



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

NATIONAL RAPID GUIDANCE

VERSION 1 - CRISM INTERIM GUIDANCE DOCUMENT



CRISM-ICRAS

Canadian Research Initiative
in Substance Misuse

Initiative Canadienne de
Recherche en Abus de Substance



CIHR IRSC

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

Citation

To quote this document:

Dong, K., Meador, K., Hyshka, E., Salokangas, E., Burton-MacLeod, S., Bablitz, C., Lail, P., Colizza, K., Etches, N., Cardinal, C., Twan, S., Gilani, F., Brooks, H.L., & Wild, T.C. *Supporting People Who Use Substances in Acute Care Settings during the COVID-19 Pandemic: CRISM - Interim Guidance Document*. Edmonton, Alberta: Canadian Research Initiative in Substance Misuse; June 9, 2020. 61 p. Version 1.

Version 1, June 9, 2020

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 drugs, 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
- Telemedicine Support for Addiction Services

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

Completed documents may be accessed at: <https://crism.ca/projects/covid/>. Each document was developed by a core CRISM 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 caring for patients, health care professionals may take this guidance document 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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document is intended to provide guidance to facilitate substance use 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.

Authors and Contributors

*CRISM Supporting People Who Use Substances in Acute Care Settings during the COVID-19 Pandemic Authorship Committee**

Kathryn Dong, MD, MSc, FRCPC, DABAM; Medical Director, Inner City Health and Wellness Program and Addiction Recovery and Community Health (ARCH) Team, Royal Alexandra Hospital; Clinical Professor, Department of Emergency Medicine, University of Alberta

Karine Meador, MD, CCFP (AM); Assistant Medical Director, Inner City Health and Wellness Program and Addiction Recovery and Community Health (ARCH) Team, Royal Alexandra Hospital; Assistant Clinical Professor, Department of Family Medicine, University of Alberta

Elaine Hyshka, PhD; Assistant Professor, School of Public Health, University of Alberta; Scientific Director, Inner City Health and Wellness Program, Royal Alexandra Hospital

Essi Salokangas, RPh BSc Pharm APA; Clinical Pharmacist, Addiction Recovery and Community Health (ARCH) Team, Inner City Health and Wellness Program, Royal Alexandra Hospital

Sarah Burton-MacLeod, MD, CCFP (PC); Palliative care physician, University of Alberta Hospital and Royal Alexandra Hospital Palliative Care Consult Teams; Assistant Clinical Professor, Division of Palliative Care Medicine, Department of Oncology, University of Alberta

Cara Bablitz, MD, CCFP (PC); Family Physician, Indigenous Wellness Clinic, Royal Alexandra Hospital; Assistant Clinical Professor, Department of Family Medicine, University of Alberta

Parabdeep Lail, BSc (Hons), MD, FRCPC; Clinical Lecturer, Department of Medicine, University of Calgary; Medical Director, Addiction Recovery and Community Health (ARCH), Peter Lougheed Hospital

Kate Colizza, BSc, MD, FRCPC, ISAM; Clinical Lecturer, Cumming School of Medicine, University of Calgary; Assistant Medical Director, Addiction Recovery and Community Health (ARCH), Peter Lougheed Centre

Nicholas Etches, MD, FRCPC; Lead Medical Officer of Health for Provincial Harm Reduction, Alberta Health Services; Clinical Assistant Professor, Community Health Sciences, University of Calgary

Chris Cardinal; Peer Support Worker, Addiction Recovery and Community Health (ARCH) Team, Inner City Health and Wellness Program, Royal Alexandra Hospital

Shanell Twan; Core Team Supervisor, Streetworks; Facilitator of AS IT IS, Alberta Addicts Who Educate and Advocate Responsibly (AAWEAR); Alberta Representative of Canadian Association of People who Use Drugs (CAPUD) Board; Community Liaison, Inner City Health and Wellness Program, Royal Alexandra Hospital

Fizza Gilani, RPh, BSc(Pharm); Program Manager Prescribing & Analytics, College of Physicians and Surgeons of Alberta

Hannah L. Brooks, MSc; Data Coordinator, School of Public Health, University of Alberta; Inner City Health and Wellness Program, Royal Alexandra Hospital

T. Cameron Wild, PhD; Nominated Principal Investigator, Prairie Node of the Canadian Research Initiative in Substance Misuse; Professor, School of Public Health, University of Alberta

* NOTE: Committee members participated in guidance development activities in their individual capacity and not as institutional representatives.

External Reviewers*

Julie Bruneau, MD, MSc; Nominated Principal Investigator, Quebec-Atlantic Node of the Canadian Research Initiative in Substance Misuse; Canada Research Chair in Addiction Medicine; Professor, Family Medicine and Emergency Department, School of Medicine, Université de Montréal

Evan Wood, MD, PhD, FRCPC; Nominated Principal Investigator, BC Node of the Canadian Research Initiative in Substance Misuse; Professor of Medicine and Canada Research Chair, University of British Columbia and British Columbia Centre on Substance Use

Rabia Ahmed, MD, FRCPC; Associate Professor, Department of Medicine, University of Alberta; Infection Control and Prevention, Alberta Health Services

Paxton Bach, MD, MSc, FRCPC; Clinical Assistant Professor, Department of Medicine; Associate Director, BCCSU Clinical Addiction Medicine Fellowship, University of British Columbia, Vancouver BC

Peter Butt, MD, CCFP (AM), FCFP; Associate Professor, Department of Family Medicine, College of Medicine, University of Saskatchewan

A. Uma Chandran, MD, MPH, FRCPC; Medical Director, Infection Prevention and Control, Royal Alexandra Hospital, Edmonton AB; Assistant Clinical Professor, University of Alberta

Simon Dubreucq, MD, MSc, FRCPC; Psychiatrist, Service de Psychiatrie des Toxicomanies du CHUM, Professor, Department of psychiatry University of Montreal, Research center, Centre Hospitalier de l'Université de Montréal

Emma Garrod, MSN, RN; Clinical Nurse Educator - Substance Use, Urban Health Program, Providence Health Care; Director, BCCSU Addiction Nursing Fellowship

Kate Harland, BNRN; Centre for Research, Education and Clinical Care for At-Risk Populations (RECAP)

Andrew Kestler, MD, MBA, MScPH, DTMH, FACEP, FRCPC; Clinical Associate Professor, Department of Emergency Medicine, University of British Columbia; Physician Lead, Emergency Department Opioid Crisis Response, St. Paul's Hospital, Vancouver BC; Scientist, Centre for Health Evaluation & Outcome Sciences; Affiliate Research Scientist, British Columbia Centre on Substance Use

Jenny Lau, MD, CCFP (PC); Princess Margaret Cancer Centre, University Health Network

Emilie Lizotte-Chin, RN, BScN; Consultation/liaison, Addiction Medicine Service, Centre Hospitalier de l'Université de Montréal (CHUM)

Francesco Mosaico, MD, CCFP (AM); Medical Director, Boyle McCauley Health Centre and Expo Isolation Shelter, Edmonton AB; Assistant Clinical Professor, Department of Family Medicine, Faculty of Medicine and Dentistry, University of Alberta

Aaron M. Orkin, MD, MSc, PhD(c), CCFP (EM), FRCPC; Department of Family and Community Medicine, University of Toronto, Toronto ON; Department of Emergency Medicine, St. Joseph's Health Centre and Humber River Hospital, Toronto ON; Inner City Health Associates

Anita Srivastava, MD, MSc, CCFP; Associate Professor, Department of Family and Community Medicine, University of Toronto

Samantha Young, BSc, MD, FRCP; Interdepartmental Division of Addiction Medicine, St. Paul's Hospital, Vancouver, British Columbia; Department of Medicine, University of British Columbia, Vancouver, British Columbia; Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario; General Internal Medicine, St. Michael's Hospital, Unity Health, Toronto, ON

*NOTE: Reviewers participated in guidance development activities in their individual capacity and not as institutional representatives.

Detailed Summary – Disclosure of Interests for CRISM Rapid Response COVID-19 Supporting People Who Use Substances in Acute Care Settings during the COVID-19 Pandemic (see Appendix 1 for conflict of interest policy)

In accordance with the Guidelines International Network's *Principles for Disclosure of Interests and Management of Conflicts* (i), 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.

Of 30 authorship committee members and external reviewers, 14 acknowledged potential direct conflicts of interest. Of these, 10 acknowledged employment or consulting with organizations including academic institutions, hospitals/health authorities, professional or regulatory associations, HIV/AIDS foundations, community outreach agencies or federal funding agencies. Only one (an external reviewer) disclosed receiving research funding prior to guidance document involvement from a commercial entity (Gilead) that could theoretically benefit from guidance document recommendations. There was one authorship committee member with a commercial interest in the form of partial ownership of a medical clinic that provides treatment to people who use substances including opioid agonist treatment. On review, potential conflicts of interest were not deemed to be of sufficient weight or relevance to warrant exclusion from the guidance committee.

Most (23, 77%) 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 acute care programs, provincial substance use treatment programs, previous guideline development, research interests). Of these, 6 acknowledged that they have publicly stated support for acute care treatment of PWUD.

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 with indirect potential sources of conflict 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.

i. 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.

Acknowledgments

The committee acknowledges the assistance of the CRISM Node managers: Denise Adams (Prairies), Farihah Ali (Ontario), Nirupa Goel (BC), and Aissata Sako (Quebec/Atlantic).

This work was undertaken, in part, thanks to funding from the Canadian Institutes of Health Research (CIHR) ***CRISM Urgent Guideline Activities Related to COVID-19***.

TABLE OF CONTENTS

ABBREVIATIONS	12
1.0 KEY POINTS OF THE GUIDANCE DOCUMENT.....	13
2.0 PURPOSE AND SCOPE	14
2.1 Development	15
2.2 Intended Audience.....	16
2.3 Background.....	16
2.3.1 Specific risks related to COVID-19 and substance use	16
2.3.2 Risks associated with hospitalization for people who use substances	17
3.0 PROVIDING CARE TO PEOPLE WHO USE SUBSTANCES IN ACUTE CARE SETTINGS	19
3.1 Addressing Stigma	19
3.2 Screening and assessment for substance use	19
3.3 Harm reduction and Recovery	20
3.4 Trauma Informed Care	20
3.5 COVID-19 specific considerations.....	21
4.0 SUBSTANCE SPECIFIC RECOMMENDATIONS.....	22
4.1 General Considerations	22
4.2 Tobacco Use.....	22
4.3 Alcohol.....	23
4.4 Cannabis	24
4.5 Opioids	24
4.6 Stimulants	26
4.7 Addressing ongoing substance use in hospital settings.....	26
4.7.1 Safer use equipment distribution in acute care settings.....	27
4.7.2 Supervised consumption services in acute care settings.....	28
5.0 PREVENTING PATIENT-INITIATED DISCHARGES IN COVID-19 POSITIVE PATIENTS	29
5.1 General Principles	29
5.2 Comfort and Entertainment resources	29
5.3 Connection to supports	30
5.4 Peer Support Services	30
5.5 Connection to substance use supports and recovery resources.....	30
5.6 Use of nursing assistants and other support staff.....	31
5.7 Use of the Public Health Act	31

6.0	END OF LIFE AND PALLIATIVE CARE CONSIDERATIONS	32
6.1	Definition of palliative care	32
6.2	Conversations and planning	32
6.3	Symptom management.....	33
6.3.1	Dyspnea	33
6.3.2	Cough	34
6.3.3	Upper respiratory secretions.....	34
6.3.4	Fever	34
6.3.5	Pain.....	35
6.3.6	Delirium.....	35
6.4	Other considerations.....	35
6.4.1	Palliative Care Consultation	35
6.4.2	Palliative care in other settings.....	36
6.4.3	Psychological and grief support.....	36
7.0	ADDRESSING OTHER HEALTH NEEDS	37
7.1	Mental health concerns	37
7.2	Social Determinants of Health	37
7.3	Immunizations.....	37
7.4	Screening for Sexually Transmitted and Blood Borne Infections.....	38
8.0	TRANSFER OF CARE TO COMMUNITY PROVIDERS AT DISCHARGE	39
8.1	General considerations.....	39
8.2	Discharge to home	39
8.3	Transfer to an Inpatient Addiction Treatment Program.....	40
8.4	Transfer to an emergency shelter.....	40
8.4.1	Adapted shelter (a shelter setting where patients are not required to self-isolate)	40
8.4.2	Medical Isolation Shelter (shelter setting where patients are required to self-isolate)	41
8.5	Discharge prescribing.....	42
	APPENDIX 1 CONFLICT OF INTEREST POLICY	44
	APPENDIX 2: DISCHARGE CHECKLIST	46
	APPENDIX 3: ONLINE SUBSTANCE USE RESOURCE LISTING	48
	APPENDIX 4: HEALTH CANADA TOOL KIT	51
	REFERENCES.....	52

ABBREVIATIONS

AUDIT: Alcohol Use Disorders Identification Test

AUDIT-C: Alcohol Use Disorders Identification Test - Consumption

BiPAP: Bilevel Positive Airway Pressure

CAGE: “Cut-Annoyed-Guilty-Eye Opener”; screening test for alcohol use

COVID-19: Novel Coronavirus disease of 2019

CPAP: Continuous Positive Airway Pressure

DAST-10: Drug Abuse Screening Test

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

ESAS-r: Edmonton Symptom Assessment System Revised

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

iOAT: Injectable Opioid Agonist Treatment

MAID: Medical Assistance in Dying

NRT: Nicotine Replacement Therapy

OAT: Opioid Agonist Treatment

PPE: Personal Protective Equipment

SDM: Substitute Decision Maker

UPHNS: Urgent Public Health Need Site

1.0 Key points of the guidance document

- In the context of COVID-19, extraordinary measures are required to support people who use substances, minimize the spread of COVID-19 within their and other communities and ensure efficient use of acute care resources.
- People who use substances are at increased risk of negative health outcomes during the COVID-19 pandemic due to coexisting medical and mental health conditions, disruptions in drug and alcohol supply, and reduced access to addiction treatment, recovery supports, and harm reduction services such as sterile equipment and supervised consumption services.
- In order to reduce the risk of patient-initiated discharge in patients under investigation for, or with known, COVID-19, steps should be taken to identify patients with substance use disorders and to swiftly initiate evidence-based treatment, as well as aggressively manage withdrawal and cravings, in hospital settings.
- Despite treatment initiation and other strategies to manage withdrawal and cravings, some patients may continue to use substances during hospital admission. In these cases, patients should be provided with access to sterile equipment, a place to safely dispose of used equipment, education about safer drug use during COVID-19, and an individualized safety plan to minimize the risk to themselves (e.g. unwitnessed overdose) and others.
- People who use substances with life-limiting illness related to COVID-19 should be offered a palliative care approach. A detailed opioid use history should be taken on all patients to guide therapy; for patients on opioid agonist treatment, collaboration should occur between the opioid agonist treatment prescriber and the physician managing end of life symptoms.
- Hospitalization should be viewed as an opportunity to address other patient specific health needs such as: mental health concerns; stabilizing the social determinants of health (e.g. providing or connecting patients to resources around housing, income supports, and medication coverage); providing immunizations; and, screening and treatment initiation for sexually transmitted and blood borne infections.
- Discharge planning should include consideration of the discharge location (home, addiction treatment program, adapted shelter, or medical isolation shelter). All patients should have follow up arranged with a prescriber (new or existing), a discharge pharmacy able to accommodate ongoing isolation requirements (if required), confirmed medication coverage, a take home naloxone kit, and an adequate supply of sterile drug use equipment (if required).

2.0 Purpose and Scope

The World Health Organization declared the 2019 Novel Coronavirus (COVID-19) viral infection a pandemic on March 11, 2020. Canada has also been experiencing a crisis of opioid-related harm with more than 14,700 apparent opioid-related deaths between January 2016 and September 2019 (1). This is superimposed on endemic high levels of morbidity and mortality from alcohol (2) and significant regional problems with methamphetamines (3). In addition, border closures related to COVID-19 have interrupted the supply of illegal drugs potentially worsening a drug market already prone to toxic contaminants (4,5). The intensity and harms associated with these simultaneously occurring events varies by province, and interventions must be tailored and prioritized to local context. The intersection of these multiple public health emergencies has the potential to magnify the harms already experienced by people who use substances as well as to overwhelm existing acute care resources (5).

In this context, extraordinary measures are required to support people who use substances, minimize the spread of COVID-19 within communities and ensure efficient use of acute care resources. In particular, insufficient and substandard care for people who use substances in acute care settings, while always unacceptable, now poses the additional risk of patient-initiated discharge potentially leading to community transmission of COVID-19.

The purpose of this national rapid guidance document is to support acute care hospital environments in providing evidence-informed care for people who use substances in the context of the COVID-19 pandemic in Canada. The strategies discussed in this document are intended to help hospital based health care providers identify people in need of substance use related support early in their health care encounter, provide care based on best practices, and mitigate the risks of both substance use related harm and COVID-19 transmission during and after hospitalization.

Specifically, this document provides:

- An overview of the combined health risks associated with COVID-19 infection, substance use, and hospitalization
- An overview of general principles for providing care to people who use substances in acute care settings, including COVID-19 specific considerations
- Substance specific management recommendations in the setting of COVID-19
- Strategies for managing ongoing substance use in hospital settings

- Techniques to minimize patient-initiated discharge prior to the completion of medical treatment
- End of life and palliative care considerations for people who use substances dying from COVID-19
- Suggestions for addressing other health and social concerns during hospitalization
- Guidance on seamless discharge to home, inpatient addiction treatment programs, and shelter settings

Readers should note that this document does not provide recommendations for medication dosing. Prescribers are encouraged to consult relevant clinical practice guidelines, specialist colleagues, or other trusted sources if unfamiliar with the indications, contraindications, drug interactions, side effects, and dosing for medications mentioned herein. It also does not provide guidance for patients requiring resuscitation or care in the intensive care unit.

2.1 DEVELOPMENT

This guidance document on supporting people who use substances in acute care 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 health authorities and other relevant organizations. The recently released document entitled, “[Management of Substance Use in Acute Care Settings in Alberta: Guidance Document](#)” also informed the development of this work and can be viewed as a complementary resource.

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 thorough description of extant literature. However, where available, academic studies are 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 acute care settings across Canada rather than prescriptive procedural instructions. Hospital policies and procedures may vary by provincial/territorial jurisdiction. Readers should consult provincial/territorial health regulatory authorities for advice on navigating their own unique policy environments, as necessary.

Note that a number of external organizations have produced relevant resources for supporting people who use substances. 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 national rapid guidance document includes both clinical and non-clinical staff caring for people who use substances in acute care hospital settings. The information contained in this document may also be relevant for senior operational and medical leaders, policy makers, public health authorities, those operating shelters for people who use substances, groups representing people who use substances, and people with lived and living experience of substance use.

2.3 BACKGROUND

Only a fraction of people who consume alcohol, cannabis, or illegal drugs experience substance-related harm or meet diagnostic criteria for a substance use disorder. Yet every day in Canada, more than 400 people are hospitalized because of harm from alcohol or drugs - more than for heart attacks and strokes combined. Alcohol contributes to more than half of these hospital stays (2). Substance use can result in morbidity and mortality from physical trauma, acute and chronic toxicity, blood borne and pathogenic infections (e.g. HIV, HCV), as well as other health conditions (6,7). Harms can arise from the effect of the substances themselves, or from the circumstances surrounding use such as unsafe injection practices, using alone, and consuming non-beverage alcohol, or contaminated or toxic substances such as fentanyl and other drugs purchased on the illegal market (1,6,7).

2.3.1 Specific risks related to COVID-19 and substance use

People who use substances may be at increased risk of related harm during the COVID-19 pandemic. Challenges coping with stress and anxiety caused by threats to both lives and livelihoods, and physical distancing recommendations, may lead to an increase in drug and alcohol use. Disruptions in access to alcohol among people with alcohol use disorders could lead to serious medical complications, including seizures and death. Disruptions in access to treatment and recovery support for people with substance use disorders may increase the risk of relapse. Disruptions in the illegal drug supply may result in increasing levels of contamination and increase the likelihood that people who use substances will experience medical complications associated with withdrawal or toxicity (5). Those who rely on harm reduction programs to obtain sterile equipment, naloxone kits, and supervised consumption services may be unable to access the care they need due to program closures or COVID-19 related capacity constraints (8). Inability to access needed equipment and services may lead to an increased risk of blood borne and other pathogenic infections among people who inject drugs through unsafe injection practices such as the reuse of equipment (9,10).

People with substance use disorders are more likely to be structurally vulnerable and to experience comorbid mental health disorders, criminalization, stigma, homelessness, and reduced social and

vocational functioning relative to members of the general public (11). Structural vulnerability is "an individual's or a population group's condition of being at risk for negative health outcomes through their interface with socioeconomic, political, and cultural/normative hierarchies" (12, p.17). These factors dramatically increase the risk of negative health outcomes in people with substance use disorders. This is especially true for those who are experiencing vulnerable housing or homelessness and those who rely on higher-risk income generating activities such as sex work, panhandling, dealing, or informal recycling, that require prolonged or close contact with many others (13–17). While the effects of structural vulnerability on COVID-19-related health outcomes requires further investigation, it is nevertheless prudent to attempt to reduce health and social inequities in the context of a pandemic. Sleeping in outdoor encampments or shelters makes practicing physical distancing or recommended hygiene practices very challenging (18). A change or reduction in community based services (e.g. loss of shower facilities and safe storage options) also creates challenges. In addition, individuals that choose to comply with Public Health mandated isolation orders in settings such as temporary medical isolation shelters may not have access to the full range of supports available in community settings, such as supervised consumption services. Lastly, for some, the risk of COVID-19 infection may be perceived to be less than the risk of their usual day-to-day activities, and thus compliance with physical distancing may be a lower priority.

2.3.2 Risks associated with hospitalization for people who use substances

People who use substances, especially those with substance use disorders, are more likely to experience acute health conditions that require immediate medical intervention and, compared to members of the general population, present to acute care settings for treatment more frequently (19,20). Rates of COVID-19 infection and related hospitalization amongst people who use substances are currently unknown, however, substance use disorders commonly occur alongside other comorbid conditions (e.g. chronic respiratory illnesses) that may increase the risk of severe outcomes related to COVID-19 in this patient group. People with a mental health disorder and co-existing substance use disorder may have more difficulty adhering to isolation precautions (21). Some symptoms of COVID-19, such as chills, sweating, rhinorrhea, and muscle aches, may be similar to withdrawal symptoms. Furthermore, consumption of certain substances may increase the user's risk of becoming seriously ill from COVID-19. Effects of opioids, benzodiazepines, and alcohol, all of which reduce the respiratory drive, may be exacerbated by COVID-19 infections. Smoking drugs such as crack cocaine, methamphetamines, and cannabis, may worsen respiratory symptoms (22–24).

Acute care hospitals can be viewed as a 'risk environment' for people who use substances, and in some cases, hospitalization may actually increase health and social harm experienced by members of this population (25). Substance use by patients in hospital may occur in patients who meet DSM-5 criteria for a substance use disorder, or for various reasons, including: relief of inadequately managed

pain or withdrawal symptoms, to minimize the symptoms of anxiety or boredom, or out of desire or habit (25,26). Acute care staff may attempt to deter ongoing substance use through formal and informal sanctions that include changes to care or increased surveillance (25,27,28). People who use drugs have described being less able to practice harm reduction strategies (e.g. using sterile injection equipment) while hospitalized. Thus, due to a combination of factors, people who use substances are more likely than members of the general population to experience poor hospital outcomes including involuntary discharge, leaving against medical advice, and lengthy and costly readmissions (27,29,30). Fostering an environment of open communication where safety concerns related to ongoing drug use can be discussed is important.

3.0 Providing care to people who use substances in acute care settings

3.1 ADDRESSING STIGMA

Stigma is the act of “showing discrimination, judgment and/or isolating and stereotyping others” (31) and frequently compounds and intersects with racism and gender bias. Stigma is a major barrier to healthcare access and can contribute to feelings of shame, blame, isolation, and guilt (32). People who use substances often encounter stigma when accessing acute care (33–36). This can include overt discrimination, such as hurtful or derogatory comments, or negative body language, such as avoiding eye contact. Stigma can also be subtle and may include ignoring requests for care or refusing to make appropriate referrals (32). Eliminating stigmatizing language is one simple way by which stigma can be reduced. This includes avoiding terms like ‘addict,’ ‘junkie,’ ‘get clean,’ etc. and adopting neutral and person-centred language like ‘people who use substances’ or ‘patient with a substance use disorder,’ ‘person in recovery,’ instead. Further, healthcare staff should advocate on behalf of people who use substances if they witness them being spoken to or treated in a disrespectful way and educate others about the importance of reducing stigma. Education alone, however, is likely not enough to change stigmatizing practice and should be accompanied by practical experiences and/or opportunities to observe positive role models.

During COVID-19, infection control measures implemented by the hospital may be perceived as stigmatizing and therefore a clear explanation and rationale for all pertinent infection control measures should be provided to the patient upon admission. As changes to hospital policies and procedures occur, these also must be clearly communicated. In addition, patients should be asked if they anticipate any challenges to being able to comply with these measures so that these can be addressed.

3.2 SCREENING AND ASSESSMENT FOR SUBSTANCE USE

Screening acute care patients for substance use is essential to providing appropriate care. The CAGE, AUDIT, and AUDIT-C tools are commonly used to screen for alcohol-use related harms (37,38) and

the DAST-10 can be used to screen for substance-use related harms (39). Another option is the NIDA Quick Screen, which asks about past year use of alcohol, tobacco, prescription drugs for non-medical reasons, and illegal drugs (40). When inquiring about substance use, clinical staff may receive more honest and detailed answers if they reassure patients that their goal is to provide them the best care possible, discuss the patient's substance use in private, and emphasize that the information provided by patients is confidential.

3.3 HARM REDUCTION AND RECOVERY

Harm reduction is an umbrella term for both a philosophy of care and a set of interventions that aim to reduce harms associated with consuming substances without making the receipt of care contingent on reducing or stopping substance use. Substance use can occur along a continuum from beneficial to harmful, and people deserve non-judgmental care that supports their rights to 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.

Recovery is an active process of ongoing growth, improving quality of life and connectedness (41). People in recovery, or those starting their recovery journey, may need unique supports in the context of COVID-19. Access to addiction treatment and recovery supports, as well as other health and social services are based on each individual's self-defined needs and goals.

3.4 TRAUMA INFORMED CARE

At times, individuals can experience events (e.g. child neglect and abuse, witnessing and experiencing violence) which overwhelm their ability to cope (42,43). These traumatic events can be direct or indirect and can have significant acute and prolonged psychological and physiological impacts, including an increased risk of substance use disorders (43,44).

A trauma-informed approach to acute care recognizes "the need to respond to an individual's intersecting experiences of trauma, mental health, and substance use concerns...in all aspects of service delivery and places priority on the individual's safety, choice, and control" (42). Foundational to this approach is ensuring that individuals experience no further trauma and that they make informed choices that feel safe to them (42). In acute care settings, this could mean asking patients with substance use disorders about their priorities regarding their care or asking patients how staff can make their hospital stay more comfortable (45).

3.5 COVID-19 SPECIFIC CONSIDERATIONS

COVID-19 has necessitated the implementation of widespread and sweeping public health efforts across the globe. These efforts are critical to controlling the pandemic and have required individual, municipal, provincial and federal cooperation on a large scale. Given the magnitude of change required, it is not surprising or inappropriate that specific populations may require special consideration in response to urgently implemented practice changes such as physical distancing, restricted visitor access and other measures required to reduce the risk of outbreaks in acute care settings.

COVID-19 related changes to the hospital environment may compound existing challenges people who use substances face while hospitalized. Early involvement of an addiction medicine consult team (if available) or expert consultation via a provincial consultation line is strongly recommended.

Those who test positive for COVID-19, are under investigation for COVID-19, or a close contact of someone with COVID-19, must isolate while in hospital and have visitor restrictions. Due to widespread visitor restrictions at many hospitals, even patients who test negative for COVID-19 or are not admitted with any symptoms of COVID-19 may be unable to have visitors. Enforced isolation may contribute to feelings of stigmatization or trigger memories of historical trauma. A clear explanation of the reasons for isolation and its associated requirements is critical. Any changes to hospital procedures that occur during hospitalization should also be communicated quickly and in a patient-centered manner. Isolation precautions may also disrupt access to alcohol or drugs (25,26). As a result, patients who use substances may be at risk of experiencing potentially serious withdrawal symptoms, or acute toxicity if using alone in their rooms. Withdrawal symptoms may confound monitoring for COVID-19 related symptoms. Additionally, those who experience a period of abstinence while hospitalized may develop reduced tolerance and be at increased risk of overdose and death if they return to substance use post-discharge (46–48). Evidence-based treatment for those with substance use disorders should be initiated and continued after discharge whenever possible. People who use substances may also struggle to communicate with their friends and family while in hospital and those who are structurally vulnerable may lack access to a cell phone for communication. Patients who earn their income through informal means may require income support or income replacement, particularly if they are supporting a loved one as well. In these cases, consideration could be given to providing financial compensation for treatment adherence (49,50).

Due to a combination of factors, some patients may experience increased emotional and physical distress while hospitalized, further exacerbating ongoing substance use as well as precipitating patient-initiated discharge. People with substance use disorders are also more likely to have an acute mental health condition (e.g. psychosis or suicidality). It is important to perform a mental health assessment so as not to erroneously attribute symptoms to another cause thus resulting in missed or undertreated mental health concerns.

4.0 Substance Specific Recommendations

4.1 GENERAL CONSIDERATIONS

While each treatment plan must be individualized to patient and provider circumstances, some general considerations include the following:

- Coordination of medication dosing times and other patient care activities to reduce the frequency of patient-facing contact and personal protective equipment (PPE) usage in patients who are COVID-19 positive or under investigation for COVID-19
- When initiating new treatments in hospital, consider the availability of ongoing treatment in the patient's local community
- All patients at risk of having an unintentional opioid overdose should have an as needed naloxone order on their chart as well as be provided with a naloxone kit upon admission
- All patients should be provided with tailored education about safer substance use in the setting of COVID-19 (more information can be found in the CRISM National Rapid Guidance Document '[Supporting people who use substances in shelter settings during the COVID-19 pandemic](#)')

4.2 TOBACCO USE

Smoking cessation should be encouraged for all patients admitted with a respiratory illness, including COVID-19. Smoking has been associated with COVID-19 progression (51,52). Nicotine replacement therapy (NRT) products (including transdermal patches, lozenges, gum, inhalers, and oral sprays) are generally safe and increase smoking cessation rates. Choice of product depends on availability and patient preference although combining two forms of NRT is associated with higher rates of smoking cessation (53). First line medication options include varenicline and bupropion SR, both of which increase rates of smoking cessation during hospitalization. Regardless of whether medication is initiated, patients may still benefit from NRT - which is safe to combine with pharmacotherapy (54) - to help them cut down on their use, or to help manage cravings and withdrawal symptoms if they

are unable to smoke as frequently as they would like due to isolation precautions. Ideally, patients on isolation precautions should always have at least two forms of NRT available at the bedside.

4.3 ALCOHOL

Alcohol use disorder is a risk factor for leaving hospital against medical advice and readmission within 15 days (29,55). In order to decrease this risk, both alcohol withdrawal and ongoing cravings to consume alcohol need to be appropriately managed in hospitalized patients.

Alcohol withdrawal is a life-threatening medical condition requiring urgent management to prevent sequelae such as cardiac arrhythmias, seizures, and delirium. Withdrawal typically presents within 6-72 hours after a patient's last drink and can be present when alcohol levels are still elevated. The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) can be used to help identify which patients may be most at risk of developing severe symptoms (56). Benzodiazepines are the standard of care for managing withdrawal and a symptom-triggered approach using the Clinical Institute Withdrawal Assessment for Alcohol Withdrawal (CIWA-Ar) (57) can be used to guide when benzodiazepines are indicated. However, in the setting of COVID-19, use of regularly scheduled benzodiazepines or use of other medication adjuncts could be considered in order to minimize healthcare worker contact and conserve PPE in COVID-19 positive patients or those under investigation for COVID-19. Care must also be taken to avoid the harms associated with benzodiazepine toxicity, particularly in patients with an overlapping acute medical illness such as COVID-19 (58). Intravenous thiamine replacement should also be provided.

Even if alcohol withdrawal has been appropriately treated and resolved, cravings may persist. First line medication options 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. Second line, off-label medications include gabapentin, topiramate, valproic acid and others (59,60).

In situations where an abstinence-based management plan is declined, or when a patient continues to use alcohol while in hospital (or is likely to continue to use alcohol), and/or when ongoing alcohol use has previously interfered with an individual's ability to address their health concerns, the provision of alcohol via a managed alcohol program should be considered. This is particularly important in patients with COVID-19 where patient-initiated discharge is likely to put the patient and others in the community at risk. In addition, patients with confirmed, or under investigation for, COVID-19 who have a history of severe withdrawal requiring previous intensive care unit admission should also be considered for an inpatient managed alcohol program so as to avoid the potential need for intubation due to severe withdrawal. The amount and frequency of alcohol required will need to be determined based on the patient's reported use and a dosing schedule determined. When

determining dosing frequency, a balance must be found between frequent dosing requiring patient-facing contact and use of PPE, and management of withdrawal and cravings. An assessment should be done prior to administration to prevent over-intoxication and doses are typically consumed under supervision [see 31, Appendix B - Sample Alcohol Order] (31,61). A managed alcohol program may reduce the daily amount of alcohol the patient consumes and assist with stabilization. At the time of discharge and following completion of isolation requirements, patients should be offered various options for ongoing treatment including managed alcohol programs in the community (if available), detoxification programs, and/or other recovery supports.

4.4 CANNABIS

First-line treatment for cannabis use disorder includes psychosocial interventions such as cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET), or contingency management (62); if available, consideration should be given to offering these via virtual platforms in hospital, if appropriate. There is currently no evidence to support using other cannabinoid preparations for the treatment of cannabis use disorder. For patients with cannabis use disorder who wish to attempt cessation while admitted to hospital, a trial of gabapentin, nabiximols (if available), or nabilone may be warranted. A small research study showed that gabapentin in doses of 1200 mg daily, in addition to psychosocial support, was associated with reduced cannabis use (63); however, gabapentin should be used with caution in patients at risk for respiratory depression or taking other sedating medications. Evidence on the use of nabiximols, a cannabis whole-plant extract, is mixed (64,65) though it may be better tolerated than gabapentin. A small study using nabilone to treat withdrawal and reduce cannabis use showed some encouraging results (66). The use of gabapentin, nabiximols, or nabilone is considered off-label use.

Patients with cannabis use disorder on isolation precautions, or those without a steady supply of cannabis, may be at risk of withdrawal symptoms which can include irritability, anxiety, and sleep disturbances. In some settings, patients may be able to use their own (or hospital provided) edible cannabis products. Most symptoms are mild and, if needed, treatment can be provided to target specific symptoms (e.g. using trazodone at night for insomnia). More severe symptoms could warrant treatment with off-label options such as gabapentin, nabilone, or nabiximols (if available) (67).

4.5 OPIOIDS

Opioid agonist treatment (OAT) is considered the standard of care for people with opioid use disorders (68). Buprenorphine/naloxone is the preferred first-line treatment and methadone is considered an alternative first-line treatment. Ideally, patients with untreated opioid use disorder admitted to acute

care environments would have rapid access to health care providers able to initiate and titrate these medications. A patient-centered approach to titration (i.e. consideration of the patient's perception of adequacy of OAT dose) is critical to achieving the expected health benefits (69). Immediate treatment initiation, along with withdrawal management, is critical for preventing premature discharge of patients under investigation for, or with confirmed, COVID-19.

Other expert-led treatments for opioid use disorder include slow release oral morphine (SROM) and injectable opioid agonist treatment (iOAT). SROM involves oral administration of opened, witnessed capsules of 24-hour extended-release morphine (70). iOAT involves patient self-administration of prescribed diacetylmorphine or hydromorphone intravenously (or intramuscularly) multiple times per day under health care provider supervision (71). For patients unable to stabilize on first-line treatments, these alternative treatment options should be considered and initiated whenever possible (71,72). Health care providers working in hospitals without addiction medicine consult teams may be able to access advice through provincial consult lines or by consulting addiction medicine specialists in the community.

When evidence-based treatments are being titrated, or are not effective, not available, or declined by the patient, an alternative harm reduction approach should be employed. This involves titrating full-agonist opioids (typically observed doses of liquid oral solution morphine or hydromorphone) to manage withdrawal and cravings. If liquid medications are not effective, consideration should be given to nursing administered subcutaneous, intravenous, or transdermal opioids as a next step (31). Under no circumstances should patients be forcibly detoxified from opioids as this is considered harmful and increases the risk of death post-discharge (68). Before initiating opioids for this purpose, discharge planning should be considered including whether referral to another provider will occur, the medication will be tapered, or a short-term supply provided.

Despite all the above measures, some patients may continue to leave hospital for periods of time to procure and/or consume illegal opioids. For patients who are COVID-19 positive, or under investigation for COVID-19, this places the patient and others in the community at risk. In these exceptional situations, provision of a prescribed supply of opioids for patients to self-administer under nursing supervision with sterile equipment (e.g. parenteral hydromorphone administered by the patient intravenously or intramuscularly, or hydromorphone 8 mg tablets which can be crushed for intranasal use) may be considered (31). In these cases, consultation with an addiction medicine specialist is advised. In some provinces, there may be recommendations to provide medications for unsupervised use as well (73). Please see the Health Canada Safer Supply Toolkit for more information (Appendix 4). Patients should continue to be offered all forms of OAT throughout their admission and, although this type of prescribing may not be possible after discharge, patients should be connected to a prescriber for follow up. An informed consent discussion with the patient outlining the risks, benefits, and alternative treatments that have been discussed should be documented on the chart.

4.6 STIMULANTS

There are currently no pharmacotherapies that have been shown to be effective for the treatment of stimulant use disorders, however research is ongoing (74). Stimulant induced psychosis may require administration of benzodiazepines and/or anti-psychotics. Stimulant withdrawal can present as hypersomnolence, anxiety, difficulty concentrating, and irritability. Withdrawal is typically mild and medications can be offered to address specific symptoms. Where available, connection to contingency management programs and addiction counselling should be considered (75).

For patients with ongoing harms related to stimulant use during hospital admission, a prescribed supply of stimulants can be considered. Prescribing stimulants may help to reduce the risk to the patient and the community from the risks associated with the illegal drug market (including contamination of stimulants with high potency synthetic opioids), as well as the activities required to procure substances which facilitate the spread of COVID-19. Medications such as dextroamphetamine SR, methylphenidate IR, or methylphenidate SR (all off-label use) could be considered for this purpose, but remain unstudied and should be considered strictly a harm reduction measure (73). For patients with a history of a mental health disorder, especially psychosis or mania, or those who are hospitalized for mental health reasons, the risks and benefits of this type of approach should be carefully considered before prescribing a psychostimulant medication. An informed consent discussion with the patient outlining the risks, benefits, contraindications, and alternative treatments that have been discussed should be documented on the chart.

4.7 ADDRESSING ONGOING SUBSTANCE USE IN HOSPITAL SETTINGS

Despite offering a full spectrum of evidence-based treatments as well as other prescribed medication options, some patients may still continue to use substances during their hospital admission. In these situations, concerted efforts should be made to ensure that the risks of infection (e.g. from the use of contaminated or reused injection equipment), death, and COVID-19 transmission are minimized. At a minimum and throughout their hospitalization, all patients should have access to safer use equipment, a way to safely dispose of used equipment, and a naloxone kit. A harm reduction and trauma informed approach should be used to inform the delivery of care. Creating an environment where patients feel comfortable disclosing ongoing injection drug use to their health care team may help to identify the patients at highest risk of unintentional overdose and those most in need of substance use related support. All patients, whether or not they can abstain from substance use, deserve respect, compassion, and treatment for their medical condition(s).

Overdose events are expected to increase as COVID-19 related disruptions in the drug supply chain lead to increased toxicity in the illegal drug market (4,5). Hospitals should prepare to experience an increase in unintentional opioid poisoning events on hospital campuses. These may involve patients, visitors, and/or staff. Strategies to consider include: performing overdose simulations in patient care and public areas; ensuring availability of naloxone and appropriate PPE across the site and across disciplines (including protective services team members); and, reviewing safety of single use washrooms available for public use. Those likely to respond to overdoses on hospital property should be updated on changes to local resuscitation guidelines designed to reduce the risk of COVID-19 transmission (e.g. the use of N95 respirators for performing cardiopulmonary resuscitation or bag-valve mask ventilation).

4.7.1 Safer use equipment distribution in acute care settings

Harm reduction programs which provide sterile syringes and other equipment substantially reduce rates of HIV transmission, have no significant unintended consequences, and are cost effective (76–78). These programs are based on the fundamental principles of harm reduction and have been shown to engage individuals in primary care and substance use treatment programs as well as reduce the frequency of injection drug use and other complications (e.g. abscesses). Patients who are admitted to hospital should have easy access to sterile injection equipment, including syringes, alcohol swabs, tourniquets, filters, cookers, sterile water, and vitamin C (to break down any tablets). This equipment can be ordered from specialized distributors or possibly obtained from local community-based harm reduction service providers. Harm reduction education about safer drug use, including avoidance of groin and neck veins, and any peripherally or centrally inserted catheters, should also be provided. It is important to provide ready access to sharps containers and instruction on how to safely dispose of used equipment (77).

For more information on equipment distribution refer to:

- [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.
- [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.

4.7.2 Supervised consumption services in acute care settings

Embedded supervised consumption services in acute care hospitals have the potential to improve safety and engage patients in addiction treatment (79). Hospitals responding to opioid poisoning events on their campus should consider opening an Urgent Public Health Need Site (UPHNS) or offering a bedside supervision model. A legal exemption is only required for the supervision of illegal (non-prescribed) substances. Information on how to obtain an exemption and set up supervised consumption services can be found in a companion document in CRISM's national rapid guidance series, [Supporting people who use substances in shelter settings during the COVID-19 pandemic](#). Information about how to operate these sites safely during COVID-19 can also be found in this companion document. Reduced access to community-based supervised consumption services due to the physical distancing requirements of COVID-19 may also prompt consideration of expanding any hospital-based UPHNS or supervised consumption sites to include access for the general public.

If supervised use is not possible, steps should be taken to identify patients at risk of unintentional overdose. Developing an individualized safety plan to minimize the risk of unwitnessed overdose during admission is warranted especially for patients with visitor restrictions who will be more likely to consume substances alone. Education on safer use practices during COVID-19 should be provided to all patients and could include information such as virtual supervision methods, strategies to minimize contact with others, and recommended hygiene practices (not sharing equipment, preparing drugs yourself, washing hands) (please see Appendix 3: Online Substance Use Resource Listing for more information).

5.0 Preventing Patient-Initiated Discharges in COVID-19 Positive Patients

5.1 GENERAL PRINCIPLES

People who use substances are more likely to leave hospital against medical advice (80). Patient-initiated discharges increase morbidity, mortality, and health care system costs. In addition, in the context of communicable diseases such as COVID-19, premature discharge against medical advice of a patient with confirmed or suspected COVID-19 has the potential to further exacerbate community spread of the virus during an outbreak. It is therefore critical to pre-empt with measures that reduce premature discharge. Immediately upon admission, efforts should be made to identify what would be helpful to support treatment completion, as well as patient-identified barriers. This may include things like the need to take care of a loved one or pet, concerns around unattended belongings, the need to maintain or secure housing, court or custody proceedings, and unmanaged withdrawal and/or cravings. Working together to identify the goals of the admission, and expectations on both sides, may help to create an open and collaborative relationship from the start.

5.2 COMFORT AND ENTERTAINMENT RESOURCES

Patients on isolation precautions for COVID-19 or other infections may be asked or required to remain in their rooms for long periods of time. This can be difficult for anyone, particularly those with comorbid anxiety, depression, post-traumatic stress disorder or attention deficit hyperactivity disorder. In addition, some people who use substances may have a history of incarceration and/or past traumatic experiences involving coercive admissions and confinement. Isolation requirements for COVID-19 should be considered in this context and implemented via the least restrictive means and in a way that provides the most comfort. If possible, patients should have access to entertainment resources; for those unable to access through other means, the hospital can consider supplying as a way to facilitate engagement in care. Some examples include free television, access to tablets, music, reading materials, and art supplies. Some individuals may desire extra food portions, or have specific dietary requests, which, if accommodated, may increase overall comfort in hospital. Working with the infection prevention and control team to ensure compliance with local guidelines is important.

5.3 CONNECTION TO SUPPORTS

During COVID-19, access to visitors at most hospitals is severely limited. This makes it difficult for patients to connect to family, friends, and existing community supports (e.g. an Alcoholics Anonymous sponsor, housing worker, addiction counsellor etc.) during an extremely stressful time. In addition, some patients may not have a phone and access to shared phones in the hospital unit may be limited due to infection prevention and control measures. In these situations, the provision of tablets and/or cell phones for patient use during hospitalization has the potential to reduce isolation, improve well-being, and facilitate ongoing connection to existing supports. For example, many community-based peer support programs have moved to a virtual format so with access to the appropriate technology, some patients may be able to participate in their usual recovery activities even while in hospital or on isolation precautions.

In addition to permitting ongoing connection to existing supports, technology may also be used to connect patients to new health care providers and community supports. With many services moving to virtual care delivery models, patients could now potentially use hospital provided technology to meet a new primary care provider, addiction counsellor, or recovery coach virtually prior to hospital discharge. These platforms may also be used to connect patients to online cognitive behavioural therapy and mental health resources during and after admission.

5.4 PEER SUPPORT SERVICES

Emotional support can be provided by a trained peer support worker to a patient where a shared common experience, such as a mental health challenge or illness, exists. Provision of peer support may be particularly important in stressful times and when access to visitors is restricted. Hospital employed peer support workers who can provide in-person support or virtual access to peer support workers in the community may be helpful for patients coping with the combined stresses of a substance use disorder and COVID-19. More information about peer support can be found at Peer Support Canada (<https://peersupportcanada.ca/>).

5.5 CONNECTION TO SUBSTANCE USE SUPPORTS AND RECOVERY RESOURCES

Where possible, patients should have access to substance use supports and recovery resources. These can either be in person (such as hospital employed addiction counsellors), via virtual connection to community-based programs, or via hospital-community partnerships that offer a hybrid model.

Emergency department visits and hospital admissions have been identified as a key point of contact with the health care system for individuals who use substances and an overlooked opportunity to initiate addiction treatment (81–83).

5.6 USE OF NURSING ASSISTANTS AND OTHER SUPPORT STAFF

Some patients may have difficulty complying with infection prevention and control guidelines. This may be due to a number of factors, including but not limited to: untreated and/or unidentified substance use concerns; cognitive impairment; and, mental health concerns. Early identification and mitigation of specific issues should be a top priority for health care providers in the acute care setting. This is particularly important in the context of a pandemic to facilitate maintenance of isolation and prevention of disease transmission. In some cases, and if within scope of practice and utilizing recommended PPE, a nursing assistant or other team member who can remain with the patient may be helpful, particularly if patients require frequent reminding, redirection, or accompaniment off unit.

5.7 USE OF THE PUBLIC HEALTH ACT

In extreme cases, patients who are confirmed to be COVID-19 positive and are unable to comply with isolation requirements may require apprehension under the relevant provincial, territorial or federal Public Health Act. This will require collaboration and consultation with the local Medical Officer of Health. Each case will require a balance between respecting individual rights and maintaining public health and safety. When these patients also require admission to acute care, every effort should be made to ensure that substance use related concerns are identified and managed.

Patients with COVID-19 who are unable to comply with isolation requirements in shelter settings may require transfer to acute care or another facility where more supports are available. Proactively developing transfer of care procedures and identifying vehicles suitable for the medical transport of people with COVID-19 will minimize the risk of community transmission.

6.0 End of life and palliative care considerations

6.1 DEFINITION OF PALLIATIVE CARE

Palliative care involves the relief of suffering (physical, emotional, spiritual and existential), and focuses on quality of life in the setting of life-limiting illness (84). The intent is to provide ‘whole person’ care in alignment with the patient's goals and values. Palliative care is not the domain of any specific team but rather an approach that can be employed by all healthcare professionals. Specialist palliative consult teams remain ready to help provide assistance and advice for refractory symptoms and for those that require more specialized care. Advocates believe that palliative care should be a human right, but there is evidence that facing a life-limiting illness can actually increase inequities particularly for those that are structurally vulnerable (85). A multidisciplinary and collaborative approach to care is essential for equitable delivery of palliative care.

6.2 CONVERSATIONS AND PLANNING

Goals of care conversations should occur in an iterative manner and, if possible, with a healthcare provider with whom the patient already has a trusting relationship. Patients focused on surviving and living in the present moment may be more reluctant to discuss these topics. Evidence has shown that with appropriate intervention a high rate of advanced care directives can be completed for those who are chronically homeless (86).

In the setting of a more acute illness and presentation to acute care, conversations about goals of care may need to be readdressed. Again, having healthcare teams with whom the patient has a relationship present, even virtually, can be very helpful. Both collaborative and trauma informed approaches are needed. Tools such as the Serious Illness Conversation Guide (87) may be helpful and provide patient-tested language to help guide such conversations.

Substitute decision-makers (SDM) are consulted if the patient is not able to participate in discussions regarding goals of care. If a SDM has not been designated and there is no clear family contact, the office of the Public Guardian (or provincial/territorial equivalent) may need to be involved, but this process takes time. If time will not allow for the involvement of a Public Guardian's office, it may be helpful to involve another team (such as palliative care) or a second physician to review the case and assist in making decisions regarding appropriate medical intervention.

Past experiences, including lived experience, systemic discrimination and loss of loved ones, may cause reluctance to discuss end of life and acceptance of a palliative care approach. Patient-centered care with provision of best possible care will help mitigate fears of abandonment or receiving substandard care. If comfort care is desired, the patient's goals and values are central to guide care.

6.3 SYMPTOM MANAGEMENT

Symptoms anticipated for patients with COVID-19 include dyspnea (along with associated anxiety), cough, upper respiratory secretions, fever, pain and delirium. Whenever possible, treatment for the underlying cause should be optimized if it is within the patient's goals of care. Collaboration should occur with allied care providers including nursing, spiritual care, cultural liaison departments, psychology, social work, infection prevention and control, and others. No one person or role can address and alleviate all the aspects of suffering experienced by patients. Nearing the end of life brings a desire to reconnect with spiritual and/or cultural roots for some patients; for others this may not be the case (88,89). Many symptoms are subjective in nature, so assessment tools such as the Edmonton Symptom Assessment System Revised (ESAS-r) are helpful to follow symptoms over time and monitor effectiveness of treatments (90). A detailed opioid history should be taken on all patients prior to initiation of opioid medications to assess for tolerance, efficacy and to guide initial dosing.

6.3.1 Dyspnea

Dyspnea is a common symptom and can be severe at the end of life in COVID-19. Re-positioning can be used including sitting upright to increase peak ventilation and reduce airway obstruction (91). Therapy that is considered higher risk of transmitting COVID-19 to health care workers and family include: a fan, oxygen flow greater than 6L/min, continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP) and nebulized medication treatments (92). Appropriate PPE must be utilized as per hospital policy if these interventions are used. If a patient is intubated and withdrawal of therapy is appropriate it is best to do this as per hospital protocol to reduce the risk of COVID-19 transmission to others.

Pharmacologic agents, including opioids, are the mainstay treatment for the relief of severe dyspnea. For patients on OAT, collaboration between the addiction medicine team or OAT prescriber will be key to determining whether OAT can be modified to be dosed more frequently, additional agents should be added, or medications should be changed to a different opioid entirely. If dyspnea is present the majority of the time, opioids should be dosed around-the-clock and consideration should be given to providing as needed opioids for breakthrough dyspnea. When initiating or titrating opioids, consider prescribing medications for the management of common side effects such as anti-emetic and laxative medications.

Dyspnea is often associated with increased anxiety and many patients benefit from specific anxiety management. If there is a history of seizure (e.g. alcohol withdrawal seizures) or the patient is at increased risk of extrapyramidal side-effects (e.g. Parkinson's), benzodiazepines are recommended. However, given their risk of delirium, neuroleptics at low dose are often preferred. Commonly prescribed neuroleptics are haloperidol, olanzapine, and methotrimeprazine as all can be administered orally or parenterally including subcutaneously. As with opioids, with severe symptoms, dose titration should occur and the patient will likely need around the clock dosing or an infusion if symptoms are refractory. Additionally, relief of severe dyspnea may require use of medications that are sedating (e.g. methotrimeprazine) and/or have quick onset of action (e.g. midazolam).

Medications used to control symptoms, such as opioids and benzodiazepines, may be a trigger for individuals who use substances (93). The use of these medications should be reviewed with the patient if they are well enough to engage in a conversation. However, if indicated for symptom management, these medications should never be withheld in those at the end of life because of past or current substance use.

6.3.2 Cough

Significant overlap exists between the treatments for cough and dyspnea. Non-pharmacological treatment such as repositioning can be initiated. For distressing symptoms of cough, opioids can be initiated if the patient is not already on opioids or OAT.

6.3.3 Upper respiratory secretions

At end of life, noisy upper airway secretions may develop due to an inability to clear secretions. Re-positioning can improve symptoms. Parenteral fluids should be reassessed as they may be contributing to the amount of secretions. In the last days or hours, fluids do not change prognosis and do not need to be routinely offered if there are no symptoms of opioid neurotoxicity (e.g. myoclonus, hallucinations). Glycopyrrolate can be useful in managing symptoms; if ineffective, scopolamine can be used instead, however it can be more sedating. In addition to thickening secretions, these medications also have anticholinergic side effects which can be bothersome if initiated too early. Deep tracheal suctioning and open airway suctioning should be avoided in patients with COVID-19 due to the risk of aerosolization of the virus (92).

6.3.4 Fever

If the patient has discomfort from fever, acetaminophen can be given orally or rectally. If goals of care are comfort and treatment for fever is symptom focused, then acetaminophen can be considered in those with elevated liver function testing without further monitoring.

6.3.5 Pain

Pain can be multifaceted in nature and is termed ‘total pain’ in the setting of significant psychological, emotional, and spiritual suffering along with physical pain. Titration and changes in opioids should be managed in a collaborative approach for patients on OAT. Similar to management of dyspnea, if pain is present the majority of the time, opioids should be dosed around the clock and consideration should be given to providing as needed opioids for breakthrough pain. When initiating or titrating opioids, consider prescribing medications for the common side effects such as anti-emetic and laxative medications.

6.3.6 Delirium

Delirium is common at the end of life and often multifactorial in nature. Delirium or altered mental status can interfere with a thorough symptom and risk factor assessment for COVID-19. Investigations and treatment of reversible causes should be aligned with goals of care. Commonly advised non-pharmacologic options, such as the presence of family or friends, are more challenging in the setting of COVID-19. If the delirium is episodic and mild in intensity, then the neuroleptics should be initially prescribed on an as needed basis to manage the agitation, distress, and confusion. For delirium that is irreversible and due to underlying disease progression, neuroleptics may be needed around the clock to manage ongoing agitation and anxiety. If haloperidol around the clock is no longer effective another agent can be trialed such as loxapine or methotrimeprazine. Methotrimeprazine is often more effective for hyperactive delirium leading to increased agitation; however, is more sedating. Irreversible delirium, progressing rapidly over days or even hours, is a poor prognostic indicator, so this should be conveyed to friends and family. Education should be provided to family and/or friends including the challenges of assessing other symptoms in the setting of delirium. It is not uncommon for family supports to misconstrue periods of somnolence and hypoactivity as being depression or overuse of medications, and periods of agitation or hyperactivity as pain, so education and reassurance is important. When delirium occurs at the end of life, it is a time to advocate that visits by family, friends and spiritual leaders, be facilitated, if at all possible.

6.4 OTHER CONSIDERATIONS

6.4.1 Palliative Care Consultation

If symptoms are persisting or additional advice around conversations and direction of care are needed, consider consulting your local palliative care team.

6.4.2 Palliative care in other settings

Palliative care should be available in all settings including home, hospital, hospice, long term care, and shelters. The Canadian government has released information on how to care for a person with COVID-19 at home which should be applied to any location that a patient identifies as home (94). Requests for Medical Assistance in Dying (MAID) do not change the course of palliative care and MAID referrals are region specific.

6.4.3 Psychological and grief support

Those affected by COVID-19 and their supports can have a psychological burden that is complicated by factors such as isolation and financial strain (95). Family and friends that experience death of a loved one will experience grief, a universal human process. Referral for grief services should be considered for friends and family of those affected. Family units should not be assumed, and contact information should be gathered by the attending health care team.

7.0 Addressing other health needs

In addition to identifying and initiating treatment and referral for substance use disorders, a period of hospitalization can also be an opportunity to address other unmet health and social needs. Four areas of particular relevance during COVID-19 include addressing mental health concerns, ensuring the social determinants of health are assessed, preventing future infections via immunization, and identifying any other untreated infections. Others areas of intervention that could be considered if feasible and appropriate include addressing sexual health and contraception needs.

7.1 MENTAL HEALTH CONCERNS

People with mental health disorders may be more susceptible to COVID-19, more substantially influenced by the emotional responses brought on by the COVID-19 pandemic, and/or unable to access their usual mental health supports (96). Patients should be screened for mental health concerns and referred to treatment or local supports as clinically indicated.

7.2 SOCIAL DETERMINANTS OF HEALTH

Effective medical treatment also involves understanding and appreciating a patient's social determinants of health. All patients should be asked about the availability and safety of housing, screened for poverty or inadequate legal income, and assessed for active medication coverage. Early involvement of social workers can be critical in addressing unmet social needs and ensuring that patients can comply with any isolation requirements after hospital discharge (97).

7.3 IMMUNIZATIONS

Some patients who use substances are at risk of developing vaccine preventable infections. In particular, patients who are immunocompromised, have liver failure or cirrhosis, or live in shelters are eligible for extended adult vaccination regimens. Where possible, consider offering immunizations during a period of hospitalization as a highly cost effective way to reduce future morbidity and mortality (98).

7.4 SCREENING FOR SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTIONS

Some patients who use substances may also be at risk of sexually transmitted and blood borne infections. If a patient consents, screening should be performed in hospital so that treatment and any appropriate referrals can be initiated (99).

8.0 Transfer of care to community providers at discharge

8.1 GENERAL CONSIDERATIONS

A discharge checklist can be found in Appendix 2. At the time of discharge, any active infection prevention and control issues need to be clarified. If appropriate, providing patients with a discharge letter stating that the individual has completed the legal/medical requirements of isolation and is safe to return to the community can reduce the risk of unfounded discrimination or refused re-entry into congregate living environments. Additionally, if clinically indicated, ensure the patient still has the take home naloxone kit provided earlier in the admission as well as up to a two week supply of sterile drug use equipment.

8.2 DISCHARGE TO HOME

If a patient is discharging home, ensure this remains a safe disposition plan. If the patient requires ongoing isolation, ensure that this will be possible within their home, that there is support for basic necessities (e.g. someone able to deliver them food, medication, cleaning supplies), and that the patient understands how to safely self-isolate. Patients on self-isolation will also need medications delivered and virtual follow-up appointments arranged until the requirement for self-isolation ends. If the patient is required to leave their home, then they must wear a mask. Confirmation of active medication coverage and income support is important to ensure a seamless discharge back to the community.

Even if the patient is not required to self-isolate, community providers may be following up with their patients via telehealth or other virtual care platforms. When able, coordinate virtual and/or phone follow ups to support patients to adhere to physical distancing recommendations in the community. Confirm whether the patient has access to a telephone or technology and, with consent, provide this contact information to the ongoing community provider and pharmacist.

8.3 TRANSFER TO AN INPATIENT ADDICTION TREATMENT PROGRAM

Even during the COVID-19 pandemic, some inpatient addiction treatment programs may still be accepting patients. When possible, and if desired by the patient, transfer from an acute care setting directly to a specialized addiction treatment program should be facilitated whenever possible. Patients admitted to an acute care setting who have stopped using substances and had their withdrawal managed will likely meet program requirements (if any) of a period of abstinence from substance use prior to admission. Direct transfer from acute care minimizes the risk of relapse which would then require another period of detoxification prior to program admission.

Prior to transfer it will be important to confirm program admission requirements (including COVID-19 specific changes) and whether the program can accommodate isolation requirements (if still needed). A plan for any ongoing prescribing should be coordinated with the program's medical team or the patient's primary care provider. In addition, some programs require that prescriptions be sent to a specific pharmacy for the duration of the treatment program.

8.4 TRANSFER TO AN EMERGENCY SHELTER

In response to the pandemic, many jurisdictions have adapted their existing shelters to comply with physical distancing requirements or moved to new settings (e.g. hotels, convention centres) to establish medical isolation shelters. As the pandemic evolves, many shelter settings are fluid and are adapting to the needs of the clients accessing their site(s). It is important to be aware of what services are offered on site and, for those services that are not, how patients can be supported to access the services they need. Prior to discharge, the acute care team should confirm with the site Infection Prevention and Control team (or Public Health, depending on hospital procedure) whether the isolation period has ended, and if not, that appropriate isolation facilities are available at the discharging facility.

8.4.1 Adapted shelter (a shelter setting where patients are not required to self-isolate)

Prior to discharging to shelter, the acute care team should confirm that the patient is agreeable to stay at the shelter and whether there is current availability.

In an adapted shelter setting, the patient may still be able to present to their pharmacy for witnessed ingestion and/or medication pick up. Carries and/or decreased frequency of dispensing may be appropriate to promote physical distancing based on a shared decision making process between

patient and provider. Decisions regarding carries should be made in collaboration with the patient's community prescriber. If carries are not appropriate and/or the patient is unable to present to the pharmacy, other options for ongoing medication access may include having the patient's community pharmacy deliver daily to the shelter or deliver several days of medications if safe to do so and there is access to a secure storage space. Confirmation of access to secure storage space at the shelter should be confirmed prior to discharge.

8.4.2 Medical Isolation Shelter (shelter setting where patients are required to self-isolate)

Each acute care setting should establish a seamless care pathway to the medical isolation shelter (if available). It is necessary to have clear communication and an understanding of the requirements, expectations, and services available at the shelter to ensure patients are supported in their transition between settings. Acute care providers should be well informed of both admission and exclusion criteria for the medical isolation shelter.

Prior to coordinating transfer to a medical isolation shelter, it is essential that the patient be informed of this plan. Patients should be supported to understand why discharge to a medical isolation shelter is required and what supports are available on site.

Acute care providers should be aware of what, if any, medical supports are available on site including access to primary care, access to OAT providers, and/or access to pharmacy services. If there are medical supports on site, this may result in a change from the patient's original community connections. As part of the seamless care pathway, it is important to establish who is responsible for notifying the patient's existing community provider and community pharmacy of the transfer of care.

Acute care settings should consider the most appropriate and safest mode of transport to the medical isolation shelter. Transport must abide by local recommendations for infection prevention and control for both the patient and staff. This may vary by jurisdiction and availability of resources. In the event a patient does not successfully arrive at the medical isolation shelter, there should be a clear plan for next actions including connecting with Public Health to determine appropriate measures to locate the patient (which may be dependent on whether the patient was known to be COVID-19 positive or under investigation) and, as appropriate, re-activating the patient's previous community connections and prescriptions for ongoing care.

On discharge from the shelter, the shelter medical team should reconnect patients to their existing community connections or, as required, refer them to new providers for ongoing care.

8.5 DISCHARGE PRESCRIBING

The acute care team must collaborate with the patient's community providers to coordinate seamless care and ongoing prescribing. Furthermore, early collaboration between the acute care team with a hospital or community pharmacist is important to proactively identify any barriers to seamless care planning including drug shortages and ability to continue therapy. Prior to discharge, it is essential to confirm that medication coverage is active. For those without coverage, collaborate with a social worker to ensure coverage is in place before discharge.

Community providers may be following up with their patients via telehealth or other virtual care platforms. Consider providing a lengthier discharge prescription than usual to accommodate for the time it may take for the patient to reconnect with their prescriber in this new climate. For all prescriptions, ensure it does not lapse on a Friday, weekend, or statutory holiday. For OAT bridge prescriptions, include documentation of the milligram dose and date last received in hospital, dispensing frequency (i.e. daily versus carries), who will be taking over prescribing as well as follow up appointment details, instruction on when doses are to be held, instruction for missed dose management, who to notify of missed doses, and whether medications can be released to an authorized individual if the patient is unavailable to receive their delivery directly. If carries are authorized, clearly document the quantity of carries approved and confirm that the patient is able to securely store the carries (at minimum, a bag that can close with two zippers along with a lock to secure the two zippers together). Patients may not be required to keep or return their empty carry containers due to the risk of COVID-19 transmission however alternate arrangements, as required, can be explored between the patient, pharmacist, and OAT prescriber.

As part of the COVID-19 pandemic response and in an effort to support seamless care, Health Canada has issued certain exemptions for prescriptions of controlled substances under the Controlled Drugs and Substances Act (CDSA) and its Regulations. These exemptions permit the extension and transfer of prescriptions of controlled substances by pharmacists, the delivery of controlled substances by pharmacy employees to patient's homes or other locations they are staying, as well as permitting prescribers to issue verbal orders to extend or refill prescriptions for controlled substances. Please refer to the [Health Canada Subsection 56\(1\) Class Exemption for Patients, Practitioners, and Pharmacists Prescribing and Providing Controlled Substances in Canada during the Coronavirus Pandemic](#) for further details regarding the exemptions and their application to specific provincial/territorial scopes of practice.

Discharge planning to a medical isolation shelter should be tailored based on the services offered at the shelter. If there are medical supports available, a bridge prescription for OAT or other medications may not be required as long as clear and direct communication occurs regarding the need for isolation shelter medical staff to manage ongoing prescribing. If pharmacy services are available at the isolation shelter, it is essential that the discharge prescription be sent to the isolation shelter pharmacy, if

different than their usual pharmacy, for continuity of care. Patients may be required to present with a 24-hour supply of their discharge medications. Not all medications may be appropriate to provide as a bridge supply. For those medications, it is best to administer the medication in the acute care setting prior to discharge. This can be communicated to isolation shelter medical staff in the discharge process and/or by faxing a copy of the medication administration record from the hospital.

Appendix 1 Conflict of Interest Policy

Conflicts of interest were assessed using the Guidelines International Network's Principles for Disclosure of Interests and Management of Conflicts (i). For this Guidance document, authorship committee members and external reviewers were required to disclose all sources and amounts of direct and indirect remuneration received in the past five years from industry, for-profit enterprises, and other entities (e.g., direct financial conflicts) that could introduce real, potential, or perceived risk of bias. In addition, authorship committee members and external reviewers were asked to disclose possible indirect conflicts of interest, such as academic advancement, clinical revenue, and professional or public standing that could potentially influence interpretation of evidence and formulation of recommendations.

Before the draft guidance document was circulated for review, two CRISM staff members independently reviewed the disclosure forms to screen potential authorship committee members and external reviewers who should be precluded from participation due to ongoing or current financial relationships (e.g., employment, paid consultancy or advisory board membership, stock ownership, intellectual property) with industry or commercial entities that could theoretically benefit from the guidance document recommendations. Consistent with the Institute of Medicine Standards for Developing Trustworthy Clinical Practice Guidelines, any individual with a current, ongoing relationship with industry, who had received any remuneration or non-monetary support from industry within the past 12 months, or with a history of significant remuneration or non-monetary support from industry (defined for our purposes as cumulative receipt of more than \$10,000 or equivalent value within the past five years), was excluded from participation on the guidance document prior to the review process. No authors nor contributors were excluded during initial screening as none met these criteria for exclusion.

Summary of disclosures

Of 30 authorship committee members and external reviewers, 14 acknowledged potential direct conflicts of interest. Of these, 10 acknowledged employment or consulting with organizations including academic institutions, hospitals/health authorities, professional or regulatory associations, HIV/AIDS foundations, community outreach agencies or federal funding agencies. Only one (an external reviewer) disclosed receiving research funding prior to guidance document involvement

i. 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.

from a commercial entity (Gilead) that could theoretically benefit from guidance document recommendations. There was one authorship committee member with a commercial interest in the form of partial ownership of a medical clinic that provides treatment to PWUD. On review, potential conflicts of interest were not deemed to be of sufficient weight or relevance to warrant exclusion from the guidance committee.

Most (23, 77%) 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 acute care programs, provincial substance use treatment programs, previous guideline development, research interests). Of these, 6 acknowledged that they have publicly stated support for acute care treatment of PWUD. 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 with indirect potential sources of conflict 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.

Appendix 2: Discharge Checklist

Discharge Checklist
Disposition planning
<p>Confirm:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Active infection prevention and control issues <input type="checkbox"/> Disposition location (home, addiction treatment program, adapted or medical isolation shelter) <input type="checkbox"/> Disposition plan remains safe and accessible to patient <input type="checkbox"/> Patient meets criteria for the disposition location (if applicable) <input type="checkbox"/> Supports and medical services available at the disposition location
Plan for ongoing care
<ul style="list-style-type: none"> <input type="checkbox"/> Reconnect to existing provider(s) (primary care, OAT provider (if different), specialists) or refer to new provider(s) if required <input type="checkbox"/> Book any required follow up appointments <ul style="list-style-type: none"> Key considerations: <ul style="list-style-type: none"> • How the community provider is connecting with patients during the pandemic • Patient's access to technology or a telephone • Any ongoing requirements to self-isolate <input type="checkbox"/> Confirm patient's contact information <input type="checkbox"/> Confirm patient has contact information for community providers (clinic, pharmacy) <input type="checkbox"/> Connect to outreach for follow-up (if available) to bridge the gap between discharge and community follow up appointment (may be available through hospital-based outreach teams, social work, Public Health, peer support organizations, home care or other local organizations) <input type="checkbox"/> Ensure the patient care unit is sending discharge information and prescription to correct ongoing care providers <input type="checkbox"/> Provide patient with a mask if the patient anticipates imminent situations where they may not be able to physically distance in the immediate post discharge period <input type="checkbox"/> Provide education around physical distancing, respiratory etiquette, and hand hygiene practices in the community
Ongoing and seamless medication support
<ul style="list-style-type: none"> <input type="checkbox"/> Reconnect to existing pharmacy care provider or refer to new pharmacy if required <ul style="list-style-type: none"> Key considerations: <ul style="list-style-type: none"> • Does the disposition location require use of a specific pharmacy provider? • Do the pharmacy hours support the preferred or required frequency of medication dispensing? • Does the pharmacy offer delivery in the event that the patient is required to self-isolate after discharge? <input type="checkbox"/> Confirm status of medication coverage <input type="checkbox"/> Confirm clarity of the prescription <ul style="list-style-type: none"> Key considerations: <ul style="list-style-type: none"> • Clear dispensing frequency

<ul style="list-style-type: none"> • Outlines approval for delivery to an authorized individual if required <input type="checkbox"/> Confirm all required elements of opioid agonist treatment prescription <p>Key considerations:</p> <ul style="list-style-type: none"> • Clear dispensing frequency including approval for carries (if applicable) • Outlines approval for delivery to an authorized individual if required • Last milligram dose and date last received in hospital • Name and contact information for provider planning to take over prescribing in the community • Follow up appointment information • Missed dose management including who to notify of missed doses <p>*Ensure that prescriptions do not lapse on a Friday, weekend, or statutory holiday</p>
Communication of specific follow up/monitoring
<p>Provide patients with a discharge letter stating that the individual has completed the legal/medical requirements of isolation and is safe to return to the community. Alternatively, provide the date of completion of isolation order if being discharged to home or an isolation shelter.</p> <p>In addition to the above letter, provide the following (if applicable) to the patient's community provider: antibiotic end dates, pending blood work, due dates of required injections or immunizations, sexually transmitted infection treatments provided in hospital</p>
Social stability
<p>Confirm access:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identification <input type="checkbox"/> Active health care number <input type="checkbox"/> Health care card <input type="checkbox"/> Income support <input type="checkbox"/> Transportation/ability to follow up with community providers
Other safety considerations
<ul style="list-style-type: none"> <input type="checkbox"/> Confirm patient has a take home naloxone kit <input type="checkbox"/> Offer any required sterile drug use equipment <p>Key considerations:</p> <ul style="list-style-type: none"> • If able, provide a two-week supply on discharge from acute care • Ensure the patient has access to a way to safely dispose of used equipment e.g. a mobile needle exchange program, community drop box, suitably sized sharps container for home use on self-isolation <input type="checkbox"/> Provide safer drug use education (see Appendix 3: Harm Reduction Resources)

Appendix 3: Online Substance Use Resource Listing

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

Subsection 3.1 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

Subsection 3.2 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](#)

Subsection 3.3 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](#)

Subsection 3.4 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](#)

Subsection 3.5 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

[Government of Canada Coronavirus disease \(COVID-19\) resources for health professionals.](#)

[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 4: 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_Ase6T0-N1Pd3uboa?dl=0

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