduction as an approach to care, and be able to provide safer drug use education and infection prevention guidance in the context of COVID-19 to all participants presenting for screening. Supervised consumption service participants should be screened for COVID-19 as they arrive according to the standard screening questionnaires and procedures recommended by local public health authorities. Examples of screening procedures developed in Ontario are listed in section **5.0 Further Reading and Resources on page 56** at the end of this document (87,88). Local recommendations may change regularly to reflect COVID-19 epidemiology, and supervised consumption service policies should be updated regularly to reflect these changes as needed.

If a participant is suspected of having COVID-19 (e.g., due to close contact with a confirmed COVID-19 case), provide a medical-grade mask for the participant to wear within the supervised consumption service. Depending on the local prevalence of COVID-19, staff might consider providing a medical-grade mask to all participants, regardless of COVID-19 tests or risk factors. All staff and participants should be advised on other infection prevention and control measures they are required to take (e.g., cough and sneeze into a tissue or their elbow, hand hygiene, physical distancing (35)) to minimize transmission of COVID-19 (88). Staff members should work closely with public health officials to facilitate formal COVID-19 screening and testing, and referral to appropriate self-isolation support.

If the supervised consumption service has separate areas for people who are positive for COVID-19, have had a high-risk exposure or are undergoing a relevant investigation, physical distancing between participants should continue and medical-grade masks or other PPE should be provided to these participants according to local public health guidance. Alternatively, sites could provide single use rooms or a partitioned area with windows or sightlines for monitoring, if feasible. Cohorting of staff to these participant groups is strongly encouraged.

It is important to note that people who are not showing symptoms might still be positive for COVID-19 and transmit the virus despite being asymptomatic (89,90). Therefore, regardless of whether COVID-19 status is known or unknown, it is imperative that sites maintain the proper physical distancing between

each supervised consumption service participant, perform hand hygiene regularly, and thoroughly clean each consumption space (and any other areas touched by participants) after each use in order to minimize transmission of the virus (see section **3.2 Setting up Supervised Consumption Services within a Shelter Setting During COVID-19 on page 23** for more information on hand hygiene and surface and environmental cleaning).

3.3.3 Staff PPE

Specific staff PPE requirements in each shelter setting should be determined in consultation with local public health authorities and account for local COVID-19 epidemiology, participant demographics, supervised consumption service infrastructure, knowledge and training of staff, PPE supplies, and employer policies. Operators should be continuously reviewing and updating PPE requirements, as necessary, to ensure they are in line with the best available science and public health guidance at all times. Seeking expert infection prevention and control consultation is strongly advised. Staff who may provide (or anticipate providing) care to participants within two metres need to be trained in PPE use, including proper donning and doffing technique and hand hygiene. This includes anyone who might respond to an overdose or medical emergency.

There are multiple methods for determining PPE requirements, including by participant COVID-19 status or task performance; Table 1 provides example guidance on selecting PPE intended for general community (i.e. non-healthcare) settings. Note that this approach to selecting PPE may differ from that taken in medical isolation shelters where patients with confirmed COVID-19 positive status are being supported by healthcare staff. Always defer to local public health guidance in determining the appropriate PPE for staff in your setting.

Staff performing COVID-19 risk factor screening who cannot do so from behind a barrier, or while maintaining physical distancing, should wear a medical-grade mask and eye protection. Please see section **3.3.2 Screening Supervised Consumption Service Participants for COVID-19 on page 27** and contact your local health authority or provincial/territorial health department for local procedures. Due to the risk of asymptomatic COVID-19 transmission and other communicable diseases (89,90), staff should always utilize “routine practices” (called “standard precautions” by the World Health Organization (91)). This includes point-of-care-risk assessment, frequent hand hygiene, and environmental cleaning (92). Subsequent PPE use should be dictated by the task being performed. In most circumstances, PPE for participant interaction can be selected based on their COVID-19 risk factors (see section **3.3.2 Screening Supervised Consumption Service Participants for COVID-19 on page 27**) and task-based risks, per the matrix below (79,88,93).

Table 1. Matrix on selecting PPE for general community (non-healthcare) settings based on participant risk factors and task-based risks[1]

PARTICIPANT RISK CATEGORY	MINIMALLY INVASIVE TASKS*	INVASIVE TASKS WITH POSSIBLE CONTACT WITH PARTICIPANTS' BODILY FLUIDS^
No risk factors for COVID-19	Medical-grade mask Consider eye protection (see text for details)	Medical-grade mask Gloves if hands exposed to non-intact skin or bodily fluids Gown if clothing exposed to bodily fluids Eye protection if face exposed to bodily fluids
Risk factors for COVID-19[1]	Medical-grade mask and eye protection	Gown, gloves, medical-grade mask, eye protection

* Minimally invasive tasks: talking to participant, contact with intact skin, vital sign monitoring, simple assessments, administering medications, distributing food/supplies

^ Invasive tasks: Nasopharyngeal swab collection, full physical exam, injectable medications and any other task with possible contact with bodily fluids including saliva, sputum, nasal secretions, vomit, urine, feces, blood, etc.

[1] This matrix is provided as an example of existing guidance for non-healthcare settings. PPE advice and recommendations vary according to specific jurisdiction, setting and service model. Operators should defer to local public health guidance in determining staff PPE requirements. Given the evolving nature of the COVID-19 pandemic and associated knowledge base, PPE requirements should be continually reviewed and updated as required.

If local prevalence of COVID-19 is high, such as in a community or shelter outbreak setting, it may be reasonable to select PPE from the matrix as though all patients have risk factors for COVID-19 (i.e., bottom row). When performing aerosol generating medical procedures (AGMPs; e.g., certain respiratory interventions (94)), staff should use Contact & Droplet precautions (gown, gloves, mask, eye protection) and a fit-tested N95 respirator instead of a medical mask for those with COVID-19 risk factors (see section **3.3.5 Responding to Overdose within Supervised Consumption Services on page 36** for detailed guidance on responding to overdoses and PPE requirements).

During the COVID-19 pandemic, continuous masking of all staff could be considered in the supervised consumption service when physical distancing cannot always be maintained with participants and other staff (95). The mask should be removed if wet or soiled with proper doffing technique including hand hygiene after handling the mask (95,96). Additionally, use of eye protection for all participant care could be considered in areas with high community prevalence of COVID-19 and can be worn continuously. Gowns and gloves should be changed between every participant encounter, with hand hygiene performed (96). Continuous PPE use strategies should follow local or international guidelines

and may reduce the need to repeatedly don and doff PPE, and thereby conserve overall PPE supplies (91). While these continuous PPE strategies have been employed in health care facilities in the COVID-19 context, there is limited evidence on their utility in community settings. Consultation with local public health authorities should be considered to help guide these strategies.

3.3.4 Monitoring Consumption and Providing Care within Supervised Consumption Services

Supervised consumption services should always be offered in a culturally safe manner that is consistent with a harm reduction and trauma-informed approach (97). Culturally safe care focuses on strategies that help build relationships with participants and minimizes harms stemming from drug-related stigma and discrimination (98). Additionally, throughout each visit, staff and participants need to follow proper hand hygiene, and other sanitation protocols to minimize the risk of COVID-19 transmission. Please see section **3.2 Setting up Supervised Consumption Services within a Shelter Setting During COVID-19 on page 23** for more details. Depending on staffing, supervised consumption service capacity, and PPE availability, operators should consider incorporating any of the following ancillary supports that are commonly offered in other supervised consumption services:

- basic medical services (e.g., first aid, naloxone training, wound care),
- demonstration of, and education on, safer consumption and injection techniques,
- peer support or outreach from people with lived or living experience of substance use,
- referrals to substance use treatment (e.g., opioid agonist therapy, specialty addiction recovery programs), and/or
- referrals to other health and social services (e.g., income support, housing, care planning and case management).

Staffing

The recommended staffing ratio is dependent on a number of factors, including the supervised consumption service layout (e.g., how many spaces and rooms), capacity of the supervised consumption service (e.g., how many participants can be in the site at once), and physical size of the site. Operators should also try to anticipate temporary periods of increased demand, such as in the week following disbursement of income support cheques (99) or if a sudden increase in the toxicity of the illegal drug supply is detected. At a minimum, there should be a staff member present in each separate area to monitor and respond to participants experiencing an overdose or other adverse medical event. Participants should be visible by staff at all locations within the site.

At all times, staff who are trained and experienced in PPE donning and doffing and recently N95 fit tested should be identified to respond to overdoses at the site. These individuals should have access to properly fitted N95 masks when responding to an overdose to ensure staff safety if an AGMP is required as part of the overdose response (see section **3.3.5 Responding to Overdose within Supervised Consumption Services on page 36** for detailed guidance on PPE required for responding to overdoses in supervised consumption services).

Across Canada, a variety of staff with different expertise are employed in supervised consumption services and most have interdisciplinary teams. Services may be staffed by people with lived and living experience of substance use, and those trained in nursing, social work, addiction counselling, as well as EMS personnel (herein referred to as staff). Employing people with lived or living experience is an essential strategy for facilitating meaningful uptake and engagement with the service (24). Guidance is available for employers on hiring, fairly compensating, and supporting staff with lived or living experience of substance use and it is strongly recommended that operators employ people with lived or living experience whenever possible (100,101). Regardless of discipline, all staff should be trained in harm reduction, cultural safety, trauma informed care/practice, basic first aid, overdose response (e.g., naloxone administration, cardiopulmonary resuscitation [CPR]), and infection prevention and control procedures. Staff training and ongoing support is essential for creating safe work environments and providing care that is sustainable. One practical strategy is a beginning of shift and end of shift team meeting or handover to provide opportunities to debrief and share pertinent information.

Pre-consumption

Participants should wait in a designated area until there is a vacant consumption space open. Staff members could place markers on the floor or chairs spaced two metres apart to ensure physical distancing requirements are met. Staff could explain to participants that wait times may be extended due to the reduced number of consumption spaces to comply with physical distancing requirements. Ideally large personal belongings should not be brought into the supervised consumption service, and staff should consider providing participants with a single use plastic bag and designated area to store their larger and smaller personal belongings while at the site. When there is a consumption space available, a staff member can screen the next participant (see section **3.3.2 Screening Supervised Consumption Service Participants for COVID-19 on page 27**), and gather any information required for intake. Intake procedures and information collected vary across supervised consumption services, and ultimately are determined by local needs, staff capacity and specific regulatory context (see section **3.4 Reporting and Evaluation on page 39** for more information). It is helpful for staff to record or be aware of the drugs the participant is planning on using and when and what they last used to assess their relative risk of overdose, and the involvement of any polysubstance use. If drug checking services are available (e.g., strips to test for the presence of fentanyl, or an FTIR or mass spectrometer), participants may test their drugs before or after entering the consumption area and preparing their drugs for consumption, depending on checking protocols. At the participant's first visit

to the supervised consumption service, they may be asked to sign a participant agreement or give verbal consent, which explains site procedures and the rights of participants and staff.

Depending on which routes of consumption were exempted under the *Controlled Drugs and Substances Act*, participants can consume their drugs through injection, intranasal, and oral routes at the booths or tables set up in the site, or through inhalation in specially ventilated rooms or outside (see section **3.2 Setting up Supervised Consumption Services within a Shelter Setting During COVID-19 on page 23**). The booths/tables and chairs should be sturdy and comply with the relevant infection prevention and control protocols (e.g., should be able to be cleaned and disinfected easily (72)); chairs should be maneuverable and light-weight so they can be easily moved in medical emergencies. Each consumption space should be a minimum of two metres apart. If using existing infrastructure, participants can be placed at every other booth/table to ensure sufficient distancing.

Consumption

To limit the potential spread of COVID-19 between participants, staff members should first perform hand hygiene then collect and distribute sterile drug consumption equipment to participants while maintaining appropriate physical distancing. The participant should complete hand hygiene prior to accepting these supplies (see section **3.2 Setting up Supervised Consumption Services within a Shelter Setting During COVID-19 on page 23** for more information on hand hygiene protocols). Operators will need to secure access to sterile harm reduction supplies (through specialized distributors) and medical waste disposal services. Staff members can either have kits of supplies prepared in advance to provide to each participant or can ask the participant about the equipment they require for their consumption and distribute it accordingly. Available equipment should include:

- needles and syringes in a variety of gauges and sizes,
- tea light candles and lighters (if matches are used, ensure they do not become a fire hazard),
- disposable cookers,
- filters (if purchased separately from cookers, use tweezers to extract filters from the bag and place into a single-use container for the participant),
- sterile and disposable water,
- acidifier (e.g., ascorbic acid),
- alcohol swabs,
- disposable or participant-specific tourniquets,

- disposable tray (for distribution of supplies),
- straws (for intranasal consumption),
- foil or other disposable container to hold drugs (for intranasal consumption),
- borosilicate (e.g., Pyrex®) glass pipes, ball pipes, or stems (for inhalation),
- mouthpieces (for inhalation),
- metal pipe screens (for inhalation),
- mirrors (handheld),
- condoms and personal lubricant, and
- disposal containers.

Supplies should be available both for use within the supervised consumption service and provided on demand to participants to take with them. Detailed guidance on distribution of harm reduction supplies are available in the following documents:

- Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Services to People who use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1; Working Group on Best Practice for Harm Reduction Programs in Canada (12)
- Best Practice Recommendations 2 for Canadian Harm Reduction Programs that Provide Service to People who use Drugs and are at Risk for HIV, HCV, and Other Harms; Working Group on Best Practice for Harm Reduction Programs in Canada (13)

Staff members should not collect used equipment; instead, staff should direct participants to dispose of their equipment in designated disposal bins. Participants should also have the opportunity to dispose of other used equipment (from prior consumption episodes outside of the supervised consumption service). Operators should refer to the shelter's biohazard disposal policy or consult their local public health authority or health department for jurisdiction-specific guidance in the context of COVID-19.

Many supervised consumption services have time limits for participants in the consumption area to minimize wait times for other participants. Staff members should gently remind a participant that their time is up but allow for a few extra minutes when feasible, and provide safer drug use education to participants where appropriate while working in the consumption room. Operators will need to determine which injection-related supports will be available to participants, and clearly communicate this to staff and participants. Possible supports include staff members helping participants find veins

for injection (e.g., using their fingers or online apps), preparing drugs, and peer-assisted injection.

Peer-assisted injection (also known as peer assistance) is when a friend or partner (injector), who is not a staff member working at the supervised consumption service, helps a participant (injectee) inject their drugs by directly administering the injection. Health Canada has specific requirements for peer-assisted injection when it occurs within federally exempted UPHNS or supervised consumption services. By definition, the injector will not be able to maintain two metres distance from the injectee, so if the injector and injectee are in a close relationship through which they are functionally sheltering-in-place together, then PPE is unlikely to be required (e.g., intimate partner, family member, room or bunk mate, or other recent close personal contact within two metres without PPE). However, if the injector and injectee are not in such a relationship and have not been in close proximity to each other, they should be provided with the appropriate PPE according to local health authority guidance. This may include gown, gloves, medical-grade mask, and eye protection. The injector and injectee should both wash their hands upon entering the consumption space and before drug consumption (see section **3.2 Setting up Supervised Consumption Services within a Shelter Setting During COVID-19 on page 23** for details on hand hygiene). Where possible, a table and chair with generous space should be reserved for peer-assisted injection that allows adequate physical distancing from other injection booths. If the injector is planning to inject as well, it is suggested that the injector inject the injectee, the injectee leave the consumption area, and then the injector injects themselves, either at the same table or a different table depending on their preference. The injector must follow the direction and guidance of the injectee. At least one staff member must observe the entire peer-assisted injection process and ensure the injectee is in control of the injection process. In federally exempted services, the injectee signs an agreement accepting liability in the event of a negative outcome, and some operators also require the injector to sign a waiver as well.

Post-consumption

After participants have finished consuming drugs, they would ideally be observed in the monitoring area for a minimum of fifteen minutes to ensure they do not overdose. Physical distancing and recommended PPE must be maintained in the monitoring area; chairs should be placed two metres apart and staff should facilitate participant flow through this area. Snacks (e.g., coffee, granola bars) are typically offered in the monitoring area but should not be provided as self-serve options and should be individualized and prepacked to prevent COVID-19 contamination and transmission. Post-consumption monitoring provides an opportunity to offer sterile drug consumption supplies for participants to take with them when they leave, which can be placed in a bag to ensure privacy along with personal sharps disposal containers. It is also strongly recommended that all participants be trained in naloxone administration and that naloxone kits be provided to every participant. Check with your local community-based naloxone program to ensure trainers have the most up-to-date information about providing CPR and administering naloxone in the context of COVID-19. An example

of newer guidance for naloxone program participants in Alberta is cited at the end of this document (102). The post-consumption area also provides an opportunity to offer harm reduction education and referral to treatment programs, health care, and social and cultural supports.

Whenever possible, staff should discuss harm reduction practices with participants, including advice on preventing COVID-19 transmission. This could include tips for:

- Maintaining proper hand hygiene by washing hands often with soap and water, or if hand washing facilities are not available, alcohol-based hand sanitizer (staff should be aware of the risks of consuming hand sanitizer as a source of non-beverage alcohol and advise participants as appropriate (103)).
- Not sharing any drug equipment (e.g. pipes) or cigarettes.
- Disinfecting packaging of drugs and equipment handled by other people.
- Preparing your own drugs.
- Preparing and consuming drugs on a sanitized surface.
- Not consuming alone but maintaining physical distancing recommendations whenever possible.
- Having more than adequate harm reduction supplies (e.g., drug consumption equipment, prescriptions, naloxone) to last the individual and other potential users two weeks, whenever possible.
- Reducing drug smoking when possible, or consuming drugs through lower-risk non-inhalation routes (e.g., oral or intranasal consumption), as COVID-19 infection impacts the respiratory system.
- When experiencing new symptoms associated with COVID-19, trying to strictly avoid other people as much as possible to reduce the potential spread of infection.
- If providing rescue breaths, use the mask provided in the naloxone kit with the understanding that this may not protect you from COVID-19.

People who use substances or are experiencing homelessness or housing vulnerability may not be able to follow all of the recommended harm reduction practices; staff should emphasize following these practices as much as possible to protect against COVID-19 infection. Examples of resources that

outline potential harm reduction practices in the context of COVID-19 include:

- COVID-19: Advice for People who use Drugs; Canadian Association of People who use Drugs, International Network of People who use Drugs, European Network of People who use Drugs (104)
- COVID-19 & Drug Use: Tips & Tricks; Harm Reduction Victoria (Australia) (105)
- COVID-19: Harm Reduction and Overdose Response; BC Centre for Disease Control (106)
- COVID-19 Planning for the Substance Dependent; Harm Reduction Victoria (Australia) (107)
- COVID and Harm Reduction; DTES Collaborative (108)
- COVID-19 Stimulant Use, and Harm Reduction; Resolve to Save Lives - Vital Strategies, Harm Reduction Coalition, Higher Ground Harm Reduction, Reynolds Health Strategies (109)
- Guidance for People who use Substances on COVID-19 (Novel Coronavirus); Yale Program in Addiction Medicine, Global Health Justice Partnership & Crackdown (110)
- Harm Reduction Tips during Corona Virus; Somerset West Community Health Centre (111)
- Safer Drug Use During the COVID-19 Outbreak; Harm Reduction Coalition & Vital Strategies (United States) (112)

Contact your local harm reduction program, public health authority, or health department for recommendations specific to your jurisdiction.

3.3.5 Responding to Overdose within Supervised Consumption Services

After supervising drug consumption, staff need to monitor participants at all times for the common signs of an opioid overdose: pinpoint pupils, respiratory depression, and unconsciousness (113). However, it is important to note that not every participant experiencing an overdose will display these symptoms; atypical symptoms such as muscle rigidity or involuntary movements have been documented with increasing frequency and can complicate overdose interventions (114,115). Special attention is required when monitoring participants, as physical distancing and PPE requirements can complicate the ability to recognize an overdose (e.g., unable to see blue lips if the participant is wearing a mask, difficult to see pinpoint pupils while maintaining two metre distance from participants). In the event of an opioid overdose occurring at the site, all other participants and staff not responding to the overdose need to exit the area. Operators should have an overdose response protocol,

outlining the preferred response to an overdose based on the resources available at the site and local current guidance for infection prevention and control. This protocol should reflect the best available COVID-19-specific evidence, be updated as new evidence becomes available, and should outline the interventions available to staff, the equipment (including PPE) necessary, roles and responsibilities (taking into account training and background), as well as the thresholds for each intervention. Ongoing staff training on this protocol is essential. Possible interventions, including some that are suspected or confirmed AGMPs (see below), are:

- Providing CPR, with or without rescue breaths.
- Providing oxygen, administered by high flow oxygen, bag valve mask, or non-rebreather equipment.
- Providing naloxone, administered intranasally or intramuscularly.
- Use of a portable automated external defibrillator (AED).
- Calling 911.

Depending on the severity, staff may need to try multiple interventions to successfully reverse the overdose. Due to the risk of exposure to participant blood or bodily fluids when responding to an overdose, staff should don PPE regardless of COVID-19 risk factors, including a medical-grade mask, eye protection, gloves, and a gown according to the principles of point-of-care risk assessment (79,92,96). Providing CPR and some types of oxygen delivery may be considered AGMPs (73,88,96,102,116–122). AGMPs are "any procedure conducted on a patient that can induce production of aerosols of various sizes", and include non-invasive ventilation interventions (e.g., bag-valve-mask) (79). AGMPs are considered a high-risk intervention as they present a risk for airborne transmission of pathogens, including COVID-19. As this is a rapidly evolving area of medical science, operators should contact their local public health authority or health department for specific guidance on which interventions are considered AGMPs, particularly for cardiopulmonary resuscitation as there is a lack of consensus across jurisdictions regarding its role as an AGMP (94). Operators may also consider consulting the shelter's first aid and CPR policies specific to COVID-19 for further guidance. When providing an intervention considered to be an AGMP, fit tested N95 respirators are recommended instead of medical-grade masks when the participant is known or suspected to have COVID-19 to reduce the risk of transmission (73,96,118–120). Staff trained in the use of this specialized equipment should be present.

Staff need to respond to overdoses quickly, so the appropriate PPE needs to be easily accessible from all locations in the site. If the appropriate PPE is not available, each staff member should determine the level of intervention they are comfortable providing by weighing professional and ethical obligations (where appropriate) and potential risk of harm. Organizational policies may also offer

specific guidance to staff in this situation. For participants who are pulseless, placing a barrier over the participant's face (e.g., a folded towel or pillow case, medical-grade mask) could be considered as a transmission risk mitigation strategy to allow chest-compressions to be performed until responders in appropriate PPE can take over care.

Following an overdose response involving an AGMP, staff should disinfect the area with Health Canada approved disinfectant. Some guidelines recommend waiting one hour "to allow aerosolized particles to drop" (96), although the risk posed by aerosolization is dependent on the building ventilation and filtration system (123). If the overdose response included an AGMP intervention, the surrounding two metre radius should also be disinfected (117). Anything that is unable to be properly disinfected (including PPE) should be properly disposed of. Operators should consider disposing of contaminated PPE in a biohazard bag, sealed inside another bag; refer to the shelter's biohazard disposal policy or contact your local public health authority or health department for jurisdiction-specific guidance. No other participants should enter the area until the disinfection is complete (117).

If possible within the space and with adequate staff observation, having consumption tables/booths in multiple separate rooms could facilitate continual access to the service by allowing consumption to continue in the other rooms while addressing an overdose. If all consumption tables/booths are in the same room, the entire consumption area will need to be closed until the overdose has been reversed and disinfection has been completed.

Examples of health authority and provincial resources on responding to an overdose within a supervised consumption service are provided below. However, as science and best practice in this area are still evolving, operators should consult local health authorities for the most up-to-date guidance.

- COVID-19: Community Members Responding to Overdose; Vancouver Coastal Health (124)
- COVID-19 Guidance: Consumption and Treatment Services (CTS) Sites; Ontario Ministry of Health (88)
- COVID-19 Protocol for Aerosol-Generating Medical Procedures (AGMP) in The Works Supervised Injection Site (SIS) Environment; Toronto Public Health, Public Health Ontario (117)
- COVID-19: Responding to Opioid Overdoses in Overdose Prevention Services (OPS) and Supervised Consumption Sites (SCS); BC Centre for Disease Control, BC Ministry of Health (125)
- Opioid Poisoning Response and COVID-19; Alberta Health Services (102)
- VCH Overdose Response in Overdose Prevention Sites and Supervised Consumption Sites for COVID-19; Vancouver Coastal Health (96)

3.3.6 Staff Exposures to COVID-19

Ensuring appropriate participant and staff screening procedures, PPE training and access, physical distancing, and cleaning procedures will minimize risk of exposure to staff. However, staff should have clear guidance on decontamination and reporting protocols in the event that they are exposed. Major breeches could adversely affect service delivery as a large number of staff may be forced to be off work. Any exposure to COVID-19 should be reported to the local public health authority.

Local public health may require that staff who are exposed to known or suspected COVID-19 participants or colleagues without appropriate PPE or physical distancing (e.g., providing care to a participant who is positive for COVID-19 without a medical-grade mask, or responding to an overdose by providing an AGMP to a participant with COVID-19 while not wearing a fit-tested N95 respirator) are excluded from work. Those excluded from work should be instructed to self-monitor for the development of new symptoms, self-isolate, and seek further direction from local public health authorities. Referral to available psychological and financial supports may also be considered.

3.4 REPORTING AND EVALUATION

The government or entity (see section **3.1 Securing an Exemption for an Urgent Public Health Need Site on page 21**) that issued the exemption, the funders, or other authorities may require reporting on supervised consumption service outputs and activities and aggregate demographic information of participants. Data collection should not impede service delivery, particularly in the context of an urgent pandemic-related response. However, where possible, operators should be prepared to collect and report the following minimum data elements:

- the average number of visits per day,
- the number of overdoses/drug emergencies, and
- the aggregated demographics of the participants, including age and gender.

If the site permits peer-assisted injection, the aggregate demographic information should include that of both the injector and the injectee. Operators should report this information in aggregate only to protect the privacy of injectors and injectees.

Operators may consider collecting data on the average number of unique visitors per day. To track unique visitors, staff will need to provide a unique identifier to each participant upon their initial presentation to the site. This identifier will be provided at each subsequent visit, so it is important to choose an identifier that the participant will remember while retaining their anonymity.

Operators may also consider tracking information on utilization of available services within the site (e.g., number of drug checking episodes, number of consumption episodes, number of referrals to other services). Other data elements that are collected at existing supervised consumption services include the self-reported drug that participants consume on site, the route of administration of each consumption episode, and details on overdose interventions and other direct health care provided.

Depending on the capacity of each site, there are a few possible avenues for collecting this information. Staff can record the data on paper, which can be collated later into a secure database, or within a software program such as Microsoft Excel or Access (see **Appendix 1: Example Form for Supervised Consumption Service Data Collection on page 57**).

If operators have the capacity, they should consider conducting evaluation or quality improvement activities at their site. Evaluations are often not required by the government body that provided the exemption, the funders, or other health authorities, but may be useful for demonstrating the effectiveness of the site in supporting participants in complying with public health recommendations, determining participant satisfaction with the service, and facilitating opportunities for service improvement and expansion to other emergency shelter settings.

4.0 Providing Addiction Treatment and Pharmacotherapy in Shelter Settings

4.1 INCREASED RISK OF ADVERSE OUTCOMES FOR PEOPLE WHO USE SUBSTANCES AND ARE EXPERIENCING HOMELESSNESS DURING THE COVID-19 PANDEMIC

People with substance use disorders residing in shelter settings may experience difficulty accessing legal and/or illegal drugs during the COVID-19 pandemic. Physical distancing requirements may make obtaining substances more difficult, and those purchasing illegal drugs are at risk of overdose, and exposure to and transmission of COVID-19. Leaving a shelter to obtain illegal or legal substances while under a directive to quarantine or self-isolate may contravene public health orders. Face-to-face interactions to purchase drugs serve as opportunities for direct transmission, and items exchanged (e.g., drugs, money) could serve as avenues for viral transmission. Further, shelter residents faced with income instability may participate in sex work, panhandling, or other income-generating activities that increase transmission risks for themselves and others (see (126) for more information on sex work and COVID-19).

Pandemic-related border closures and supply disruptions may further complicate access to drugs, potentially increasing levels of drug adulteration or contamination, making the potency and toxicity of the illegal market even less predictable (5,127). Abrupt cessation or reduction of substance use can lead to withdrawal symptoms that vary in severity and presentation according to substance, the typical frequency of use, and dose consumed. Withdrawal from tobacco and cannabis can result in non-life-threatening withdrawal symptoms that cause significant discomfort (128). Withdrawal from opioids (e.g. fentanyl, heroin, hydromorphone, morphine) can lead to extreme discomfort though generally does not cause serious medical complications (128). Stimulant (e.g. methamphetamine, cocaine) withdrawal can result in agitation and irritability, or conversely depression and increased sleeping. Benzodiazepine and alcohol withdrawal, in severe cases, can result in potentially life-threatening symptoms that require emergency medical care (e.g., seizures, delirium, hallucinations, extreme agitation, and fluctuations in body temperature and blood pressure) (129).

Periods of abstinence from substance use can lead to reduced physiological tolerance (130). Risk of mortality may be seven to twelve-fold for some people who use substances in the immediate period following a return to substance use (131–133). Complicating this situation is the fact that some withdrawal syndromes can mimic the symptoms of COVID-19. For example, opioid withdrawal often presents as influenza-like illness (e.g. runny nose, chills, gastrointestinal upset, fatigue). This may complicate screening and isolation protocols and increase the risk of COVID-19 transmission if symptoms of opioid withdrawal are mistaken for influenza-like illness, and potentially lead to exclusion from shelter services or inappropriate cohorting of COVID-19 negative people with others who are COVID-19 positive or at high-risk of COVID-19 infection.

4.1.1 Overview of Substance Use Disorder Treatment and Risk Mitigation Strategies for Supporting People who use Substances in Shelter Settings During the COVID-19 Pandemic

Supporting shelter residents in reducing or stabilizing their substance use and preventing withdrawal and overdose is thus critical for preserving their health and wellbeing and reducing strain on shelter staff and the health care system. This may be achieved through the provision of a range of on-site or off-site substance use supports.

The following sections outline: [1] evidence-based first- and second-line substance use disorder treatments that are commonly offered in Canada for people seeking help reducing or abstaining from substance use (section **4.2 Ensuring Access to Substance Use Disorder Treatment on page 44**), and [2] risk mitigation strategies involving provision of replacement pharmacotherapy or managed alcohol for those who decline treatment or for whom conventional treatments have not been effective (section **4.3 Risk Mitigation Strategies to Reduce Harms Associated with Ongoing Drug and Alcohol Use on page 47**). These risk mitigation strategies have developed in response to the combined health risks of the overdose epidemic and COVID-19. They are not considered substance use disorder treatment but rather are intended to support people with substance use disorders to self-isolate or social distance and avoid health risks of withdrawal, overdose or other harms related to drug use.

Readers should note that the sections below are intended to provide general information to a wide variety of clinical and non-clinical staff working to support people who use substances in diverse shelter settings during the COVID-19 pandemic. Ability to connect residents to various substance use disorder treatment options and risk mitigation strategies described herein will vary according to the setting, the degree to which operators and residents have access to various health care professionals (including medical doctors or nurse practitioners who can prescribe medications when indicated (134,135)), and the availability of external resources to which residents can be effectively referred. Physicians and nurse practitioners working in shelter settings with limited experience in the

management of substance use disorders and presentations of intoxication or withdrawal, may benefit from identifying local resources or mentorship. In some jurisdictions expert consultation telephone services on the management of substance use disorders may be available.

4.1.2 Assessment

At any time during their stay at the shelter, participants might indicate a need for support with their substance use. If desired by the resident, shelter staff should facilitate access to healthcare providers who are able to assist with substance use disorder treatment, withdrawal management, or substance use stabilization/risk mitigation. Health care providers should assess patients' substance use history and medical needs and work with each patient to determine their goals and develop an appropriate care plan. The following resources may be useful for health care professionals looking for more detailed guidance on assessing patients' substance use, diagnosing substance use disorder, and documenting the appropriateness of various substance use disorder treatment or risk mitigation strategies:

- CRISM National Guideline for the Clinical Management of Opioid Use Disorder; CRISM (136)
- National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline; CRISM (137)
- A Guideline for the Clinical Management of Opioid Use Disorder; British Columbia Centre on Substance Use and British Columbia Ministry of Health (138)
- Guidance Document on the Management of Substance Use in Acute Care (139)
- Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder; British Columbia Centre on Substance Use, British Columbia Ministry of Health, and British Columbia Ministry of Mental Health and Addiction (140)
- Risk Mitigation in the Context of Dual Public Health Emergencies; British Columbia Centre on Substance Use (141)
- Screening & Assessment Tools; American Society of Addiction Medicine (142)

4.2 ENSURING ACCESS TO SUBSTANCE USE DISORDER TREATMENT

All shelter residents should have access to evidence-based treatment for their substance use disorder(s). To provide treatment to shelter residents, operators will need to develop partnerships with health care professionals (i.e., medical doctors or nurse practitioners (134,135) who can prescribe medications when indicated), pharmacists, counsellors, social workers, peer support workers and other allied health professionals. How these partnerships look is dependent on a variety of factors, including shelter capacity and available community resources. Partnership options include embedding health care professionals within the shelter, using telehealth or other virtual care models, and partnering with nearby primary care practices, opioid agonist treatment clinics, or addiction medicine clinics. The partnership model chosen will influence which treatments can be initiated and maintained on site. Whether there is access to a pharmacy will also play a role in determining which treatments can be offered. Regardless of the partnership model, the goal should be ongoing access to care both during the COVID-19 pandemic and after it ends (either with the same health care professional or via seamless transfer of care; see section **4.6 Ensuring Continuity of Care after a Period of Isolation and Once the Immediate Threat of COVID-19 Subsides on page 53** for more information).

When assessing the most appropriate option for a patient, health care professionals should take into account which medications will be covered by the public drug benefit plans (see (143) for details on provincial/territorial coverage of common medications). Individuals without medication coverage should be supported to obtain coverage; this may be facilitated by partnership with local social workers or government offices (144). Any specific storage requirements should also be considered. Note that Health Canada has recently introduced new regulatory measures designed to reduce barriers to prescribing and dispensing controlled substances during the COVID-19 pandemic. Please see their document Subsection 56(1) Class Exemption for Patients, Practitioners and Pharmacists Prescribing and Providing Controlled Substances in Canada during the Coronavirus Pandemic (144) for more information.

4.2.1 Treatment of Opioid Use Disorder

Healthcare professionals should work with their patients diagnosed with opioid use disorder to determine the most appropriate treatment option. Treatment for opioid use disorder typically includes opioid agonist treatment (OAT) with buprenorphine/naloxone, methadone, slow release oral morphine (SROM), or injectable opioid agonist treatment (iOAT) with hydromorphone or diacetylmorphine (where available).

Buprenorphine/naloxone is the preferred first-line treatment approach for individuals with opioid use disorder when induction is feasible and there are no contraindications to its use, as it has fewer side

effects and important safety advantages compared to methadone. Methadone can be considered an alternate first-line option in cases where buprenorphine/naloxone induction would be challenging or according to patient preference. For individuals not benefiting from adequately-dosed buprenorphine/naloxone or methadone, transitioning to the alternative first-line agent may be considered. In patients for whom first-line treatment options are ineffective, contraindicated, or refused, OAT with SROM may be considered. Kadian®, a 24 hour long acting morphine formulation, is the only product studied for SROM. [*excerpts from the CRISM National Guideline for the Clinical Management of Opioid Use Disorder* (136)]

For patients with treatment refractory opioid use disorder and ongoing illegal injection opioid use, iOAT with diacetylmorphine or hydromorphone may be appropriate treatment options where available. [*see CRISM's Injectable Opioid Agonist Treatment for Opioid Use Disorder National Clinical Guideline* (137)]

For some treatment options (e.g., methadone), the stabilization period can be long. If the patient is isolated during the stabilization period, they may still require management of withdrawal in addition to their OAT. This may include provision of other prescribed opioids; see section **4.3.1 Ongoing Opioid Use on page 48** for more information.

Operators and health care professionals providing treatment for opioid use disorder may find the following resources useful:

- CRISM National Guideline for the Clinical Management of Opioid Use Disorder; CRISM (136)
- National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline; CRISM (137)
- Risk Mitigation in the Context of Dual Public Health Emergencies; British Columbia Centre on Substance Use (141)
- Toolkit for Substance Use and Addictions Program Applicants: Stream 2 - Increasing Access to Pharmaceutical-Grade Medications; Health Canada (145)
- Buprenorphine/Naloxone Microdosing: The Bernese Method: A Brief Summary for Primary Care Clinicians (146)
- COVID-19 Opioid Agonist Treatment Guidance; CAMH, META:PHI, and OMA (147)

4.2.2 Treatment of Stimulant Use Disorder

There are currently no approved pharmacotherapy options for the treatment of stimulant use disorder; guidance on risk mitigation prescribing is provided below (see section **4.3.2 Ongoing Stimulant Use on page 49**). Stimulant intoxication or withdrawal should be managed symptomatically (prescribing medications to address specific symptoms like agitation). Where possible, effective psychosocial treatments for stimulant use disorder should be offered, including contingency management programs (148–150).

4.2.3 Treatment of Benzodiazepine Use Disorder

Abrupt discontinuation of legal or illegal benzodiazepines could lead to benzodiazepine withdrawal, which can constitute a medical emergency and requires urgent treatment using symptom-triggered administration of benzodiazepines. Benzodiazepine use disorder can be managed through gradual benzodiazepine tapering or a period of benzodiazepine maintenance therapy (129). Since maintenance therapy is generally felt to increase harm (e.g. risk of fatal overdose, falls, worsening of mental health symptoms), an approach to maintenance may include a period of support and stabilization with regularly dispensing slow-onset, long-acting benzodiazepines to allow for a case-by-case assessment of risks and benefits (129,151,152). Health care professionals should attempt to ascertain the patient's current dose, although this may be challenging due to the counterfeit products available on the illegal market. To account for the variability in actual dosing, health care professionals should start patients on a reduced dose with supplemental doses available to determine the effective dose (141). If patients are also using opioids or if there is concurrent alcohol use, close monitoring is required as benzodiazepines particularly increase the risk of respiratory depression and overdose when co-used with these substances (141).

4.2.4 Treatment of Alcohol Use Disorder

Severe alcohol withdrawal is a life-threatening medical condition that may require urgent management to prevent complications such as cardiac arrhythmias, seizures, and delirium. Prevention of severe withdrawal requires regular (e.g. initially hourly) symptom assessment; if this is not feasible within the shelter, the patient should be transferred to acute care. Withdrawal typically presents within 6-24 hours after a person's last drink and can be present when alcohol levels are still elevated. Benzodiazepines are the standard of care for patients at risk of severe withdrawal and the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) (153) can reliably be used to differentiate patients at high or low risk of severe withdrawal. Even once alcohol withdrawal has been appropriately treated and resolved, cravings to drink and relapse routinely occur. Medications such as naltrexone and acamprosate have been found to assist those with alcohol use disorder to reduce intake, support abstinence, and delay time to first relapse. Examples of first line medications include naltrexone and

acamprosate, and second line medications include gabapentin, baclofen, and valproic acid (154). Naltrexone should not be prescribed to patients with severe alcoholic hepatitis or decompensated cirrhosis, or who take opioids (including both prescribed and illegal opioids). Acamprosate is recommended for patients who have a treatment goal of abstinence, and is contingent on sufficient renal function and availability (as it is often on shortage). Neither naltrexone nor acamprosate are contraindicated if the patient resumes drinking (139).

4.2.5 Treatment of Tobacco Use Disorder

Many people staying at shelters consume tobacco on a daily basis, and will require nicotine replacement therapy (NRT) to avoid withdrawal if wishing to abstain from tobacco use. There is a low risk of adverse effects with NRT. NRT in the form of gum, lozenges, or transdermal patches can be obtained without a prescription in some provinces, and a stock of each of these NRT options can be stocked on site. External funding sources may be available to aid with the cost (155); collaborating with the patient's pharmacist can help to clarify what products will be covered. The type of NRT dispensed may depend on availability, funding, and patient preference. Patients should be encouraged to shift to NRT as a way of reducing vulnerability to severe outcomes associated with COVID-19, which is primarily a respiratory illness.

4.2.6 Treatment of Cannabis Use Disorder

Although research into pharmacological options to support individuals experiencing cannabis withdrawal is ongoing (156,157), these options do not have a strong evidence base as of yet. First line treatment for cannabis use disorder includes psychosocial treatments such as cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET), or contingency management (158) if available in a shelter setting. When indicated, health care providers might consider authorizing cannabis for patients who qualify for medical cannabis though costs may be a barrier to access (156).

4.3 RISK MITIGATION STRATEGIES TO REDUCE HARMS ASSOCIATED WITH ONGOING DRUG AND ALCOHOL USE

Not all patients will accept or stabilize on evidence-based treatment options for their substance use disorders. In these cases, steps should be taken to minimize the harms associated with ongoing procurement and use of substances from the illegal drug market. As described above, if COVID-19 positive patients leave shelters or isolation settings to procure and use substances, it puts themselves and others at risk. When evidence-based treatment options are not effective or are declined, health

care professionals should consider providing access to replacement medications for withdrawal and craving management. When prescribing replacement medications for the prevention of withdrawal, health care professionals should document their assessment and justification of medication choice, including that evidence-based, approved treatment options were ineffective or declined by the patient.

Ideally, patients would be encouraged to consume medications orally, as oral ingestion is generally associated with the least potential harm. If this is not possible, patients would ideally be supported in consuming the prescribed substances through their preferred route of administration (i.e., intranasal, injection, inhalation). Witnessed dosing of prescribed substances may be required by regulators in some jurisdictions, although not all jurisdictions require witnessed dosing in the context of COVID-19 risk mitigation (e.g., British Columbia, (141)) and some jurisdictions have not announced policies on this. Shelter operators could implement a designated area with consumption spaces that maintain physical distancing protocols and are compliant with infection prevention and control precautions, is monitored by staff trained in overdose response and harm reduction principles, and provides sterile drug consumption equipment to each patient. Note that if patients are only consuming substances prescribed to them, a federal exemption under section 56.1 of the *Controlled Drugs and Substances Act* is not required. Alternatively, the provision of pharmacotherapy could be integrated into an on-site or an external proximal supervised consumption service, which will comply with the required criteria for safer drug consumption. Depending on the medication, formulation, and jurisdiction, daily-dispensing of unobserved doses to shelter residents may also be feasible. British Columbia Centre for Substance Use' *Risk Mitigation in the Context of Dual Public Health Emergencies* provides detailed guidance on recommended prescribing practices (141).

4.3.1 Ongoing Opioid Use

If a patient is using illegal opioids in addition to their OAT or declines OAT, prescribe according to current use and use patient preference and clinical judgment to select appropriate medications and dosage. Dose and medication should be decided on collaboratively with each individual, via a shared decision-making process. Important considerations include: OAT co-prescription, amount and pattern of substance use (i.e., daily or binge), ongoing use of alcohol and/or other substances, and vulnerability to overdose and COVID-19 infection. Patients should be advised that injection of controlled release opioid formulations has been associated with an increased risk of serious bacterial infections including endocarditis (159–161). Injectable formulations or immediate release tablets could be considered for people who indicate a preference for injecting, although each option carries its own risk. The dose can be adjusted over time, with a goal of the person being comfortable and not needing to access the illegal drug market. [*excerpts from Risk Mitigation in the Context of Dual Public Health Emergencies*; see this document for detailed guidance on prescribing practices (141)]

4.3.2 Ongoing Stimulant Use

The generally good safety profile of prescribed stimulants suggests that replacement therapy with psychostimulants could be a reasonable clinical decision in these extraordinary circumstances though the potential risks of exacerbating mental health challenges (e.g. agitation, psychosis) must be balanced with potential benefits. The available pharmacotherapy options for stimulants include dextroamphetamine (Dexedrine®) and methylphenidate (Ritalin®) [*excerpts from Risk Mitigation in the Context of Dual Public Health Emergencies*; see this document for detailed guidance on prescribing practices (141)].

4.3.3 Ongoing Alcohol Use

Managed alcohol programs (MAPs) are a promising option for supporting shelter residents whose pattern of alcohol consumption may place them at increased risk of harm during COVID-19. MAPs provide measured quantities of beverage alcohol to people with alcohol use disorder, and are offered in many settings in Canada (162). Eligible participants should be assessed for the amount and frequency of alcohol required, which will depend on individual needs based on established drinking patterns to reduce harms and reduce/prevent withdrawal symptoms. The Canadian Institute for Substance Use Research provides a conversion tool to identify the standard drinks or volume required for the participant based on their typical alcohol consumption (163). While administration times may vary by shelter, participants should be offered alcohol after waking and prior to sleeping at a minimum. The patient typically signs a participation agreement document, which should clearly state the expectations of the patient while in the MAP (e.g., let the staff know if the dosage or frequency is inadequate rather than seeking out other sources of alcohol, no violence or aggression towards other people in the shelter, etc.) as well as outline their individualized dosing plan. The agreement can be modified and re-signed as necessary.

Depending on the type of shelter setting, staff could create a centralized alcohol consumption space only for MAP participants or provide distributed delivery of alcohol to shelter residents. For centralized areas, the space needs to be large enough that physical distancing is maintained, which can be further supported by staggering administration times if appropriate PPE is available. Other MAP models are distributed in that participants may consume alcohol in their room; this may include a daily delivery of a preset amount of alcohol allowing the participant to determine the timing of their own consumption. Such a model may only be possible in shelter settings where participants have their own room or other physical space. Prior to administering a dose, staff should assess the participant's level of intoxication. If the participant is walking and standing unaided but has slight impairment to speech and cognition, consider administering the dose. However, if the participant has gross motor skill impairment and experiences challenges moving and communicating, defer the dose to the next administration time. Alcohol should be administered in disposable cups to eliminate the risk of

COVID-19 transmission. Details regarding each administration episode should be recorded. Education on safer drinking strategies and self-management of alcohol consumption should be provided. For more information on MAPs, please see The Canadian Managed Alcohol Program Study.

While a formal MAP is the ideal standard for supporting people with alcohol use disorder or high-risk patterns of alcohol consumption, it may not be feasible in all settings. In shelters where it is not possible to administer a managed alcohol program, consider providing advice on alcohol harm reduction to residents instead. Other potential supports include: assisting with the monitoring of residents' alcohol consumption; storing residents' own alcohol in a secure location; encouraging them to space out their drinks, eat before consuming alcohol and switch to lower-percentage alcohol products; and facilitating purchase of beverage alcohol as an alternative to non-beverage alcohol (e.g., hand sanitizer, mouthwash, rubbing alcohol). Disposable cups should be available so that people do not need to drink directly from the bottle or share bottles. Sharing cups should be avoided, and facilities for immediate disposal of cups after use should be provided. Staff should also be aware of the elevated risks associated with consuming non-beverage alcohol, such as hand sanitizer, (e.g., toxic ingredients and increased ethanol concentration (164)), and take measures to avoid diversion of larger quantities of these products given that alcohol-based hand sanitizers will be more available in shelter settings due to their role in COVID-19 infection prevention and control efforts.

For further information on safer consumption guidelines for alcohol, please see the following resources:

- Alcohol Use & COVID-19 (165)
- Alcohol and COVID-19: What you Need to Know; World Health Organization (166)
- Canada's Low-Risk Alcohol Drinking Guidelines; Canadian Centre on Substance Use and Addiction (167)
- Safer Drinking Tips; Canadian Institute for Substance Use Research & Eastside Illicit Drinkers Group for Education (168)
- Safer Drinking Tips During COVID-19; Canadian Institute for Substance Use Research & Eastside Illicit Drinkers Group for Education (169)

4.3.4 Ongoing Tobacco Use

For people who continue to use tobacco, operators should designate an outdoor location at the emergency shelter for tobacco consumption that allows patients to maintain appropriate physical distancing (this area should be separate from the designated inhalation area of any supervised consumption service, if possible). While tobacco consumption is legal and products are relatively easily

accessible in Canada, access will be limited for people staying at the emergency shelter. Therefore, some may require support in accessing adequate nicotine to meet their needs. Consider providing tobacco products to residents who are not willing to participate in NRT (or as a supplement to NRT) as a risk reduction measure to prevent sharing of cigarettes during the COVID-19 pandemic. To promote health and reduce the risk of complications from possible COVID-19 infection, encourage residents to switch to lower strength tobacco products or to reduce the amount of cigarettes they consume per day. Advise against sharing cigarettes or collecting butts. Ensure that appropriate, tamper-proof ashtrays are provided for safely discarding cigarette butts after they have been used. Regularly empty ashtrays and clean smoking areas of improperly discarded butts.

Chewing tobacco is frequently used covertly in settings where smoked tobacco products are prohibited, as it is inside most shelters. Advise residents on infection prevention and control measures when using chewing tobacco, as spitting associated with chewing tobacco poses COVID-19 transmission risks. Providing single use containers with secure lids for 'spittoons' will minimize the use of informal solutions, such as dishes or disposable drink containers, which may spill and contaminate the surrounding area.

4.3.5 Ongoing Cannabis Use

As cannabis consumption is legal in Canada, residents who wish to smoke cannabis should have access to a designated outdoor location for consumption (this can be incorporated into the area for tobacco consumption), and those who wish to consume cannabis through other routes (e.g., edibles) should be permitted to do so within the shelter. For those who wish to continue smoking cannabis, staff may consider partnering with local programs distributing cannabis at reduced cost (170) and providing safer cannabis consumption advice based on the Lower Risk Cannabis Use Guidelines, such as consuming via routes other than smoking, not smoking synthetic cannabinoids and avoiding inhaling deeply or holding one's breath (171), as the risk of harm from cannabis consumption is generally lower than that of tobacco, alcohol, and other psychoactive drugs (172). Sharing joints or other consumption equipment (e.g., bongs, vape pens, etc.) or collecting butts (roaches) should be discouraged. Appropriate, tamper-proof ashtrays should be available for joint disposal and regularly emptied. The smoking area should be frequently cleaned of improperly discarded debris.

4.4 ADDITIONAL CONSIDERATIONS FOR HEALTH CARE PROFESSIONALS

All prescriptions should consider the need for physical distancing and/or self-isolation requirements, and - while balancing risks of diversion to vulnerable populations - should be of long enough duration to facilitate compliance with these goals wherever possible.

There are multiple possible avenues for patients to receive their prescribed medications:

- Community pharmacies could deliver day-ahead or day-of daily dispensed medications to the shelter. The prescriber should indicate on the prescription that medications can be delivered to the patient at the shelter. Alternatively, for patients in isolation, the medication may be released to an authorized individual who agrees to ensure delivery to the patient (173).

- A dedicated pharmacy space could be set up on site where pharmacy staff could dispense medications, support witnessed ingestion of required therapies, and prescribe and administer maintenance medications (e.g., long acting antipsychotics, contraception). The pharmacy could also have essential medications on site (e.g., antibiotics). This would require appropriate staffing, PPE, and adequate secure storage within the shelter.

- For patients who have access to a secure storage space, several days of medication may be dispensed at a time. However, daily dispensation may be preferred by some patients for certain therapies.

The following resources provide further details on considerations for prescribing and accessing controlled substances in Canada:

- Frequently Asked Questions: Access to Controlled Substances; Health Canada (135)

- Process for Establishing a Safer Supply Program in Canada; Health Canada (134)

- Relevant Exemptions to the Controlled Drugs and Substances Act; Health Canada (174)

4.5 PSYCHOSOCIAL SUPPORTS FOR PEOPLE USING SUBSTANCES, ACCESSING TREATMENT OR IN RECOVERY

Psychosocial treatment interventions and supports should be routinely offered alone or in conjunction with pharmacological treatment but should not be viewed as a mandatory requirement for accessing medications. Research evidence suggests that in uncomplicated patient populations, the addition of structured psychosocial treatment interventions as adjuncts to opioid agonist treatment does not improve treatment outcomes compared to standard medical management (i.e., general support and unstructured counselling in clinical encounters), which is traditionally provided as standard of care for treatment of substance use disorder. However, this does not suggest that pharmacotherapy should be offered in isolation, but rather that medical management includes ongoing assessment, monitoring, and support for all aspects of physical, emotional, mental, and spiritual health, as these remain

equally important components of treating substance use disorders; addressing these needs should be considered the standard of care. Evidence-based psychosocial supports focused on individual circumstances (e.g., employment, addiction counselling) and other survival needs (e.g., social assistance, housing, disability supports) may also be helpful in supporting recovery from substance use disorder. [*excerpts from CRISM National Guideline for the Clinical Management of Opioid Use Disorder* (137); see (154) for more information on psychosocial supports for alcohol use disorder].

People seeking to reduce their use of alcohol and drugs or work towards other self-determined goals should also be referred to available inpatient or outpatient treatment programs, peer support groups (contact Alcoholics Anonymous, SMART Recovery, or Canadian Association of People who Use Drugs to find out information about local groups), and other recovery supports when requested, depending on local availability. Where indicated, other healthcare should be provided, or a referral to appropriate services made.

Entertainment options for shelter residents who use substances and those attempting to abstain from drug or alcohol use could help distract from potential boredom, particularly for those in isolation. This could include access to loaner cell phones, tablets, music devices; art supplies, and reading materials. These supplies must meet infection prevention and control guidelines, and must be either disposable or be able to be thoroughly sanitized in between uses. Where possible, to avoid risk of relapse, shelters may wish to designate certain areas for individuals pursuing abstinence and those in recovery that are separate from individuals who remain active in their drug or alcohol use.

4.6 ENSURING CONTINUITY OF CARE AFTER A PERIOD OF ISOLATION AND ONCE THE IMMEDIATE THREAT OF COVID-19 SUBSIDES

It is important that a plan for continuing to support shelter residents who use substances be developed and implemented post-pandemic. Additionally, proper transition of care into the community after medical isolation or discharge from a temporary shelter is vital to ensuring positive outcomes and ultimately reducing homelessness. This includes seeking longer term housing options and robust healthcare access. When residents are discharged from shelter settings, community clinicians (if a transfer of medical care is required) should be provided with relevant documents to ensure continuity of therapy and management plans that include follow up appointments, medications administered while in the shelter, and changes in management (including its rationale) that are to continue once a patient completes medical isolation or is discharged from a temporary shelter. Residents should be discharged with a concrete plan for obtaining safe, appropriate housing and referred to relevant harm reduction, treatment, and recovery supports in the community.

Health care professionals caring for residents of medical isolation shelters should consider communicating with the patient's regular community providers, as the community provider can provide background history and valuable input into discharge planning. If possible and appropriate, consider facilitating virtual care options so that people can remain attached to any regular health care providers. This is optimal for ensuring continuity of care. Community providers can also convey what goals have been set when the patient was in the community and support the medical team in furthering these goals while in the shelter. Inclusion of the community provider can also maximize the efficient use of resources.

The following elements should be considered when preparing for the patient's discharge from medical isolation or a temporary shelter and return to the care of a community provider:

- Ensure the patient has a community provider.
- Consider providing the patient with documentation of time spent in the shelter and illness status in case proof of illness resolution is required to access community resources or return to prior housing.
- Ensure safe housing/location for discharge.
- For those on managed alcohol, refer to a community or housing-based managed alcohol programs, or otherwise ensure the patient has ability to maintain access to alcohol post-discharge.
- Ensure medication coverage is in place for all prescriptions.
- Ensure community pharmacy has prescribed medications available.
- Ensure prescriptions are sent to the community pharmacy for any ongoing medications - prescriptions should continue until the next follow up date and should not end on a Friday, Saturday, Sunday or statutory holiday. Communicate the following items to the community pharmacist:
  - Dose and date/time of last dose of medication administered at the shelter.
  - Who will be taking over prescribing, and date and time of next appointment.
  - Who to notify of any missed doses of medication.
  - When to hold doses.
  - Specific instructions on how to handle missed doses (if appropriate).
- Ensure primary care or other specialist appointment is arranged for ongoing prescribing.

- Ensure discharge prescription is sufficient in duration to prevent withdrawal while the patient is transitioning to community supports.
- Ensure the patient has a take home naloxone kit, and other harm reduction supplies, as needed.
- All follow up plans provided verbally and in writing to the patient and any support people as requested by the patient.

[*excerpts from the Guidance Document on the Management of Substance Use in Acute Care* (139)].

4.7 REPORTING AND EVALUATION

Funding and regulatory bodies may require sites or health care professionals providing substance use disorder treatment or replacement pharmacotherapy to report on or evaluate the provision of care in support of people who use substances in shelter settings. Data collection should not impede service delivery, particularly in the context of an urgent pandemic-related response. Where possible, operators may still find value in evaluation activities to explore whether the provision of pharmacotherapy in the shelter enabled adherence to public health orders or guidance, to assess patient satisfaction with the care received, to identify opportunities for improvement, and to support the expansion of this service to other emergency shelter settings.

5.0 Further Reading and Resources

- A Treatment Improvement Protocol: Trauma-Informed Care In Behavioral Health Services; Substance Abuse and Mental Health Services Administration (175)
- Challenges in Maintaining Treatment Services for People who use Drugs during the COVID-19 Pandemic; Harm Reduction Journal (176)
- COVID-19 Guidance: Consumption and Treatment Services (CTS) Sites; Ontario Ministry of Health (88)
- COVID-19: How to Include Marginalized and Vulnerable People in Risk Communication and Community Engagement; The Regional Risk Communication and Community Engagement Working Group (177)
- COVID-19: Information for Opioid Agonist Treatment Prescribers and Pharmacists; British Columbia Centre on Substance Use (178)
- EMCDDA Update on the Implications of COVID-19 for People who use Drugs (PWUD) and Drug Service Providers; European Monitoring Centre for Drugs and Drug Addiction (179)
- Housing Services: COVID-19 Guidance for Homelessness Service Providers; Region of Peel (87)
- Interim Guidance: Scaling-Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations Including Camps and Camp-Like Settings; Inter-Agency Standing Committee Secretariat (180)
- Safe Supply and Harm Reduction During COVID-19; Homeless Hub (181)
- Suggestions about Treatment, Care and Rehabilitation of People with Drug Use Disorder in the Context of the COVID-19 Pandemic; United Nations Office on Drugs and Crime (182)
- Toolkit for Substance Use and Addictions Program Applicants: Stream 2 - Increasing Access to Pharmaceutical-Grade Medications; Health Canada (145)
- Trauma Informed Practice Guide; BC Provincial Mental Health and Substance Use Planning Council (183)
- VCH Overdose Response in Overdose Prevention Sites and Supervised Consumption Sites for COVID-19; Vancouver Coastal Health (96)

Appendix 1: Example Form for Supervised Consumption Service Data Collection

Form 1 – First Time Visit Only

Participant's Unique Code	
Date (dd/mm/yyyy):	
Time (24:00):	

How does the participant identify?	□ Male	□ Female	□ Other:
How old is the participant?			
Other notes:			

Form 2 – Consumption and Supply Visit Form

Visit Info

Participant's Unique Code	
Date (dd/mm/yyyy):	
Time (24:00):	

Consumption Info

If the participant consumed, how did they consume? (you may choose more than one)			
□ Injection	□ Oral	□ Intranasal	□ Inhalation
If the participant consumed, what did they consume? (you may choose more than one**)**			
□ Cocaine/crack □ Fentanyl □ Heroin	□ Meth/amphetamine □ Morphine □ Unknown	□ Dilaudid/Hydromorphone □ Indeterminate 'down' □ Other:	
If the participant didn't consume, why not? (you may choose more than one)			
□ Couldn't find a vein □ Did not like no splitting rule □ Needs assistance injecting □ Other:	□ Too intoxicated/sick/unable □ Uncomfortable/problem with space	□ No/insufficient/misplaced drugs □ No reason given	

Form 3 - Medical Emergency Information

MEDICAL EMERGENCY INFORMATION

If the participant experienced an overdose:

Was naloxone administered?	□ Yes	□ No
[If yes] exact mg: or number of doses		
What other interventions were performed?		
Was 911 called?	□ Yes	□ No
Outcome of 911 call?		
Other notes:		

If the participant experienced a non-overdose medical emergency:

Description of medical emergency:		
What interventions were performed?		
Was 911 called?	□ Yes	□ No
Outcome of 911 call?		
Other notes:		

Appendix 2: Online Substance Use Resources Listing

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

Clinical Support Resources for Patients and Healthcare Providers

Anxiety Canada's free MindShift™ CBT app
This app focuses on assisting in the management of anxiety using scientifically proven strategies (*free for iOS and Android devices*)

British Columbia Centre on Substance Use: COVID-19

Canadian Addiction Counsellors Certification Federation
Virtual addiction counselling

CATIE – Canada's source for HIV and hepatitis C information

College of Physicians and Surgeons of Newfoundland and Labrador - Opioid Agonist Treatment (OAT) Guidance during COVID-19

Community Addictions Peers Support Association (CAPSA) **and** **Breaking Free Online**
In response to COVID-19 and the increased risks for those with substance use disorders, the Community Addictions Peers Support Association (CAPSA) has partnered with Breaking Free Online to provide free access to Canadians (service code CAPSA2020)

Draft Emergency Carry Agreement

Nova Scotia Department of Health and Wellness: Points to Guide Clinical Decision for OAT Prescribers

Nova Scotia Health Authority (NSHA) Standard Operating Procedures for Opioid Use Disorder Treatment (OUDT) Programs
Documents included: Overview and Infection Control Practices SOP, New Admissions and Transfers SOP, Ongoing Client Being Prescribed Methadone SOP, and Clients in Self-Isolation or Quarantine SOP.

Providence Health Care Nursing Practice Standard Dispensing Injectable Opioid Agonist Therapy to Client With or at Risk of COVID-19

SMART Recovery Program
This website includes message boards, chat rooms, online meetings, and an online library of recovery resources

Take Home Naloxone
Free online naloxone training

Toward the Heart
Free online naloxone training

Harm Reduction Resources

Canadian Association of People Who Use Drugs (CAPUD)

Canadian Drug Policy Coalition: COVID-19 Harm Reduction Resources

International Network of People Who Used Drugs: COVID-19 Crisis: Harm Reduction Resources for People who Use Drugs

Mental Health and Substance Use Resources

Centre for Addiction and Mental Health (CAMH): Mental Health and the COVID-19 Pandemic

Narcotics Anonymous

Taking Care of Your Mental Health (COVID-19)

Wellness Together Canada: Mental Health and Substance Use Support

Indigenous Communities

Assembly of First Nations: COVID-19

First Nations Health Managers Association: COVID-19 Resources and Announcement
Up-to-date information on COVID-19

First Peoples Wellness Circle: COVID-19 Resources page

Provides printable Information Sheets for Mental Wellness for Community; Parents and Children; Elders and Seniors; and Health Professionals

Thunderbird Partnership Foundation: Harm Reduction during COVID-19

Support Resources for Healthcare Providers

Canadian Foundation for Healthcare Improvement (CFHI)

Supports partners to accelerate the identification, spread and scale of proven healthcare innovations. Webinar Series: Patient Partnership in a Time of COVID-19

Health Canada Subsection 56(1) Class Exemption for Patients, Practitioners and Pharmacists Prescribing and Providing Controlled Substances in Canada during the Coronavirus Pandemic

In response to the evolving health risk due to COVID-19, to maintain Canadians' access to controlled substances for medical treatments (e.g., treatment of substance use disorders and chronic pain), while they adhere to social distancing guidance from public health officials or if they need to self-isolate, Health Canada has issued exemptions for prescriptions of controlled substances under the Controlled Drugs and Substances Act (CDSA) and its Regulations.

Mental Health First Aid Canada

Resource hub which provides credible information and resources for mental health for the Healthcare professionals "Resources for Healthcare Sector"

Appendix 3: Health Canada Tool Kit

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

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

https://www.dropbox.com/sh/x622qndzvmydsvm/AABi888G_As

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