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

NATIONAL RAPID GUIDANCE

VERSION 2 GUIDANCE DOCUMENT

CRISM-ICRAS
Canadian Research Initiative in Substance Misuse
Initiative Canadienne de Recherche en Abus de Substance

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This publication is available in English. A French version will be available on the Canadian Research Initiative in Substance Misuse (CRISM)'s website on December 1st: 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.

We recognize that the ongoing criminalization, institutionalization, and discrimination against people who use substances disproportionately harm Indigenous Peoples, and that continuous efforts are needed to dismantle colonial systems of oppression. We are committed to the process of reconciliation with Indigenous Peoples, and recognize that it requires significant and ongoing changes to the health care system.

We hope that this guidance document helps to reduce the harms faced by people who use substances in the COVID-19 pandemic.

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 five large interdisciplinary regional teams (Nodes) representing Atlantic, British Columbia, the Prairie Provinces, Ontario, and Quebec. Each CRISM Node includes regional research scientists, service providers, policy makers, community leaders, and people with lived and/or living experience of substance use. CRISM's mission is to translate the best scientific evidence into clinical practice, health services, and policy change. More information about CRISM can be found at: https://crism.ca.

About this Document

This document is one of a series of six national guidance documents, rapidly developed by the CRISM network at the request of the Government of Canada. Collectively, the six documents address urgent needs of people who use substances, service providers, and decision makers in relation to the COVID-19 pandemic. The urgent nature of this work required rapid development and dissemination of this guidance in the early months of the COVID-19 pandemic. 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. Two years after its initial publication, and with an ongoing need to provide guidance on supporting people who use substances in shelter settings during the COVID-19 pandemic, the authors reviewed and incorporated new evidence throughout this document.

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, and as they relate to provincial and territorial COVID-19 directives and recommendations. The following resources provide the most up-to-date information on COVID-19 public health directives and recommendations for each jurisdiction: Alberta (1); British Columbia (2); Manitoba (3); New Brunswick (4); Newfoundland and Labrador (5); Northwest Territories (6); Nova Scotia (7); Nunavut (8); Ontario (9); Prince Edward Island (10); Quebec (11); Saskatchewan (12); Yukon (13).

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

- Supporting people who use substances in shelter settings during the COVID-19 pandemic (this document);
- Telemedicine support for addiction service (14);
- Supporting people who use substances in acute care settings during the COVID-19 pandemic (15);
- Medications and other clinical approaches to support physical distancing for people who use substances during the COVID-19 pandemic (16);
- Strategies to reduce SARS-CoV-2 transmission in supportive recovery programs and residential addiction treatment services (17); and,
- Harm reduction worker safety during the COVID-19 global pandemic (18).

Completed documents may be accessed at: https://crism.ca/projects/covid/. Each document was developed by a core CRISM regional authorship committee, drawing on expert knowledge, available scientific evidence, and a review of relevant documentation from public health authorities. Draft documents produced by each authorship committee were reviewed by pan-Canadian panels of content and clinical experts. People with lived and/or 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 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 and External Reviewers, arrived at after careful consideration of the available scientific evidence and external expert peer review. The application of the guidance contained in this document does not override the responsibility of health care professionals to make decisions appropriate to the needs, preferences, and values of an individual patient, in consultation with that patient (and their guardian[s] or family members, when appropriate), and, when appropriate, external experts (e.g. specialty consultation). When exercising clinical judgment in supervising

substance consumption and caring for patients, health care professionals are expected to take this guidance document fully into account while upholding their duties to adhere to the fundamental principles and values of their relevant codes of ethics. Nothing in this guidance document should be interpreted in a way that would be inconsistent with compliance with those duties.

Legal Disclaimer

While the individuals and groups involved in the production of this document have made every effort to ensure the accuracy of the information contained in this guidance document, please note that the information is provided "as is" and that CIHR and CRISM make no representation or warranty of any kind, either expressed or implied, as to the accuracy of the information or the fitness of the information for any particular use. To the fullest extent possible under applicable law, CIHR and CRISM disclaim and will not be bound by any express, implied, or statutory representation or warranty (including, without limitation, representations, or warranties of title or non-infringement). This document is intended to provide guidance on implementing supervised consumption services and facilitating substance use care in shelter settings during the COVID-19 pandemic. This guidance document is not intended as a substitute for the advice or professional judgment of a health professional, nor is it intended to be the only approach to the management of a clinical problem. We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a local health care professional.

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ABBREVIATIONS

AED: Automated External Defibrillator
AGMP: Aerosol Generating Medical Procedure
CIHR: Canadian Institutes of Health Research
COVID-19: Coronavirus Disease of 2019
CPR: Cardiopulmonary Resuscitation
CRISM: Canadian Research Institute in Substance Misuse
EMS: Emergency Medical Service
ESCR: Essential Services Contingency Reserve
HCV: Hepatitis C Virus
HIV: Human Immunodeficiency Virus
iOAT: Injectable Opioid Agonist Treatment
ICU: Intensive Care Unit
MAPs: Managed Alcohol Programs
NRT: Nicotine Replacement Therapy
OAT: Opioid Agonist Treatment
OPS: Overdose Prevention Sites
PPE: Personal Protective Equipment
PAWSS: Prediction of Alcohol Withdrawal Severity Scale
RPIC: Responsible Person in Charge
SROM: Slow Release Oral Morphine
UPHNS: Urgent Public Health Need Sites

1.0 Key Points of The Guidance Document

- **The COVID-19 pandemic has compounded risks already posed by the overdose epidemic, and placed people who use substances and are experiencing homelessness or housing vulnerability at high risk of negative health outcomes, including death.**

- **The purpose of this guidance document is to support organizations operating new or existing shelter settings to provide evidence-informed care for people who use substances during the COVID-19 pandemic in Canada.**

- **For shelters providing care to people who use substances during the COVID-19 pandemic, a pragmatic approach assumes that some level of drug and alcohol use will continue irrespective of formal or informal bans or criminal prohibitions.**

- **Under a harm reduction approach, modifying risks associated with unsafe substance use practices or settings takes precedence over enforcing abstinence, and residents are supported to access care based on self-determined needs and goals.**

- **Design and delivery of shelter services should incorporate perspectives of people with lived and/or living experience of substance use and homelessness or housing vulnerability.**

- **Shelter staff can practice universal trauma precautions to ensure residents receive safe, stigma-free, and equitable support that minimizes their chances of experiencing further harm or re-traumatization.**

- **As Indigenous Peoples continue to experience racism, oppression, and the impacts of colonization, it is important that shelters and their staff practice culturally safe care that focuses on strategies that help build relationships with participants and minimize harms stemming from drug-related stigma and discrimination.**

- **Integrating supervised illegal drug consumption services into shelter settings is feasible, and has the potential to reduce overdose-related mortality and other negative health outcomes.**

- **A variety of supervised consumption service models can be operated during the COVID-19 pandemic through use of appropriate infection prevention and control measures and personal protective equipment.**

- **Supervised consumption services should regularly review infection prevention and control and personal protective equipment procedures to ensure they remain consistent with the latest public health guidance in their jurisdictions.**

- **Shelters should facilitate access to healthcare providers who are able to assist with substance use disorder treatment, withdrawal management, and substance use stabilization/risk mitigation.**

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

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

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

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

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

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

- **Shelters provide a unique opportunity to offer low-barrier access to COVID-19 vaccinations for shelter residents.**

2.0 Purpose and Scope

On March 11, 2020, the World Health Organization declared COVID-19, caused by a novel coronavirus, a pandemic, citing concern over alarming levels of spread and severity across the globe. People who are experiencing homelessness or housing vulnerability are particularly at risk of exposure to COVID-19 (19). In Canada, homelessness is defined as "the living situation of an individual or family who does not have stable, permanent, appropriate housing, or the immediate prospect, means, and ability of acquiring it" (20), and incorporates people who do not have housing and those living in inadequate conditions. People experiencing homelessness often live in dense and overcrowded conditions and do not have access to the resources required to take protective measures against the virus, such as space to practice physical distancing and access to hygiene amenities, increasing their risk of infection (21). In addition to lacking housing that would facilitate adhering to infection prevention recommendations, people who are experiencing homelessness or housing vulnerability are also more likely to congregate with others to access essential services (e.g. drop-in services, government resources, pharmacies), use public transit, regularly travel long distances, and be subject to law enforcement and incarceration, further increasing their risk of exposure to COVID-19.

We know that lack of safe, stable housing increases the risk of a host of negative health outcomes, and COVID-19 is no exception. Populations experiencing homelessness or housing vulnerability have a higher prevalence of chronic disease and other comorbidities (e.g. respiratory problems and health conditions that compromise immunity) compared to the general population, making them more susceptible to severe outcomes associated with COVID-19 infection (22,23). Many jurisdictions are attempting to rapidly shelter people who are experiencing homelessness or housing vulnerability as part of a broader pandemic response, either by implementing new, or reconfiguring existing, shelter settings (e.g. 24–27). These efforts should prioritize the health, safety, and human rights of people who are experiencing homelessness or housing vulnerability and support them in addressing their pre-existing health conditions when possible.

People who use illegal substances and are experiencing homelessness or housing vulnerability represent a particularly at-risk subpopulation. Those reliant on a highly toxic illegal drug market are at high risk of overdose morbidity and mortality and other negative health outcomes (e.g. cellulitis, endocarditis, human immunodeficiency virus [HIV], hepatitis C virus [HCV]). Travel restrictions and border closures related to COVID-19 are causing new disruptions in the illegal drug supply (28–30), which can change consumption practices (28,29) and increase levels of drug adulteration or contamination (28,30), placing individuals who use substances at greater risk of drug-related harms. A number of Canadian jurisdictions have reported unprecedented increases in overdose deaths during the COVID-19 pandemic (31); however, the extent to which these trends reflect changes to the illegal drug supply, versus the impacts

of physical distancing, isolation, stress and anxiety, socioeconomic precarity, or other underlying factors is not currently known (32–35).

Stress, boredom, and isolation resulting from the COVID-19 pandemic (e.g. extended public health restrictions and business closures resulting in unemployment and unstable finances) may also lead to increased use of legal substances such as alcohol, tobacco, and cannabis, increasing risk of addiction, withdrawal, overdose, and other health-related complications. Disruptions in alcohol access for people with high-risk drinking patterns and alcohol use disorders may lead to serious medical complications, including alcohol withdrawal syndrome, seizures, and increased risk of significant harm or death. People who use alcohol, tobacco, and cannabis frequently may also be at increased risk of weakened immune function, making them more susceptible to COVID-19 infection (36–38).

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

The guidance herein addresses the needs of two distinct subpopulations of people staying in shelters: [1] those accessing services who are asymptomatic, not under any public health directive or recommendation to self-isolate, and not undergoing any investigations related to COVID-19; and [2] those who have tested positive for COVID-19 or are symptomatic. Specifically, this document provides:

- An overview of the rationale for the need to support people who use substances and are experiencing homelessness or housing vulnerability during the COVID-19 pandemic;
- Guidance on how to obtain a legal exemption, implement, and operate a temporary supervised consumption service (also referred to as an Urgent Public Health Need Site [UPHNS]);
- Guidance on providing or facilitating access to a range of conventional substance use disorder treatments, recovery options, and risk mitigation strategies (e.g. replacement pharmacotherapy or managed alcohol programs [MAPs]) to support people with substance use disorders in emergency shelter settings;
- Advice for monitoring and evaluating the provision of these services; and,
- Suggestions for offering low-barrier access to COVID-19 vaccinations.

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

- Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Services to People who use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1; Working Group on Best Practice for Harm Reduction Programs in Canada (39); and,
- 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 (40).

2.1 DEVELOPMENT

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

The urgent nature of this work required rapid development and dissemination of this guidance in the early months of the COVID-19 pandemic. This timeline and the continuing evolution of the knowledge base regarding COVID-19 precluded a comprehensive review of the relevant literature. However, where available, academic research was cited in support of the expert advice offered herein. Two years after its initial publication, and with an ongoing need to provide guidance on supporting people who use substances in shelter settings during the COVID-19 pandemic, the authors reviewed and incorporated new evidence throughout this document. The guidance provided in this document is subject to change as new information becomes available.

Readers should note that the intent of this document is to provide *general* guidance for supporting people who use substances in shelter settings across Canada rather than detailed procedural instructions for implementing supervised consumption services or prescribing pharmacotherapy. Implementation processes and regulations may vary by local, regional, or provincial/territorial jurisdiction. Readers should consult local public health and medical authorities for advice on navigating their own unique regulatory and policy environments, as necessary, and as they relate to provincial and territorial COVID-19 directives and recommendations. The following resources provide the most up-to-date information on COVID-19 public health directives and recommendations for each jurisdiction: Alberta (1); British Columbia (2); Manitoba (3); New Brunswick (4); Newfoundland and Labrador (5); Northwest Territories (6); Nova Scotia (7); Nunavut (8); Ontario (9); Prince Edward Island (10); Quebec (11); Saskatchewan (12); Yukon (13).

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

2.2 INTENDED AUDIENCE

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

2.3 GUIDING PRINCIPLES

This document is guided by the following four principles: 1) harm reduction; 2) engaging people with lived and/or living experience of substance use and homelessness or housing vulnerability in the development and operation of services; 3) trauma- and violence-informed care; and 4) Indigenous cultural safety and humility.

Harm reduction is an umbrella term for various policies and practices that aim to reduce harms associated with consuming substances without requiring a reduction in or abstinence from substance use. Substance use can occur along a continuum from beneficial to harmful, and people deserve non-judgmental care that supports their autonomy and dignity regardless of where they fall on that continuum. Under a harm reduction approach, modifying risks associated with unsafe substance use practices or settings takes precedence over enforcing abstinence (41,42), and people are supported to access health and social services (e.g. medical care, substance use treatment, counselling, housing, income support) based on self-determined needs and goals. Shelters or any organization adopting the interventions outlined in this document should endorse clear and well communicated harm reduction policies that embrace core international principles (43,44). Harm reduction training and education should be available to all staff and include a review of related principles and values, and opportunities to reflect on the broader social, legal, and policy context of substance use. If hiring new staff, look for applicants with values that align with harm reduction philosophy. This is essential to create a culture of harm reduction (45,46).

Engaging people with lived and/or living experience of substance use and homelessness or housing vulnerability in the design and delivery of services is essential to ensure that the services achieve their

intended outcomes and meet the needs of their target population. While meaningfully engaging people with lived and/or living experience of substance use may be challenging in the context of the pandemic, operators should attempt to abide by the principle of 'nothing about us without us' as much as possible. Regional or national groups advocating for people who use substances can often facilitate contact with local people who use substances. When consulting or employing people with lived and/or living experience of substance use, it is important to ensure equitable compensation for expertise and labour (47,48). The following resources provide more guidance on engaging people with lived and/or living experience of substance use:

- Having a Voice and Saving Lives; CRISM People with Lived Expertise of Drug Use National Working Group (49);
- Engaging People who use Drugs in Policy and Program Development: A Review of the Literature; Substance Abuse Treatment, Prevention, and Policy (50);
- "Nothing About Us Without Us" Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative; Canadian HIV/AIDS Legal Network (51);
- Peer Worker Involvement in Low-Threshold Supervised Consumption Facilities in the Context of an Overdose Epidemic in Vancouver, Canada; Social Science & Medicine (52); and,
- Peerology: A guide by and for people who use drugs; Canadian AIDS Society (48).

Trauma- and violence-informed care creates safe and respectful environments by recognizing the interconnection between trauma, violence, behaviours, and health outcomes (53). The goal is not to treat trauma, but rather to minimize the chances of harm or re-traumatization. Shelters and their staff can provide safe and equitable support by practicing universal trauma precautions that are built upon the principles of knowledge, safety, collaboration/choice/autonomy, and strength-based capacity-building (53,54). The following are a few examples of how shelters can apply the four principles of trauma- and violence-informed care:

- Build awareness and understanding of how trauma and violence contribute to substance use and challenges in securing housing, and vice versa;
- Create emotionally and physically safe environments by providing respectful, non-judgmental care and ensuring physical infrastructure is welcoming, comfortable, and can provide privacy when necessary;
- Collaborate with shelter residents to provide meaningful care choices based on their preferences (e.g. substance use disorder treatment, withdrawal management, substance use stabilization/risk mitigation). Education about safer substance use and COVID-19 infection prevention practices can create additional opportunities for choice, collaboration, and connection; and,

- Acknowledge shelter residents' life circumstances, including the historical and structural conditions that have contributed to substance use and homelessness or housing vulnerability. Facilitate resilience and trust building by identifying and validating individual strengths.

The following resources provide additional guidance on trauma- and violence-informed care:

- Trauma- and Violence-Informed Approaches to Policy and Practice; Public Health Agency of Canada (53);
- Trauma-informed Approaches to Substance Use Interventions with Indigenous Peoples: A Scoping Review; Pride et al. (55); and,
- Trauma- and Violence-Informed Care; A Tool for Health and Social Service Organizations and Providers; Gender, Trauma & Violence: Knowledge Incubator @ Western and EQUIP Health Care: Equipping Health Care for Equity (54).

Indigenous cultural safety and humility creates an environment where Indigenous Peoples feel safe accessing health and social services. It recognizes that Indigenous Peoples continue to experience racism, oppression, and the impacts of colonization, and that many service providers do not fully understand the life experiences, cultural practices, histories, and perspectives of Indigenous Peoples (56). Culturally safe care focuses on strategies that help build relationships with participants and minimizes harms stemming from drug-related stigma and discrimination (57). Shelter staff can demonstrate cultural humility by adopting "a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust" (p.11) (56). The following resources provide more guidance on Indigenous cultural safety and humility:

- First Nations Health Authority's Policy Statement on Cultural Safety and Humility; First Nations Health Authority (56);
- Cultural Safety and Humility: Key Drivers and Ideas for Change; First Nations Health Authority (58);
- National Indigenous Cultural Safety Learning Series; Provincial Health Services Authority Indigenous Health (59);
- Cultural Safety Collection; National Collaborating Centre for Indigenous Health (60);
- Indigenous Harm Reduction Policy Brief = Reducing the Harms of Colonialism; Canadian Aboriginal AIDS Network and Interagency Coalition on AIDS and Development (61);
- Trauma-Informed Interventions through an Indigenous Worldview Presentation; Olson through the Western Centre for Research & Education on Violence Against Women and Children Learning Network (62); and,
- Blending Aboriginal and Western Healing Methods to Treat Intergenerational Trauma with Substance Use Disorder in Aboriginal Peoples; Marsh, et al. (63).

2.4 BACKGROUND

Canada has a growing homelessness crisis. An estimated 35,000 people experienced homelessness each night in 2016 (64), and this number has likely increased since. People experiencing homelessness have a high prevalence of substance use disorders, but to date there have been only relatively small Canadian studies on the topic. Based on these, up to 82% of people who were experiencing homelessness qualified for a diagnosis of substance use disorder (65), defined as either alcohol use disorders or other drug use disorders. Other studies found lower prevalence, but in all studies, prevalence was multifold to that found in the general population (66,67). Amidst rising homelessness, Canada is also experiencing an overdose epidemic.

Canada has seen an increase in overdose deaths since the 1990s (68), and the widespread contamination of the illegal drug supply has further intensified the crisis (69). The opioid-related overdose death rate reached 11.9 per 100,000 in 2018, decreased to 9.8 per 100,000 in 2019, then increased to 17.1 per 100,000 in 2020 and 20.5 per 100,000 in 2021 (70). This translates to a staggering 96% increase in opioid-related deaths in the first year the COVID-19 pandemic, and continued increases in death rates as the pandemic continues (70). The devastating impact of the overdose epidemic on our communities requires comprehensive public health and addiction treatment responses.

The outbreak of COVID-19 was declared a global pandemic by the World Health Organization on March 11, 2020 (71). The most common symptoms of this viral infection include fever, cough, difficulty breathing or shortness of breath, sore throat, and runny nose or nasal congestion (72,73). In more severe cases, sepsis, respiratory failure, and heart failure can occur (73). COVID-19 spreads through respiratory droplets and aerosols from coughing or sneezing, close personal contact, or contact with contaminated surfaces (74–76). However, evidence suggests that COVID-19 also spreads through airborne transmission, leading to recommendations on improving indoor air quality to mitigate COVID-19 transmission (e.g. improved HVAC systems) (77). Although new variants of COVID-19 may increase transmissibility, the modes of transmission are the same (78). Globally, there have been over 609 million confirmed cases and over 6.5 million deaths (79), although this is likely underestimated. In Canada, as of September 10, 2022, there have been over 4.2 million confirmed cases and 44,740 deaths (80).

The COVID-19 pandemic has compounded risks already posed by the overdose epidemic, and these intersecting public health emergencies place people who use substances and are experiencing homelessness or housing vulnerability at extreme risk of negative outcomes. Recent studies reveal that having a substance use disorder diagnosis exacerbates the risk of contracting COVID-19 eight-fold (81) and once someone is infected, they are at significantly elevated risk of hospitalization, intensive care unit (ICU) admission, mechanical ventilation, and death (81–83). Comorbid health conditions commonly experienced by people with substance use disorders (84–86) further elevate risk for severe COVID-19-related complications and mortality (81,83,87). People who are experiencing homelessness or housing

vulnerability may lack basic resources to protect themselves from COVID-19 by adhering to public health recommendations including physical distancing, self-isolation, and hygiene guidelines (75), increasing their risk of infection. In addition, recent research has demonstrated that people experiencing homelessness are more likely to test positive for COVID-19, more likely to be hospitalized due to COVID-19 infection, and more likely to die of COVID-19 complications (88,89).

COVID-19-related public health directives and recommendations may have unintentionally undermined progress addressing the overdose epidemic (29). Physical distancing recommendations may have made obtaining substances more difficult, and purchasing substances served as an opportunity for direct transmission (i.e. through face-to-face interactions). Public health orders forbidding public congregating disrupted 'open air' drug markets. As a result, those reliant on these markets may have needed to obtain substances from unfamiliar sellers (90), travel longer distances to obtain substances, and consume drugs in new environments (28), which exacerbates risk of COVID-19 infection or transmission, overdose, arrest and incarceration, and violent victimization. Further increasing risk was the financial instability due to unemployment caused by COVID-19-related business closures, reduced donations by the public, and challenges selling items as a means to provide for oneself (29,91). People who use substances and were faced with income instability may have participated in sex work, panhandling, or other income-generating activities that increased transmission risks for themselves and others (see COVID-19 Guidelines for Sex Workers, Clients, 3rd Parties by the Canadian Drug Policy Coalition (92) for more information on sex work and COVID-19).

Border closures and travel restrictions related to COVID-19 have caused disruptions in the illegal drug supply (28–30,91,93,94), further increasing risk of overdose. Over the first few months of the pandemic, people who use substances in Canada frequently reported a decrease in drug potency, resulting in greater withdrawal symptoms, lower drug tolerance, and increased risk of overdose (28). Supply interruptions further exacerbated risks of health-related complications by encouraging stockpiling to ensure continued access to substances, potentially resulting in greater substance use (28,29,91). Unstable access to substances can increase their costs, which can lead to changes in consumption practices to more affordable options (29), including mixing substances (91) or riskier routes of administration (30). Furthermore, supply disruptions and shortages can increase levels of drug adulteration or contamination, making the potency and toxicity of the illegal drug market even less predictable (29,30,94).

Physical distancing and self-isolation recommendations exacerbate the risk of overdose death, as these public health measures have led more people to use substances alone (28,90,95,96), limiting the presence of bystanders who could intervene in the event of an overdose or the willingness of bystanders to intervene (29,97,98). If an overdose occurs in public, intervening bystanders may inadvertently expose themselves or the person who has overdosed to COVID-19 when providing cardiopulmonary resuscitation (CPR) or other interventions, if not equipped with appropriate personal protective equipment (PPE). In shelter settings where PPE may be in short supply, staff are less able to respond

effectively without risking potential COVID-19 exposure or transmission. Alternatively, lifesaving interventions such as rescue breathing and/or CPR may be delayed until Emergency Medical Services (EMS) arrives, increasing the risk of anoxia and brain damage. These situations may lead to adverse outcomes for the person experiencing an overdose, including death, and significant moral distress for staff.

The COVID-19 pandemic has also intensified existing barriers to harm reduction services (28,29,91,93,95,98,99). Public health responses such as physical distancing and isolation recommendations can decrease access to opioid agonist treatment (OAT), supervised consumption services, addiction treatment, peer support programs, and outreach services (29). Reduced or relocated staff and resources further diminish harm reduction service availability (29), and the resulting limited capacity of such services has deterred participants from accessing harm reduction services throughout the COVID-19 pandemic (91).

Complicating this situation is the fact that some withdrawal syndromes can mimic the symptoms of COVID-19. For example, opioid withdrawal often presents as influenza-like illness (e.g. runny nose, chills, pallor, gastrointestinal upset, fatigue). This may complicate screening and isolation protocols and increase the risk of COVID-19 transmission if symptoms of opioid withdrawal are mistaken for influenza-like illness, and potentially lead to exclusion from shelter services or inappropriate cohorting of uninfected individuals with others who are suspected or confirmed cases of COVID-19 infection. Misclassification of opioid withdrawal as COVID-19 symptoms along with the reduced operating capacity to align with public health recommendations further intensifies barriers to accessing addiction, harm reduction, housing, and social services, and reinforces the syndemic nature of these public health emergencies (29). As previously mentioned, people who use substances and are experiencing homelessness or unstable housing are at greater risk of substance-use- and COVID-19-related harms and mortality; however, when they are denied access to these services because their withdrawal symptoms are misclassified, their circumstances become more precarious and their risks intensify. Furthermore, the risk of an opioid overdose also increases when people who use opioids self-medicate to treat misclassified COVID-19 symptoms as withdrawal symptoms (100).

Shelter settings in Canada have adapted their service models in response to the pandemic. Many existing emergency shelters that house people overnight or provide daytime drop-in spaces are reducing the number of people allowed in at one time and/or modifying their spaces to try to align with physical distancing recommendations. These services may also be altering their hours or temporarily relocating to larger facilities in an attempt to reduce COVID-19 transmission risks and outbreaks (24). Many jurisdictions are also establishing medical isolation shelters, within existing or in new settings (e.g. recreation centres (24), or other large facilities), to support people who are experiencing homelessness or housing vulnerability to self-isolate if they have had a known high-risk exposure, are under COVID-19 investigation, or test positive for the virus. Several jurisdictions are also supporting people to either physically distance or isolate using hotels or similar kinds of temporary accommodations with integrated

support services (24–27). For instance, hotel shelters in Halifax, Nova Scotia, provided residents with safe supply and MAPs to facilitate COVID-19 isolation (25) and temporary hotel housing with on-site OAT in Hamilton, Ontario, was reported to decrease residents' illicit substance use (27).

Although shelters are implementing various measures to reduce the risk of COVID-19 transmission, many continue to face challenges containing infection (101,102). From March to mid-June 2020, shelters in Toronto, Ontario reported 601 COVID-19 outbreaks (103), which is over 35 times greater than all of Ontario's childcare centre industry and seven times higher than Ontario's corrections industry (103). Early studies from the United States reported case rates of 15-66% in some shelter settings (104–107). However, a more recent systematic review and meta-analysis of COVID-19 in homeless shelters reported a 32% pooled prevalence of COVID-19 infection for shelter residents and 15% for shelter staff during outbreaks (108). The COVID-19 pandemic dramatically illustrates a public health and human rights imperative to provide housing for all. Safe and stable housing is the first-line defense against COVID-19 (109,110). While shelters can help respond to the immediate need to mitigate public health risks of COVID-19, they are only a temporary and inadequate solution to pre-existing structures of marginalization and exclusion (111) and ultimately do not advance the human right to housing (110,112). While shelters may be acceptable interim measures, they should not replace work to ensure safe and adequate housing for all.

For shelters providing care to people who use substances during the COVID-19 pandemic, a pragmatic approach assumes that some level of drug and alcohol use will continue irrespective of formal or informal bans or criminal prohibitions, and that abstinence-based approaches may be ineffective (113,114). This means that people who use substances should not be excluded from shelter settings because of substance use policies that prohibit use on site or possession of substances. Beyond addiction, people use substances for a variety of reasons including for stimulation, to reduce stress and anxiety, to manage pain and mental health conditions, and for pleasure. To reduce risk of substance-related harms and promote safety of both residents and staff, shelters should integrate harm reduction approaches and interventions into their service models.

Operators providing temporary housing or shelter during the COVID-19 pandemic should consider adding or bolstering strategies for accommodating active substance use and make concerted efforts to support people who use substances to stay as safe and healthy as possible. Promising strategies for achieving this are: [1] integration of supervised illegal drug consumption services into shelters, and [2] provision of substance use disorder treatment and related recovery supports, MAPs, and replacement pharmacotherapy to support those who use substances to mitigate their risk of COVID-19 transmission, overdose, and withdrawal (25–27,115,116). Within the context of COVID-19, Canadian shelters and temporary housing services that have adopted these strategies have reported reductions in overdose-related mortality (116), decreased illegal substance use (27), and improved adherence to public health recommendations (25). A recent systematic review of reviews further illustrates the utility of these approaches (117). It found that supervised consumption services and pharmaceutical interventions (e.g.

buprenorphine, methadone, and injectable diacetylmorphine or hydromorphone) reduced mortality and morbidity, and improved other outcomes amongst people experiencing homelessness, and that MAPs helped reduce or stabilize alcohol consumption (117). For some settings, integration of these strategies may be in addition to an already established culture and set of policies related to harm reduction. In other cases, specific attention may be needed to develop organizational harm reduction policies and ensure staff education in harm reduction (for guidance on implementing harm reduction in shelters and housing, see the Harm Reduction Implementation Framework (118) and Infrastructure for Harm Reduction in Residential and Hotel Settings (119)).

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

Supervised consumption services provide monitored spaces where people consume illegal substances without the risk of police intervention or criminal sanctions, in the presence of staff trained to respond in the event of an overdose or other adverse event. They also provide access to sterile substance consumption supplies and typically offer other health and social supports. Supervised consumption services are associated with reductions in overdose-related mortality and drug-related risks (e.g. syringe-sharing), increased access to social, health, and addiction-related services, and have not been shown to have a negative impact on public disorder or drug-related crime in the surrounding area (120,121).

3.1 SECURING AN EXEMPTION FOR AN URGENT PUBLIC HEALTH NEED SITE

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

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

of health and social services for people who use substances, UPHNS typically have less capacity to offer these ancillary supports.

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

First, in response to COVID-19, Health Canada issued temporary class exemptions to all Canadian provinces and territories from April 2020 to September 2022. This class exemption enables provincial or territorial Ministers of Health to approve UPHNS applications in their jurisdictions, or delegate approval to other entities within their jurisdiction (e.g. municipalities). Any approved entity can set up and administer the UPHNS, yet the province or territory remains ultimately responsible for complying with the terms and conditions of the class exemption. Some provinces or territories may decide not to activate their class exemptions, and others may or may not grant other entities the permission to approve UPHNS applications. Provinces and territories may also have their own application process and criteria for prospective UPHNS operators. To obtain more information or to apply to operate UPHNS under a provincial or territorial class exemption, contact your provincial or territorial department of health.

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

UPHNS applications submitted to the federal government typically include (122):

- Contact information and a signed applicant statement from each applicant;
- Name of the designated responsible person in charge (RPIC);
- Location of the proposed site;
- Details regarding the services to be provided (e.g. the routes of consumption that will be permitted, the hours of operation, etc.);
- Information on why the site is required (i.e. describe the urgent public health need that the site is addressing);
- Confirmation that relevant policies and procedures are in place (e.g. procedures for proper disposal of substance use equipment that was inappropriately discarded within the site's vicinity); and,
- List of source(s) and duration of funding.

Other information may be required by Health Canada in assessing temporary exemption applications. With regard to funding, Health Canada has stated that at this time they will not fund supervised consumption sites or UPHNS; "however, due to the impacts of COVID-19 on communities and vulnerable populations, there may be other sources of funding available from community partners dealing with harm reduction, homelessness, community services, and other donors. As examples, many cities and organizations have been provided federal funding for homelessness that could be potentially used to alleviate funding pressures for urgent public health need sites or supervised consumption sites" (123).

Please note, all further guidance and recommendations referring to "supervised consumption services" in this document refers to both supervised consumption sites and the more temporary UPHNS.

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

- Questions and Answers - Provincial/Territorial Class Exemptions: For Supervised Consumption Site Operators (123).

The ability for participants to access supervised consumption services is contingent upon their mobility, geographic location, and fear of criminalization and stigmatization (124–126); these barriers may be further exacerbated by COVID-19 and its associated public health measures, as well as fear of infection. One potential solution to mitigate these barriers to accessing overdose response-related care is technology-based overdose prevention interventions, such as phone or app-based drug witnessing that dispatch EMS or other emergency response solutions in the case of an overdose. Although not included in the Health Canada exemption process and therefore out of scope of the current document, the following resources on virtual supervised consumption services may be useful:

- Lifeguard App; BC Provincial Health Services Authority, Regional Health Authorities and Lifeguard Digital Health (127);
- National Overdose Response Service (NORS); (1-888-688-NORS) – Grenfell Ministries, the Brave Technology Coop and Dr. Monty Ghosh (128);
- Brave App; Brave Technology Coop (129);
- Be Safe; mindyourmind (130);

- Digital Overdose Response System (DORS) for Alberta (see FAQ | DORS App for a list of communities that DORS serves); Alberta Government, Aware 360, and STARS Vigilant Services (131); and,
- Virtual peer spotting comic book (English, French) and animation (English, French); Canadian Association of People who Use Drugs (132).

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

Many different models of supervised consumption services have been implemented in Canada. Additionally, supervised consumption services can be adapted to a range of contexts; there are precedents for integrating these services into hospitals (133), hotels temporarily housing people who are experiencing homelessness or housing vulnerability (24–27), shelters (116,134), mobile units (135), and housing facilities (52,136). Supervised consumption services in reclaimed spaces (e.g. converted medical or office spaces in existing shelters, shipping containers outside of shelters (137)) demonstrate the potential flexibility of supervised consumption services to fit within available space, and provide practical examples for shelter settings who wish to implement supervised consumption services during the COVID-19 pandemic. However, there are many factors to consider when determining key attributes of supervised consumption services within shelter settings. Some considerations related to the physical infrastructure of supervised consumption services; staffing ratios, characteristics, and immunizations; COVID-19 hygiene protocols; and how to maintain a participant-oriented service are outlined below.

3.2.1 Physical Infrastructure

Centralized models. For shelters seeking to implement one or more centralized spaces for supervised consumption (e.g. all residents attend one or more designated areas dedicated to supervised consumption only), a large, closed-in space is recommended to help manage entry and flow of participants while maintaining physical distancing (e.g. participants and staff are encouraged to remain two metres apart as much as possible throughout all areas of the service). Staff members could place markers on the floor or chairs spaced two metres apart to facilitate physical distancing. However, if participants use the service alone (e.g. staff observe from behind a window or door), space for physical distancing is not required. Any supervised consumption service area should be easily observed by staff and large enough to meet applicable accessibility requirements and safety codes, and ensure EMS can access it in the case of a medical emergency. A separate, designated area could be included for screening participants for COVID-19 prior to them entering the supervised consumption service, if required. Staff should inform participants that in the event of an overdose or other medical emergency, the space may need to be cleared of all other participants and staff not responding to the emergency to ensure safety and reduce potential risk of COVID-19 transmission. The space should be sufficiently separate (ideally

enclosed) from other areas of the shelter to minimize the potential spread of respiratory droplets and aerosols in the event that a supervised consumption service participant has COVID-19 and requires an intervention, including certain methods of respiratory support, that is considered to be an aerosol-generating medical procedure (AGMP; see section **3.3.5 Responding to Overdose within Supervised Consumption Services** on page 42 for more information on AGMPs in supervised consumption services). It is recommended that all surfaces, including barriers separating patient areas and furniture, be made of non-porous materials that can be easily cleaned (138).

Grouping participants depending on COVID-19 status. With centralized supervised consumption service models, when feasible, there should ideally be separate services (with waiting, consumption, and monitoring areas) for each of the three populations at varying degrees of COVID-19 risk: [1] those who are asymptomatic, not under any public health guidance to self-isolate, and not undergoing any investigations related to COVID-19; [2] those who are suspected of having COVID-19 (i.e. are symptomatic); and [3] those with confirmed COVID-19 infection. Specific cohorts or participant groups within each setting should be determined in consultation with local public health and infection prevention and control experts and account for local COVID-19 epidemiology. Grouping participants by their COVID-19 status aims to limit risk to other participants and shelter staff and conserve PPE (139). For more information on recommended screening practices, please refer to section 3.2 "Screening," in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18).

Privacy. Where possible, supervised consumption services should be located in an area that protects privacy by limiting the visibility of participants entering and exiting the service by people in other areas of the shelter (140).

Universal design. The built environment of supervised consumption spaces should be as inclusive and accessible as possible (e.g. wheelchair accessible spaces). For more information on how to ensure your space and services are barrier-free, please refer to Accessibility Standards Canada's Guidelines: Accessible service delivery during emergencies including COVID-19 (141)**.**

Storing participant belongings. Ideally, large personal belongings should not be brought into the supervised consumption service, and staff should consider providing participants with a single use plastic bag and a designated area to store their larger and smaller personal belongings while at the site. It is up to each shelter to discern which items are permitted on site. For example, everyday items that can cause bodily harm (e.g. tools, sports equipment) may be stored while the participant uses shelter services, whereas weapons (e.g. guns) are typically prohibited on site. It is recommended that shelters develop comprehensive policies and procedures on items that are prohibited or stored. Further guidance on check-in procedures for personal belongings can be found in the sample "Weapons Policy and Procedure" in BC Housing's Emergency Shelter Program – Sample Policies and Procedures (142).

Consumption booths. The booths/tables and chairs should be sturdy and comply with the relevant infection prevention and control protocols (e.g. easily cleaned and disinfected (138)); chairs should be maneuverable and light-weight so they can be easily moved for accessibility (e.g. wheelchairs, walkers) and in medical emergencies. Ideally, each consumption space should be two metres apart or, if using existing infrastructure, participants can be placed at every other booth/table to support physical distancing. If supported by existing infrastructure and with adequate staff observation, having consumption tables/booths in multiple separate rooms could facilitate continual access to the service by allowing consumption to continue in the other rooms in the event of an overdose, as well as allowing for privacy if needed. Otherwise, if all consumption tables/booths are in the same room, consider closing the entire consumption area until the overdose has been reversed and disinfection has been completed (see section **3.3.5 Responding to Overdose within Supervised Consumption Services** on page 42 for more details on responding to overdoses including interventions and disinfection guidance).

Decentralized or dispersed model. Instead of one centralized area for supervising substance consumption episodes, shelter operators and medical teams may explore the possibility of providing a decentralized, 'bedside' or 'episodic' supervised consumption service model where a participant consumes substances within their own designated area or room and are supervised by a staff member maintaining physical distancing and wearing the appropriate PPE (for more information on PPE for staff, see section **3.3.3 Staff PPE** on page 37 and section 3.3 "PPE" in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18)). If there are multiple people staying together (e.g. couples, family members), peer-witnessing and monitoring for overdose may be another practical option. Harm reduction supplies and sharps disposal containers could be distributed to participants to be stored with their personal belongings. This may be an especially useful option in medical isolation shelters with multiple separate areas for cohorting participants based on COVID-19 status. See COVID-19 Provincial Episodic Overdose Prevention Service (e-OPS) Protocol (143) from the British Columbia Centre for Disease Control for more information on implementing this kind of model.

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

Mode of administration. Ideally, all common modes of drug administration (oral, intranasal, injection, and inhalation) should be accommodated. The majority of supervised consumption sites in Canada accommodate injection, oral, and intranasal routes. However, these services typically exclude people who consume via inhalation, despite the increased risks and rates of drug toxicity deaths associated with smoking substances since the onset of COVID-19 (144,145). There is currently one operating supervised consumption site in Saskatoon, Saskatchewan that is exempted federally to monitor substance consumption via inhalation/smoking (146). This facility has a specially ventilated room that follows occupational health and safety protocols to protect staff and other participants from exposure to secondhand smoke. While this is unlikely to be practical in UPHNS scenarios, there is precedence for supervising inhalation activities in a designated outdoor area (147). Pop-up inhalation tents could be

established in courtyards or adjacent outdoor areas within view of staff. However, operators should note that outdoor locations are not ideal because concrete or asphalt flooring does not facilitate thorough cleaning and disinfecting. Another important consideration for outdoor inhalation areas is the shelter's geographic location and its corresponding seasonal temperatures. In addition to cold and dry environments lowering immunity and increasing risk of COVID-19 transmission (148), the extreme temperatures experienced in many areas of Canada restricts the usability of outdoor consumption spaces to only a few months of the year.

3.2.2 Staffing Considerations

Staff to participant ratio. The recommended staffing ratio is dependent on a number of factors, including the supervised consumption service layout (e.g. how many spaces and rooms), capacity of the supervised consumption service (e.g. how many participants can be in the site at once), and physical size of the site. Operators should also try to anticipate temporary periods of increased demand, such as in the week following disbursement of income support cheques (149) or if a sudden increase in the toxicity of the illegal drug supply is detected. At a minimum, there should be a staff member present in each separate area to monitor and respond to participants experiencing an overdose or other adverse medical events. Participants should be visible by staff at all locations within the site.

Staff characteristics and training. Across Canada, a variety of staff with different expertise are employed in supervised consumption services and most have interdisciplinary teams. Services may be staffed by people with lived and/or living experience of substance use, and those trained in nursing, social work, addiction counselling, as well as EMS personnel (herein referred to as staff). Employing people with lived and/or living experience of substance use is an essential strategy for facilitating meaningful uptake and engagement with the service (52). Guidance is available for employers on hiring, fairly compensating, and supporting staff with lived or living experience of substance use and it is strongly recommended that operators employ people with lived and/or living experience of substance use whenever possible (150,151). Regardless of discipline, all staff should be trained in harm reduction, cultural safety, trauma informed care/practice, basic first aid, overdose response (e.g. naloxone administration, CPR), and infection prevention and control procedures. Staff training and ongoing support is essential for creating safe work environments and providing care that is sustainable. One practical strategy is a beginning-of-shift and end-of-shift team meeting or handover to provide opportunities to debrief and share pertinent information.

Staff COVID-19 immunizations. Shelters should consider taking every reasonable precaution to maintain the health and safety of its staff and residents, which can include developing a COVID-19 vaccination strategy and/or policy for staff. Immunizations in shelter staff prevents COVID-19 infections and outbreaks, decreases risk of severe COVID-19 outcomes if infected, and protects the health of other staff and shelter residents (152). The COVID-19 immunization strategy could include a identifying a reoccurring time and space (e.g. team meeting agenda item) to regularly encourage staff vaccinations,

provide a platform for vaccine education, and support staff discussions (e.g. addressing safety and efficacy concerns (153)). Messaging that emphasizes the vaccination benefits on personal health have been reported to have the largest impact on vaccine intentions (154).

In accordance with local policies, employment contracts, collective agreements, and if operationally feasible, a shelter policy that provides time-off without loss of pay would further encourage staff vaccinations (e.g. half day of paid time off (155)). Ultimately, leading by example and championing COVID-19 immunization are of the upmost importance in creating a safe shelter environment that protects the health of its residents and staff (for more information on how to encourage immunizations amongst shelter residents, please see section **5.0 Facilitating COVID-19 Vaccinations for Shelter Residents** on page 57).

Of note, mandatory staff vaccination requirements are currently at the discretion of each shelter. However, given the rapid developments in Canadian case law on this topic, it is recommended that shelters seeking to mandate COVID-19 staff immunizations should consult with legal representation prior to policy implementation (156).

3.2.3 COVID-19 Hygiene Protocols

Hand hygiene. Supervised consumption service staff and participants need to have access to hand hygiene sinks and/or a Health Canada-approved hand sanitizer (see Hard-surface disinfectants and hand sanitizers (COVID-19): List of hand sanitizers authorized by Health Canada (157)). Participants should perform hand hygiene, either by washing their hands with mild soap and lukewarm water for 20 seconds, or applying hand sanitizer prior to entering the supervised consumption service, before and after substance consumption, and upon leaving the supervised consumption service. Staff should perform hand hygiene regularly, including before and after any physical contact with any participants or their belongings (see section 3.5 “Hand Hygiene,” in CRISM’s National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18)). Posters for Hand Rub and Hand Wash procedures (158,159) should be posted at all hand hygiene stations in the supervised consumption service.

Surface and environmental cleaning. The supervised consumption service should be implemented in an area of the shelter amenable to regular cleaning. Shelters are advised to consult local public health and medical authorities for specific jurisdictional COVID-19 directives and recommendations for cleaning. Ideally, a process should be developed for cleaning that delineates roles and responsibilities, frequency, and tracking. The process should include cleaning and disinfecting (two-step process) all surfaces and reusable equipment contacted by participants regardless of their COVID-19 status, between each participant. Other high touch areas and shared spaces should be cleaned and disinfected at least twice a day and this should be documented. A Health Canada approved disinfectant with activity against COVID-19 should be used (157,160). Additional guidance can be found in section 3.8 “Facility Cleaning

and Disinfecting," in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18).

Sourcing PPE. The global COVID-19 pandemic has created an unprecedented demand for PPE, even resulting in shortages of masks, gloves, disinfecting products, and other critical supplies at times. To address challenges in obtaining PPE, the Government of Canada has created a resource hub (161) that lists available suppliers by province or territory. Shelters may also be eligible to access free PPE and supplies through the Government of Canada's Essential Services Contingency Reserve (ESCR) as an organization in the social service sector or as an organization serving Indigenous communities. To review the ESCR eligibility requirements and application process, please refer to the following links: Stream 2: Organizations serving Indigenous communities (162) and Stream 3: Social service sectors (163). See sections **3.3.3 Staff PPE** on page 37 and **3.3.5 Responding to Overdose within Supervised Consumption Services** on page 42 for staff PPE requirements and for guidance on PPE when responding to an overdose, respectively.

3.2.4 Participant-Oriented Services

Low barrier access. Supervised consumption services should be easily accessible to anyone seeking its services by minimizing barriers (e.g. unnecessary paperwork, excessive eligibility requirements). Funding and regulatory bodies often require reporting on outputs and activities of the service and aggregate demographic information of participants, so it is important to balance service accessibility with data collection that does not impede service delivery (see section **3.4 Reporting and Evaluation** on page 44).

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

Sterile drug consumption equipment. Operators will need to secure access to sterile harm reduction supplies (through specialized distributors) and medical waste disposal services. Staff members can either have kits of supplies prepared in advance to provide to each participant or can ask the participant about the equipment they require for their consumption and distribute it accordingly. Available equipment should include:

- Needles and syringes in a variety of gauges and sizes;

- Tea light candles and lighters (if matches are used, ensure they do not become a fire hazard);
- Disposable cookers;
- Filters (if purchased separately from cookers, use tweezers to extract filters from the bag and place into a single-use container for the participant);
- Sterile and disposable water;
- Acidifier (e.g. ascorbic acid);
- Alcohol swabs;
- Disposable or participant-specific tourniquets;
- Disposable tray (for distribution of supplies);
- Straws (for intranasal consumption);
- Foil or other disposable container to hold drugs (for intranasal consumption);
- Borosilicate (e.g. Pyrex®) glass pipes, ball pipes, or stems (for inhalation);
- Mouthpieces (for inhalation);
- Metal pipe screens (for inhalation);
- Disposable cups (for alcohol, water);
- Mirrors (handheld);
- Condoms and personal lubricant; and,
- Disposal containers.

Detailed guidance on distribution of harm reduction supplies is available in the following documents:

- Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Services to People who use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1; Working Group on Best Practice for Harm Reduction Programs in Canada (39); and,
- 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 (40).

Offering ancillary supports. Depending on staffing, supervised consumption service capacity, and PPE availability, operators should consider incorporating any of the following ancillary supports:

- Basic medical services (e.g. first aid, naloxone training, wound care);
- Demonstration of, and education on, safer consumption and injection techniques;
- Peer support or outreach from people with lived and/or living experience of substance use;
- Referrals to substance use treatment (e.g. opioid agonist treatment, specialty addiction recovery programs);
- Referrals to other health and social services (e.g. income support, housing, care planning, case management or counselling, family planning, victim support services, cultural supports [e.g., Indigenous Friendship Centres (164)]);
- Drug checking (e.g., strips to test for the presence of fentanyl, or a spectrometer);

- Naloxone training and distribution (check with your local community-based naloxone program to ensure trainers have the most up-to-date information about providing CPR and administering naloxone in the context of COVID-19. An example of guidance for naloxone program participants in Alberta is cited at the end of this document (165)); and,
- Access to Indigenous healing practices, medicines, and other relevant cultural supports. To learn more about Indigenous worldviews and traditional healing modalities, please see Aboriginal Medicine and Healing Practices (166).

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

Preventing overdose in adjacent shelter areas. Even with the implementation of supervised consumption services in shelter settings, bathrooms and other private or semi-private areas may still be used to consume substances to avoid the perceived or real threat of punitive measures from staff (e.g. eviction), when the supervised consumption service is closed or at capacity, or in an effort to conceal drug possession or use from peers (46,167,168). Substance use within bathrooms or other areas can result in unhygienic practices and increase the possibility of unwitnessed overdoses (169). Therefore, whether or not a supervised consumption service is operational, it is recommended to include regular monitoring and safety checks of bathrooms and other high-risk areas. Bathrooms should ideally have locks that can be opened from the outside and/or a door which unlocks after a fixed amount of time to allow staff to check on occupants while maintaining the individual's privacy and dignity as much as possible (170). Secured and tamper resistant sharps containers should be installed in bathrooms and other areas where substance use could occur, and overdose prevention information posted (171–173).

3.3 SUPERVISING CONSUMPTION IN SHELTERS DURING COVID-19

3.3.1 Screening Supervised Consumption Service Staff for COVID-19

Every supervised consumption service staff member should self-screen for COVID-19 symptoms prior to arriving at work (COVID-19 Self-Assessment Tools by Province or Territory (174)). Staff who are symptomatic or meet other high-risk criteria should inform management, go home, and follow local public health authorities' guidance on self-isolation based on COVID-19 vaccination status (155). Shelters should consider adopting supportive sick leave policies that compensate for lost wages due to self-

isolation. Operators should also consider scheduling cohorts of staff together on the same rotations to help mitigate potential staff shortages if an outbreak occurs by potentially limiting the number of staff exposed. For additional information on staff screening, see section 3.2.4 "Active Screening: Staff," in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-Global Pandemic (18).

3.3.2 Screening Supervised Consumption Service Participants for COVID-19

Staff should warmly greet each supervised consumption service participant in the intake area. If screening participants for COVID-19 symptoms, it is recommended that screening be done either from behind a physical barrier (e.g. plexiglass or by a call-in from outside), with physical distancing, or with appropriate PPE (see section **3.3.3 Staff PPE** on page 37 for information on PPE), and participants should be screened for COVID-19 symptoms and possible exposures upon arrival according to the standard screening questionnaires and procedures recommended by local public health authorities (Province- and Territory-specific Screening Tools (174)). Local recommendations may change regularly to reflect COVID-19 epidemiology, and supervised consumption service policies should be updated regularly to reflect these changes as needed. Staff members should be knowledgeable about harm reduction as an approach to care, and be able to provide safer substance use education and infection prevention guidance in the context of COVID-19 to all participants presenting to the supervised consumption service.

If a participant screens positive for COVID-19 (e.g. symptomatic or confirmed COVID-19 infection) and still requires shelter services, staff should instruct the participant to perform hand hygiene and provide them with a medical-grade mask to wear within the supervised consumption service. For detailed screening procedures for supervised consumption service participants, including guidance on positive COVID-19 screenings, see section 3.2.2 "Active Screening: Clients" and 3.2.3 "If a Client Screens Positive," in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18). Additional examples of screening procedures developed in Ontario are listed in section **6.0 Further Reading and Resources** on page 59 at the end of this document (175,176).

Staff are encouraged to consider providing a medical-grade mask to all participants, regardless of COVID-19 test results, risk factors, or current public health regulations on masking in public spaces. All staff and participants should be advised on other infection prevention and control measures they are required to take to be in accordance with guidance from local public health authorities (e.g. cough and sneeze into a tissue or their elbow, hand hygiene, physical distancing (75)) to minimize transmission of COVID-19. Alternatively, sites could provide single use rooms or a partitioned area with windows or sightlines for monitoring, if feasible. Cohorting of staff to these symptomatic or high risk participant groups is strongly encouraged. Staff members should work closely with public health officials to facilitate formal COVID-19 screening and testing, and referral to appropriate self-isolation support as appropriate.

It is important to note that people who are not showing symptoms might still be positive for COVID-19 and transmit the virus despite being asymptomatic (177,178). Therefore, regardless of whether COVID-19 status is known or unknown, it is imperative that sites try to maintain the proper physical distancing between each supervised consumption service participant, perform hand hygiene regularly, and thoroughly clean each consumption space (and any other areas touched by participants) after each use in order to minimize transmission of the virus (see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 and sections 3.5 "Hand Hygiene" and 3.8 "Facility Cleaning and Disinfecting," in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18) for more information on hand hygiene and surface and environmental cleaning).

3.3.3 Staff PPE

Detailed guidance on PPE for staff working in harm reduction is provided in section 3.3 "Personal Protective Equipment (PPE)" in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18). We provide an overview of the important considerations and recommendations here. See sections **3.2.3 COVID-19 Hygiene Protocols** on page 32 and **3.3.5 Responding to Overdose within Supervised Consumption Services** on page 42 for guidance on sourcing PPE and on recommended PPE when responding to an overdose, respectively.

Specific staff PPE requirements in each shelter setting should be determined in consultation with local public health authorities and account for local COVID-19 epidemiology, participant demographics, supervised consumption service infrastructure, knowledge and training of staff, PPE supplies, and employer policies. Operators should be continuously reviewing and updating PPE requirements, as necessary, to ensure they are in line with the best available science and public health guidance at all times. Seeking expert infection prevention and control consultation is strongly advised. Staff who may provide (or anticipate providing) care to participants within two metres should be trained in PPE use, including proper donning and doffing technique and hand hygiene (see sections 3.5 "Hand Hygiene" and 3.6 "Donning and Doffing PPE," in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18)). This includes anyone who might respond to an overdose or medical emergency.

Due to the risk of asymptomatic COVID-19 transmission and other communicable diseases (177,178), staff should always utilize "routine practices" (called "standard precautions" by the World Health Organization (179)). This includes point-of-care-risk assessment (including PPE selection as necessary for the anticipated interaction), frequent hand hygiene, and environmental cleaning (180). Ideally, subsequent PPE use should be dictated by the task being performed:

- COVID-19 screening: staff performing COVID-19 risk factor screening who cannot do so from behind a barrier or while maintaining physical distance should wear a medical-grade mask and eye protection (goggles or face shield);

- Administrative areas without direct contact with participants: staff should wear a medical mask if physical distancing cannot be maintained; staff should consider eye protection based on local COVID-19 epidemiology and their personal COVID-19 risk;
- Direct care performing non-AGMP procedures: staff should wear eye protection, non-latex gloves, and a medical mask; a gown should also be used if contact with blood or bodily fluids is anticipated; and,
- Direct care performing AGMP procedures: staff should wear eye protection, non-latex gloves, a gown, and a properly fitted N-95 mask.

Note that this approach to selecting PPE may differ from that taken in medical isolation shelters where patients with confirmed COVID-19 infection are being supported by healthcare staff. Always defer to local public health guidance in determining the appropriate PPE for staff in your setting.

3.3.4 Monitoring Consumption and Providing Care within Supervised Consumption Services

Supervised consumption services should always be offered in a culturally safe manner that is consistent with a harm reduction and trauma-informed approach (181) (see section **2.3 Guiding Principles** on page 17). All staff, regardless of discipline or role, must thus be trained on how to provide the best care and support to participants (see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 for further details on staff characteristics and training). Additionally, throughout each visit, staff and participants should follow proper hand hygiene, and other sanitation protocols to minimize the risk of COVID-19 transmission. Please see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 for more details. At all times, staff who are trained and experienced in PPE donning and doffing and recently N95 fit tested should be identified to respond to overdoses at the site. These individuals should have access to properly fitted N95 masks when responding to an overdose to ensure staff safety if an AGMP is required as part of the overdose response (see section **3.3.5 Responding to Overdose within Supervised Consumption Services** on page 42 for detailed guidance and on PPE required for responding to overdoses in supervised consumption services).

Pre-consumption. Participants should wait, while distanced from staff or other participants, in a designated area until there is a vacant consumption space open. Staff could explain to participants that wait times may be extended due to the reduced number of consumption spaces to comply with physical distancing recommendations, if applicable. Participants should take this time to place their belongings in single use plastic bags or in the designated storage area for participant belongings. When there is a consumption space available, a staff member can screen the next participant (if screening participants; see section **3.3.2 Screening Supervised Consumption Service Participants for COVID-19** on page 36), and gather any information required for intake. Intake procedures and information collected vary across supervised consumption services, and ultimately are determined by local needs, staff capacity, and

specific regulatory context (see section **3.4 Reporting and Evaluation** on page 44 for more information). It is helpful for staff to record or be aware of the drugs the participant is planning on using and when and what they last used to assess their relative risk of overdose, and the involvement of any polysubstance use. If drug checking services are available, participants may test their drugs before or after entering the consumption area and preparing their drugs for consumption, depending on checking protocols. At the participant's first visit to the supervised consumption service, they may be asked to sign a participant agreement or give verbal consent, which explains site procedures and the rights of participants and staff.

Depending on which routes of consumption were exempted under the *Controlled Drugs and Substances Act*, participants can consume their drugs through injection, intranasal, and oral routes at the booths or tables set up in the site, or through inhalation in specially ventilated rooms or outside (see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 for more details on modes of administration and on how to set up consumption booths).

Consumption. To limit the potential spread of COVID-19 between participants, staff members should first perform hand hygiene, then collect and distribute sterile drug consumption equipment to participants while maintaining recommended physical distancing. Supplies should be available both for use within the supervised consumption service and provided on demand to participants to take with them. The participant should complete hand hygiene prior to accepting these supplies (see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 for more information on hand hygiene protocols and sterile drug consumption equipment).

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

Many supervised consumption services have time limits for participants in the consumption area to minimize wait times for other participants. Staff members should gently remind a participant that their time is up but allow for a few extra minutes when feasible, and provide safer substance use education to participants where appropriate while working in the consumption room.

Operators will need to determine which consumption-related supports will be available to participants, and clearly communicate this to staff and participants. Possible supports include staff members helping participants find veins for injection (e.g. using their fingers or online apps), preparing drugs, and peer-assisted injection (also known as peer assistance). Peer-assistance is when a friend or partner (injector), who is not a staff member working at the supervised consumption service, helps a participant (injectee) inject their drugs by directly administering the injection. Another practice that may require particular

attention is the splitting and sharing of pre-purchased substances amongst two or more participants within the supervised consumption service. Allowing splitting and sharing within supervised consumption services reflects common drug use culture, and reduces harms associated with requiring participants to otherwise split/share their substances outside of the supervised consumption service, where they may be at greater risk for criminalization and stigmatization (182). Health Canada has specific requirements for both of these practices (i.e. peer assistance and splitting/sharing) when they occur within federally exempted supervised consumption services. By definition, the participants will not be able to maintain two metres distance from each other, so if they are in a close relationship through which they are functionally sheltering-in-place together, then PPE is unlikely to be recommended (e.g. intimate partner, family member, room or bunk mate, other recent close personal contact within two metres without PPE). However, if they are not in such a relationship and have not been in close proximity to each other, they should be provided with the appropriate PPE according to local health authority guidance. This may include gown, gloves, medical-grade mask, and eye protection. The participants should both wash their hands upon entering the consumption space and before drug consumption (see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 for details on hand hygiene). Where possible, a table and chair with generous space should be reserved for splitting and sharing and/or peer-assistance that allows adequate physical distancing from other consumption booths. For peer-assistance, if the injector is planning to inject as well, it is suggested that the injector inject the injectee, the injectee leave the consumption area, and then the injector injects themselves, either at the same table or a different table depending on their preference. The injector must follow the direction and guidance of the injectee. In federally exempted services, the injectee signs an agreement accepting liability in the event of a negative outcome, and some operators also require the injector to sign a waiver as well. At least one staff member must observe the peer-assistance or the entire splitting and sharing process.

Post-consumption. After participants have finished consuming drugs, they would ideally be observed in the monitoring area for a minimum of fifteen minutes to ensure they do not overdose. Physical distancing and recommended PPE should be maintained in the monitoring area; chairs should be placed two metres apart and staff should facilitate participant flow through this area. Snacks (e.g. coffee, granola bars) are typically offered in the monitoring area. Shelters are encouraged to avoid snacks that are self-serve options and, where possible, snacks should be individualized and prepacked to prevent COVID-19 contamination and transmission.

Post-consumption monitoring provides an opportunity to offer sterile drug consumption supplies for participants to take with them when they leave, which can be placed in a bag to ensure privacy along with personal sharps disposal containers. This time is also an opportunity to offer harm reduction education and referral to treatment programs, health care, and social and cultural supports. It is also strongly recommended that all participants be trained in naloxone administration and that naloxone kits be provided to every participant (see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 for details on ancillary supports including naloxone

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

- Maintaining proper hand hygiene by washing hands often with soap and water, or if hand washing facilities are not available, Health Canada-approved hand sanitizer (see Hard-surface disinfectants and hand sanitizers (COVID-19): List of hand sanitizers authorized by Health Canada (157)) (staff should be aware of the risks of consuming hand sanitizer as a source of non-beverage alcohol and advise participants as appropriate (183));
- Not sharing any drug equipment (e.g. pipes) or cigarettes;
- Disinfecting packaging of drugs and equipment handled by other people;
- Preparing their own drugs;
- Preparing and consuming drugs on a sanitized surface;
- Not consuming alone but maintaining physical distancing recommendations whenever possible;
- Using virtual supervised consumption services (see **3.1 Securing an Exemption for an Urgent Public Health Need Site** on pages 27 and 28 for a list of virtual services);
- Having more than adequate harm reduction supplies (e.g. drug consumption equipment, prescriptions, naloxone) to last the individual and other potential users two weeks, whenever possible;
- Reducing drug smoking when possible, or consuming drugs through lower-risk non-inhalation routes (e.g. oral or intranasal consumption), as COVID-19 infection impacts the respiratory system;
- When experiencing new symptoms associated with COVID-19, trying to strictly avoid other people as much as possible to reduce the potential spread of infection; and,
- If providing rescue breaths, use the mask provided in the naloxone kit with the understanding that this may not protect you from COVID-19.

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

- COVID-19 & Drug Use: Tips & Tricks; Harm Reduction Victoria (Australia) (184);
- COVID-19: Harm Reduction and Overdose Response; BC Centre for Disease Control (185);
- COVID-19 Planning for the Substance Dependent; Harm Reduction Victoria (Australia) (186);
- COVID-19 Stimulant Use, and Harm Reduction; Resolve to Save Lives - Vital Strategies, Harm Reduction Coalition, Higher Ground Harm Reduction, Reynolds Health Strategies (187);

- Guidance for People who use Substances on COVID-19 (Novel Coronavirus); Yale Program in Addiction Medicine, Global Health Justice Partnership & Crackdown (188);
- Harm Reduction Tips during Corona Virus; Somerset West Community Health Centre (189); and,
- Safer Drug Use During the COVID-19 Outbreak; Harm Reduction Coalition & Vital Strategies (United States) (190).

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

3.3.5 Responding to Overdose within Supervised Consumption Services

After supervising drug consumption, staff need to monitor participants at all times for the common signs of an opioid overdose: pinpoint pupils, respiratory depression, and unconsciousness (191). However, it is important to note that not every participant experiencing an overdose will display these symptoms; atypical symptoms such as muscle rigidity or involuntary movements have been documented with increasing frequency and can complicate overdose interventions (192,193). Special attention is required when monitoring participants, as physical distancing and PPE recommendations can complicate the ability to recognize an overdose (e.g. unable to see blue lips if the participant is wearing a mask, difficult to see pinpoint pupils while maintaining two metre distance from participants). In the event of an opioid overdose occurring at the site, all other participants and staff not responding to the overdose should exit the area. If all consumption tables/booths are in the same room, consider closing the entire consumption area until the overdose has been reversed and area has been disinfected (see section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28 for more information).

Possible overdose interventions, including some that are suspected or confirmed AGMPs, are:

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

PPE requirements for AGMPs are more extensive than non-AGMPs, which can delay lifesaving interventions when responding to an overdose. Appropriate PPE needs to be easily accessible from all locations in the site. If the appropriate PPE is not available, each staff member should determine the level of intervention they are comfortable providing by weighing professional and ethical obligations (where appropriate) and potential risk of harm. Organizational policies may also offer specific guidance to staff in this situation. PPE recommendations for non-AGMPs (e.g. administering nasal or injectable

naloxone, using a portable AED, providing CPR without rescue breaths (194–199)) are eye protection, non-latex gloves, and a medical mask (18,78,194,200). However, respondents choosing to perform compression-only CPR are encouraged to put a medical mask on the individual or cover the individual's mouth and nose with a cloth or sheet prior to commencing (197,198,201). PPE for AGMPs (e.g. CPR with rescue breaths, manual ventilation, intubation, high flow nasal oxygen) should include eye protection, non-latex gloves, a gown, and a properly fitted N-95 mask (18,78,194–196,200,202). See sections **3.2.3 COVID-19 Hygiene Protocols** on page 32 for guidance on sourcing PPE and **3.3.3 Staff PPE** on page 37 for regulations on staff PPE during operating hours. Operators should have an overdose response protocol, outlining the preferred response to an overdose based on the resources available at the site and local current guidance for infection prevention and control. This protocol should reflect the best available COVID-19-specific evidence, be updated as new evidence becomes available, and should outline the interventions available to staff, the equipment (including PPE) necessary, roles and responsibilities (considering training and background), as well as the thresholds for each intervention.

Following an overdose response involving an AGMP, staff should disinfect the area with Health Canada approved disinfectant. Some guidelines recommend waiting one hour "to allow aerosolized particles to drop"(203), although the risk posed by aerosolization is dependent on the building ventilation and filtration system (204). If the overdose response included an AGMP intervention, the surrounding two metre radius should also be disinfected (205). Anything that is unable to be properly disinfected (including PPE) should be properly disposed of. Operators should consider disposing of contaminated PPE in a biohazard bag, sealed inside another bag; refer to the shelter's biohazard disposal policy or contact your local public health authority or health department for jurisdiction-specific guidance. Ideally, no other participants should enter the area until the disinfection is complete (205).

For additional guidance on responding to overdoses, and cleaning and disinfecting practices during the COVID-19 pandemic, please see in Section 3.9 "Responding to an Overdose" and Section 3.8 "Facility Cleaning and Disinfecting," in CRISM's National Rapid Guidance: Harm Reduction Worker Safety during the COVID-19 Global Pandemic (18). Examples of health authority and provincial resources on responding to an overdose within a supervised consumption service are provided below. However, as science and best practice in this area are still evolving, operators should consult local health authorities for the most up-to-date guidance.

- COVID-19 Guidance: Consumption and Treatment Services (CTS) Sites; Ontario Ministry of Health (176);
- COVID-19: Responding to Opioid Overdoses in OPS and Supervised Consumption Sites; BC Centre for Disease Control, BC Ministry of Health (201);
- FAQ: Overdose Response in Overdose Prevention Sites & Supervised Consumption Sites During COVID-19; Vancouver Coastal Health (200);
- COVID-19: Community Members Responding to Overdose; Vancouver Coastal Health (206);
- Opioid Poisoning Response and COVID-19; Alberta Health Services (165); and,

- Vancouver Coastal Health Overdose Response in OPS and Supervised Consumption Sites for COVID-19; Vancouver Coastal Health (203).

3.3.6 Staff Exposures to COVID-19

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

Local public health may encourage asymptomatic staff who are exposed to known or suspected COVID-19 participants or colleagues without recommended PPE or physical distancing (e.g. providing care to a participant with confirmed COVID-19 infection without a medical-grade mask, responding to an overdose by providing an AGMP to a participant with COVID-19 while not wearing a fit-tested N95 respirator) take certain precautions after exposure (e.g. wear medical-grade mask, practice physical distancing and hand hygiene, avoid high-risk locations and vulnerable people for at least seven days (207)). Exposed staff should be encouraged to self-monitor for the development of new symptoms. If symptoms develop, staff should remain at home for the recommended self-isolation period (155). Operators should be familiar with local public health recommendations for close contacts with confirmed COVID-19 infection and differing isolation recommendations or directives for symptomatic or asymptomatic staff based on COVID-19 vaccination status.

3.4 REPORTING AND EVALUATION

The government or entity (see section **3.1 Securing an Exemption for an Urgent Public Health Need Site** on page 25) that issued the exemption, the funders, or other authorities may require reporting on supervised consumption service outputs and activities and aggregate demographic information of participants. Data collection should not impede service delivery, particularly in the context of an urgent pandemic-related response. However, where possible, operators should be prepared to collect and report the following minimum data elements:

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

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

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

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

Depending on the capacity of each site, there are a few possible avenues for collecting this information. Staff can record the data on paper, which can be collated later into a secure database, or within a software program such as Microsoft Excel or Access (see **Appendix 2: Example Forms for Supervised Consumption Service Data Collection** on page 62).

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

4.0 Providing Addiction Treatment and Pharmacotherapy in Shelter Settings

All shelter residents should have access to evidence-based treatment for their substance use disorder(s), support in stabilizing their substance use, and services to reduce their reliance on purchasing substances from the illegal drug market. Preventing withdrawal and overdose is critical for preserving their health and wellbeing and reducing strain on shelter staff and the health care system. This may be achieved through the provision of a range of on-site or off-site substance use supports.

To provide treatment to shelter residents, operators will need to develop partnerships with health care professionals (i.e. medical doctors or nurse practitioners (208,209) who can prescribe medications when indicated), pharmacists, counsellors, social workers, peer support workers, and other allied health professionals. How these partnerships look is dependent on a variety of factors, including shelter capacity and available community resources. Partnership options include embedding health care professionals within the shelter, using telehealth or other virtual care models, and partnering with nearby primary care practices, opioid agonist treatment clinics, or addiction medicine clinics. The partnership model chosen will influence which treatments can be initiated and maintained on site. Whether there is access to a pharmacy will also play a role in determining which treatments can be offered. Regardless of the partnership model, the goal should be ongoing access to care both during the COVID-19 pandemic and after it ends (either with the same health care professional or via seamless transfer of care; see section **4.5 Ensuring Continuity of Care After a Period of Isolation and Once The Immediate Threat Of COVID-19 Subsides** on page 54 for more information).

Not all patients will accept or stabilize on evidence-based treatment options for their substance use. In these cases, steps should be taken to minimize the harms associated with ongoing procurement and use of substances from the illegal drug market. As described previously, if shelter residents with confirmed COVID-19 infection leave shelters or isolation settings to procure and use substances, it puts themselves and others at risk. When evidence-based treatment options are not effective or are declined, health care professionals should consider providing access to replacement medications for withdrawal and craving management. Psychosocial interventions and supports should be routinely offered alone or in conjunction with pharmacological treatment but should not be viewed as a mandatory requirement for accessing medications (see section **4.3 Psychosocial Supports** on page 53 for more information). When prescribing replacement medications for the prevention of withdrawal, health care professionals should document their assessment and justification of medication choice, including that evidence-based, approved treatment options were ineffective or declined by the patient.

Ideally, patients would be encouraged to consume medications orally, as oral ingestion is generally associated with the least potential harm. If this is not possible, patients would ideally be supported in consuming the prescribed substances through their preferred route of administration (i.e. intranasal, injection, inhalation). Witnessed dosing of prescribed substances may be required by regulators in some jurisdictions, although not all jurisdictions require witnessed dosing in the context of COVID-19 risk mitigation (e.g. British Columbia, (210)). Shelter operators could implement a designated area with consumption spaces that maintain physical distancing and are compliant with infection prevention and control precautions, is monitored by staff trained in overdose response and harm reduction principles, and provides sterile substance consumption equipment to each patient. Note that if patients are only consuming substances prescribed to them, a federal exemption under section 56.1 of the *Controlled Drugs and Substances Act* is not required. Alternatively, the provision of pharmacotherapy could be integrated into an on-site or an external proximal supervised consumption service, which will comply with the required criteria for safer substance consumption. Depending on the medication, formulation, and jurisdiction, daily-dispensing of unobserved doses to shelter residents may also be feasible. British Columbia Centre for Substance Use's Risk Mitigation in the Context of Dual Public Health Emergencies provides detailed guidance on recommended prescribing practices (210).

The following sections summarize assessment, treatment and risk mitigation strategies, and additional considerations for health care providers to best support people who use substances in shelter settings during the COVID-19 pandemic. Note that Health Canada has recently introduced new regulatory measures designed to reduce barriers to prescribing and dispensing controlled substances during the COVID-19 pandemic. Please see their document Subsection 56(1) Class Exemption for Patients, Practitioners and Pharmacists Prescribing and Providing Controlled Substances in Canada during the Coronavirus Pandemic (211) for more information. For further details and guidance, please see CRISM's National Rapid Guidance: Medications and Other Clinical Approaches to Support Physical Distancing for People Who Use Substances During the COVID-19 Pandemic (16).

4.1 ASSESSMENT

At any time during their stay at the shelter, residents might indicate a need for support with their substance use. If desired by the resident, shelter staff should facilitate access to healthcare providers who are able to assist with substance use disorder treatment, withdrawal management, or substance use stabilization/risk mitigation. Health care providers should assess patients' substance use history and medical needs and work with each patient to determine their goals and develop an appropriate care plan. If replacement pharmacotherapy is explored, healthcare providers should weigh the benefits of this risk mitigation strategy against the risk of diversion (212). The following resources may be useful for health care professionals looking for more detailed guidance on assessing patients' substance use, diagnosing substance use disorder, and documenting the appropriateness of various substance use disorder treatment or risk mitigation strategies:

- Medications and other clinical approaches to support physical distancing for people who use substances during the COVID-19 pandemic; CRISM (16);
- CRISM National Guideline for the Clinical Management of Opioid Use Disorder; CRISM (213);
- National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline; CRISM (214);
- A Guideline for the Clinical Management of Opioid Use Disorder; British Columbia Centre on Substance Use and British Columbia Ministry of Health (215);
- Guidance Document on the Management of Substance Use in Acute Care; CRISM (216);
- Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder; British Columbia Centre on Substance Use, British Columbia Ministry of Health, and British Columbia Ministry of Mental Health and Addiction (217);
- Risk Mitigation in the Context of Dual Public Health Emergencies; British Columbia Centre on Substance Use (210);
- Screening & Assessment Tools; American Society of Addiction Medicine (218); and,
- Prediction of Alcohol Withdrawal Severity Scale (PAWSS) Tool; Maldonoda et al. (219,220).

When assessing the most appropriate option for a patient, health care professionals should take into account which medications will be covered by the public drug benefit plans (see (221) for details on provincial/territorial coverage of common medications). Individuals without medication coverage should be supported to obtain coverage; this may be facilitated by partnership with local social workers or government offices. Any specific storage requirements should also be considered.

4.2 TREATMENT AND RISK MITIGATION STRATEGIES

The following sections outline shelter-specific treatment and risk mitigation strategies to support people who use substances during the COVID-19 pandemic. For shelter residents seeking help reducing or abstaining from substance use, operators should provide or facilitate access to evidence-based treatment options. For shelter residents who decline treatment or for whom conventional treatments have not been effective, operators should explore risk mitigation strategies involving the provision of replacement pharmacotherapy or managed alcohol. These risk mitigation strategies have developed in response to the combined health risks of the overdose epidemic and COVID-19. They are not considered substance use disorder treatment but rather are intended to support people with substance use disorders to self-isolate or social distance and avoid health risks of withdrawal, overdose, or other harms related to substance use. As noted earlier, psychosocial interventions and supports should be routinely offered but should not be viewed as a mandatory requirement for accessing treatment or medications (see section **4.3 Psychosocial Supports** on page 53 for more information).

Detailed guidance on evidence-based substance use disorder treatments and pharmaceutical alternatives commonly offered in Canada are found in CRISM's National Rapid Guidance: Medications and Other Clinical Approaches to Support Physical Distancing for People Who Use Substances During the COVID-19 Pandemic (16). Below is a brief overview of their recommendations and additional shelter-specific recommendations.

Opioids. Treatment for opioid use disorder typically includes OAT with buprenorphine/naloxone, methadone, slow release oral morphine (SROM), or injectable opioid agonist treatment (iOAT) with hydromorphone or diacetylmorphine (where available), often with adjunct psychosocial treatments and supports. If a patient is using illegal opioids in addition to their OAT, consider optimizing their OAT, which may include increased dosage, transitioning to a different OAT medication, or prescribing additional opioids.

Stimulants. There are currently no approved pharmacotherapy options for the treatment of stimulant use disorder. Stimulant intoxication or withdrawal should be managed symptomatically (prescribing medications to address specific symptoms like agitation). Where possible, effective psychosocial treatments for stimulant use disorder should be offered, including contingency management programs (222–224). Prescribed psychostimulants could be a reasonable clinical decision in these extraordinary circumstances if the potential benefits outweigh the potential risks of contraindications, such as ischemic heart disease and exacerbating mental health challenges (e.g. agitation, psychosis) (225,226).

Benzodiazepines. Abrupt discontinuation of legal or illegal benzodiazepines could lead to benzodiazepine withdrawal, which can constitute a medical emergency and requires urgent treatment using symptom-triggered administration of benzodiazepines. Benzodiazepine use disorder can be managed through gradual benzodiazepine tapering or a period of benzodiazepine maintenance therapy (227). Since maintenance therapy is generally felt to increase harm (e.g. risk of fatal overdose, falls, worsening of mental health symptoms), an approach to maintenance may include a period of support and stabilization with regularly dispensing slow-onset, long-acting benzodiazepines to allow for a case-by-case assessment of risks and benefits (227–229).

Alcohol. For shelter residents seeking help in reducing or abstaining from alcohol use, an alcohol withdrawal severity risk assessment (e.g. PAWSS (219,220)) may be useful in identifying participants at high risk of severe alcohol withdrawal. The prevention of severe withdrawal requires regular (e.g. initially hourly) symptom assessment; if this is not feasible within the shelter, the patient should be transferred to acute care. Medications such as naltrexone and acamprosate have been found to assist those with alcohol use disorder to reduce intake, support abstinence, and delay time to first relapse.

MAPs are a promising option for supporting shelter residents whose pattern of alcohol consumption may place them at increased risk of harm during the COVID-19 pandemic. MAPs provide measured

quantities of beverage alcohol to people with alcohol use disorder, and are offered in many settings in Canada (230). Eligible participants should be assessed for the amount and frequency of alcohol required, which will depend on individual needs based on established drinking patterns to reduce harms and reduce/prevent withdrawal symptoms. The Canadian Institute for Substance Use Research provides a conversion tool to identify the standard drinks or volume required for the participant based on their typical alcohol consumption (231). While administration times may vary by shelter, participants should be offered alcohol after waking and prior to sleeping at a minimum. The patient typically signs a participation agreement document, which should clearly state the expectations of the patient while in the MAP (e.g. let the staff know if the dosage or frequency is inadequate rather than seeking out other sources of alcohol, no violence or aggression towards other people in the shelter, etc.) as well as outline their individualized dosing plan. The agreement can be modified and re-signed as necessary.

Depending on the type of shelter setting, staff could create a centralized alcohol consumption space only for MAP participants or provide distributed delivery of alcohol to shelter residents. For centralized areas, the space should ideally be large enough that physical distancing can be maintained, which can be further supported by staggering administration times. MAPs should follow many of the same considerations as those described in section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28. For example, a MAP that is private, has proper lighting, can be sufficiently cleaned/sanitized, and offers ancillary supports would facilitate the best support for MAP participants. Other MAPs are distribution models, in that participants may consume alcohol in their room; this may include a daily delivery of a preset amount of alcohol allowing the participant to determine the timing of their own consumption. Such a model may only be possible in shelter settings where participants have their own room or other physical space. Regardless of the model used, proper hand hygiene and appropriate PPE by participants and staff, as described in section **3.2 Setting Up Supervised Consumption Services Within a Shelter Setting During COVID-19** on page 28, is recommended. Prior to administering a dose, staff should assess the participant's level of intoxication. If the participant is walking and standing unaided but has slight impairment to speech and cognition, consider administering the dose. However, if the participant has gross motor skill impairment and experiences challenges moving and communicating, defer the dose to the next administration time. Alcohol should be administered in disposable cups to eliminate the risk of COVID-19 transmission. Details regarding each administration episode should be recorded. Education on safer drinking strategies and self-management of alcohol consumption should be provided.

For more information on MAPs, please see:

- Operational Guidance for Implementation of Managed Alcohol for Vulnerable Populations; University of Victoria, Canadian Institute for Substance Use Research; British Columbia Centre on Substance Use (232);
- Scale up of Managed Alcohol Programs; Pauly et al. (233);

- The Canadian Managed Alcohol Program Study; University of Victoria, Canadian Institute for Substance Use Research (234);
- Managed Alcohol Program: Evaluating Effectiveness of Alcohol Harm Reduction and Housing Instability; University of Victoria, Centre for Addictions Research of British Columbia (235);
- Finding safety: A pilot study of managed alcohol program participants' perceptions of housing and quality of life; Harm Reduction Journal (236); and,
- "There is a Place": Impacts of managed alcohol programs for people experiencing severe alcohol dependence and homelessness; Harm Reduction Journal (237).

While a formal MAP is the ideal standard for supporting people with alcohol use disorder or high-risk patterns of alcohol consumption, it may not be feasible in all settings. In shelters where it is not possible to administer a MAP, consider developing referral pathways to MAPs in the area and/or providing advice on alcohol harm reduction to residents instead. Other potential supports include: assisting with the monitoring of residents' alcohol consumption; storing residents' own alcohol in a secure location; encouraging them to space out their drinks, eat before consuming alcohol and switch to lower-percentage alcohol products; and facilitating purchase of beverage alcohol as an alternative to non-beverage alcohol (e.g. hand sanitizer, mouthwash, rubbing alcohol). Disposable cups should be available so that people do not need to drink directly from the bottle or share bottles. Sharing cups should be avoided, and facilities for immediate disposal of cups after use should be provided. To reduce the risk of COVID-19 transmission, a pilot initiative in Alberta (Cups for COVID) distributed disposable cups to people who were experiencing homelessness or unstable housing and used alcohol (238). The study reported that the intervention was effective in changing participants' drink sharing behaviours and provided service providers with more opportunities to educate participants on COVID-19 and harm reduction. (238). As such, providing disposable cups to shelter participants for use inside and outside the shelter setting are effective and low-cost harm reduction interventions for people who use alcohol.

Staff should also be aware of the elevated risks associated with consuming non-beverage alcohol, such as hand sanitizer (e.g. toxic ingredients and increased ethanol concentration) (183,239), and take measures to avoid diversion of larger quantities of these products given that alcohol-based hand sanitizers will be more available in shelter settings due to their role in COVID-19 infection prevention and control efforts.

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

- Alcohol Use & COVID-19; Canadian Drug Policy Coalition (240);
- Alcohol and COVID-19: What you Need to Know; World Health Organization (241);
- Canada's Low-Risk Alcohol Drinking Guidelines; Canadian Centre on Substance Use and Addiction (242);

- Safer Drinking Tips; Canadian Institute for Substance Use Research & Eastside Illicit Drinkers Group for Education (243); and,
- Safer Drinking Tips During COVID-19; Canadian Institute for Substance Use Research & Eastside Illicit Drinkers Group for Education (244).

Tobacco. Many people staying at shelters consume tobacco on a daily basis and will require nicotine replacement therapy (NRT) to avoid withdrawal if wishing to abstain from tobacco use. NRT can be obtained without a prescription in some provinces, and a variety of each of these NRT options can be stocked on site. External funding sources may be available to aid with the cost (245); collaborating with the patient's pharmacist can help to clarify what products will be covered. The type of NRT dispensed may depend on availability, funding, and patient preference.

For people who continue to use tobacco, operators should designate an outdoor location at the emergency shelter for tobacco consumption that is large enough to encourage physical distancing (this area should be separate from the designated inhalation area of any supervised consumption service, if possible). While tobacco consumption is legal and products are relatively easily accessible in Canada, access will be limited for people staying at the emergency shelter. Therefore, some may require support in accessing adequate nicotine to meet their needs. Consider providing tobacco products to residents who are not willing to participate in NRT (or as a supplement to NRT) as a risk reduction measure to prevent sharing of cigarettes during the COVID-19 pandemic. To promote health and reduce the risk of complications from possible COVID-19 infection, encourage residents to switch to lower strength tobacco products or to reduce the amount of cigarettes they consume per day. Advise against sharing cigarettes or collecting butts. Ensure that appropriate, tamper-proof ashtrays are provided for safely discarding cigarette butts after they have been used. Regularly empty ashtrays and clean smoking areas of improperly discarded butts.

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

Cannabis. As cannabis consumption is legal in Canada, residents who wish to smoke cannabis should have access to a designated outdoor location for consumption (this can be incorporated into the area for tobacco consumption), and those who wish to consume cannabis through other routes (e.g. edibles) should be permitted to do so within the shelter. For those who wish to continue smoking cannabis, staff may consider partnering with local programs distributing cannabis at reduced cost (246) and providing safer cannabis consumption advice based on the Lower Risk Cannabis Use Guidelines, such as consuming via routes other than smoking, not smoking synthetic cannabinoids, and avoiding inhaling deeply or

holding one's breath (38), as the risk of harm from cannabis consumption is generally lower than that of tobacco, alcohol, and other psychoactive drugs (247). Sharing joints or other consumption equipment (e.g. bongs, vape pens, etc.) or collecting butts (roaches) should be discouraged. Appropriate, tamper-proof ashtrays should be available for joint disposal and regularly emptied. The smoking area should be frequently cleaned of improperly discarded debris.

4.3 PSYCHOSOCIAL SUPPORTS

Psychosocial treatment interventions and supports should be routinely offered alone or in conjunction with pharmacological treatment but should not be viewed as a mandatory requirement for accessing medications. Research evidence suggests that in uncomplicated patient populations, the addition of structured psychosocial treatment interventions as adjuncts to opioid agonist treatment does not improve treatment outcomes compared to standard medical management (i.e. general support and unstructured counselling in clinical encounters), which is traditionally provided as standard of care for treatment of substance use disorder. However, this does not suggest that pharmacotherapy should be offered in isolation, but rather that medical management includes ongoing assessment, monitoring, and support for all aspects of physical, emotional, mental, and spiritual health, as these remain equally important components of treating substance use disorders; addressing these needs should be considered the standard of care. Evidence-based psychosocial supports focused on individual circumstances (e.g. employment, addiction counselling) and other survival needs (e.g. social assistance, housing, disability supports) may also be helpful in supporting recovery from substance use disorder. [*excerpts from CRISM National Guideline for the Clinical Management of Opioid Use Disorder* (213); see (248) for more information on psychosocial supports for alcohol use disorder].

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

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

4.4 FACILITATING PRESCRIPTIONS AND ACCESS TO CONTROLLED SUBSTANCES

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

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

- Community pharmacies could deliver day-ahead or day-of daily dispensed medications to the shelter. The prescriber should indicate on the prescription that medications can be delivered to the patient at the shelter. Alternatively, for patients in isolation, the medication may be released to an authorized individual who agrees to ensure delivery to the patient (249).
- A dedicated pharmacy space could be set up on site where pharmacy staff could dispense medications, support witnessed ingestion of required therapies, and prescribe and administer maintenance medications (e.g. long acting antipsychotics, contraception). The pharmacy could also have essential medications on site (e.g. antibiotics). This would require appropriate staffing, PPE, and adequate secure storage within the shelter.
- For patients who have access to a secure storage space, several days of medication may be dispensed at a time. However, daily dispensation may be preferred by some patients for certain therapies.

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

- Frequently Asked Questions: Access to Controlled Substances; Health Canada (209);
- Process for Establishing a Safer Supply Program in Canada; Health Canada (208); and,
- Relevant Exemptions to the Controlled Drugs and Substances Act; Health Canada (250).

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

It is important that a plan for continuing to support shelter residents who use substances be developed and implemented post-pandemic. Additionally, proper transition of care into the community after medical isolation or discharge from a temporary shelter is vital to ensuring positive outcomes and ultimately reducing homelessness. This includes seeking longer term housing options and robust

healthcare access. When residents are discharged from shelter settings, community clinicians (if a transfer of medical care is required) should be provided with relevant documents to ensure continuity of therapy and management plans that include follow up appointments, medications administered while in the shelter, and changes in management (including its rationale) that are to continue once a patient completes medical isolation or is discharged from a temporary shelter. Residents should be discharged with a concrete plan for obtaining safe, appropriate housing and referred to relevant harm reduction, treatment, and recovery supports in the community.

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

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

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

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

[*excerpts from the Guidance Document on the Management of Substance Use in Acute Care* (216)].

4.6 REPORTING AND EVALUATION

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

5.0 Facilitating COVID-19 Vaccinations for Shelter Residents

As of September 11, 2022, Health Canada has approved six COVID-19 vaccines (Pfizer-BioNTech Comirnaty, Moderna Spikevax, AstraZeneca Vaxzervria, Janssen (Johnson & Johnson), Novavax Nunaxovid, and Medicago Covfenz) (251). Following approvals, 86.30% of Canadians five years and older have been fully vaccinated (i.e. received the primary series of two COVID-19 vaccines), and 56.77% of Canadians 12 years and older have also received at least one booster (252). Please see Health Canada's Vaccines for COVID-19 website for the most up-to-date information about COVID-19 vaccine booking, safety and side effects, authorization process, data, shareable resources, and vaccination rates (251).

A retrospective, population-based cohort study in Ontario revealed that, as of September 30, 2021, fully vaccinated rates for individuals with a recent history of homelessness were 34% lower than Ontario's general adult population (253). Similarly, a prospective cohort study of 275 individuals who use drugs in downtown Vancouver reported that as of January 2022, fully vaccinated rates in their sample were 17% lower than BC's general population (254). Despite not knowing the precise vaccination rates for Canadians who use substances and/or are experiencing homelessness or housing vulnerability, we know that a higher prevalence of comorbid health conditions and socioeconomic instability make these individuals more susceptible to COVID-19 infection and severe outcomes (22,75,81–83,87,89) and can also increase barriers to accessing and adhering to preventative medicine (255). Historically, this is highlighted by increased rates of vaccine-preventable diseases in these populations (256,257) and is now apparent with COVID-19 infection rates (81,89). As such, people who use substances and are experiencing homelessness or housing vulnerability represent a particularly at-risk population that require an adapted COVID-19 immunization strategy. Shelters often have exclusive contact with those who use substances and are experiencing homelessness or housing vulnerability, which can position them to bridge the vaccination gap for this vulnerable group. The following are key strategies to facilitate COVID-19 vaccinations in shelter settings.

Low-barrier access to COVID-19 vaccines, that considers resident mobility, trust, and available clinical resources, is necessary to reach shelter residents (256). Successful vaccination strategies for people who are experiencing homelessness or housing vulnerability typically involve vaccination centres that have flexible or drop-in appointment times and are set up in convenient and frequently visited locations (258), such as shelters, food service locations, encampments, and day programs (259). Ideally, partnerships with local community health centres could embed on-site vaccine delivery within shelter settings. For an example of how four Toronto shelters planned and implemented vaccination centres and mobile

vaccination teams, please see COVID-19 Vaccine Playbook for Shelters (260). An alternative to setting up a vaccination centre in your shelter could consist of coordinating day trips to existing COVID-19 vaccination centres using outreach vehicles, if available.

At minimum, COVID-19 vaccine education should be integrated within normal service delivery (258). People experiencing homelessness or housing vulnerability have indicated that their COVID-19 vaccine hesitancy is related to their desire to see safety and efficacy data, wanting to wait for others to get vaccinated first, prior negative experiences with vaccines, and a mistrust of the government (261). Shelter staff are in a unique position to address these hesitations, as they can leverage their pre-existing relationships to build health literacy and informally identify and address personal barriers to receiving the vaccine (e.g. virtual booking platforms, missing personal information, limited mobility, fears about side effects, sharing personal experiences with receiving the COVID-19 vaccine). It may be best to develop a printed infographic that contains local information and resources that is distributed to all shelter residents upon their arrival. The following are example information sheets and infographics that can be posted in your shelter or distributed to shelter residents:

- The Facts About COVID-19 Vaccines: Government of Canada (262);
- Vaccinated Against COVID-19? What Does it Mean to Me?: Public Health Agency of Canada (263);
- Vaccine Development and Approval in Canada; Health Canada (264); and,
- COVID-19 Vaccines: Debunking the Myths; Correctional Service Canada (265).

6.0 Further Reading and Resources

- A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services; Substance Abuse and Mental Health Services Administration (266)
- Challenges in Maintaining Treatment Services for People who use Drugs during the COVID-19 Pandemic; Harm Reduction Journal (100)
- COVID-19 Guidance: Consumption and Treatment Services (CTS) Sites; Ontario Ministry of Health (176)
- COVID-19: How to Include Marginalized and Vulnerable People in Risk Communication and Community Engagement; The Regional Risk Communication and Community Engagement Working Group (267)
- COVID-19: Information for Opioid Agonist Treatment Prescribers and Pharmacists; British Columbia Centre on Substance Use (268)
- EMCDDA Update on the Implications of COVID-19 for People who use Drugs (PWUD) and Drug Service Providers; European Monitoring Centre for Drugs and Drug Addiction (269)
- Housing Services: COVID-19 Guidance for Homelessness Service Providers; Region of Peel (175)
- Interim Guidance: Scaling-Up COVID-19 Outbreak Readiness and Response Operations in Humanitarian Situations Including Camps and Camp-Like Settings; Inter-Agency Standing Committee Secretariat (270)
- Safe Supply and Harm Reduction During COVID-19; Homeless Hub (271)
- Suggestions about Treatment, Care and Rehabilitation of People with Drug Use Disorder in the Context of the COVID-19 Pandemic; United Nations Office on Drugs and Crime (272)
- Toolkit for Substance Use and Addictions Program Applicants: Stream 2 - Increasing Access to Pharmaceutical-Grade Medications; Health Canada (273)
- Trauma Informed Practice Guide; BC Provincial Mental Health and Substance Use Planning Council (274)
- Vancouver Coastal Health Overdose Response in Overdose Prevention Sites and Supervised Consumption Sites for COVID-19; Vancouver Coastal Health (203)

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*[1]. For this Guidance document, authorship committee members and external reviewers were required to disclose all sources and amounts of direct and indirect (i.e. research support) 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 27 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) provided paid consultation to private companies including Merck, Abbott, ViiV, Rickett-Benkiser, Gilead, BMS and Indivior. The same reviewer also disclosed receiving research funding prior to guidance

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

document involvement from a commercial entity (Gilead) that could theoretically benefit from guidance document recommendations. There were no authorship committee members or external reviewers with commercial interests. On review, potential conflicts of interest were not deemed to be of sufficient weight or relevance to warrant exclusion from the guidance committee.

Most (22, 81%) authorship committee members and external reviewers disclosed potential indirect sources of bias (e.g. specialization in addiction medicine, advisory board and committee membership, involvement with supervised consumption service programs, provincial substance use treatment programs, previous guideline development, research interests). Of these, 11 acknowledged that they have publicly stated support for supervised consumption services. 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: Example Forms for Supervised Consumption Service Data Collection

Form 1 – First Time Visit Only			
Participant's Unique Code			
Date (dd/mm/yyyy):			
Time (24:00):			
How does the participant identify?	□ Male	□ Female	□ Other:
How old is the participant?			
Other notes:			

Form 2 – Consumption and Supply Visit Form

Visit Info

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

Consumption Info

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

Form 3 - Medical Emergency Information

MEDICAL EMERGENCY INFORMATION

If the participant experienced an overdose:

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

If the participant experienced a non-overdose medical emergency:

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

Appendix 3: Online Substance Use Resources Listing

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

CLINICAL SUPPORT RESOURCES FOR PATIENTS AND HEALTHCARE PROVIDERS

Anxiety Canada's free MindShift™ CBT app
This app focuses on assisting in the management of anxiety using scientifically proven strategies (f*ree 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

Self-Management and Recovery Training (SMART Recovery) Program
This website includes message boards, chat rooms, online meetings, and an online library of recovery resources

Take Home Naloxone
Free online naloxone training

Toward the Heart
Free online naloxone training

HARM REDUCTION RESOURCES

Canadian Association of People Who Use Drugs (CAPUD)

Canadian Drug Policy Coalition: COVID-19 Harm Reduction Resources

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

CATIE: Harm Reduction Fundamentals: A Toolkit for Service Providers

First Nations Health Authority: Indigenous Harm Reduction Principles and Practices

An Evidence Brief: Harm Reduction Implementation Framework

A Practice Brief: Infrastructure for Harm Reduction in Residential and Hotel Settings

Operational Guidance for Implementation of Managed Alcohol for Vulnerable Populations

MENTAL HEALTH AND SUBSTANCE USE RESOURCES

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

Narcotics Anonymous

Taking Care of Your Mental Health (COVID-19)

Wellness Together Canada: Mental Health and Substance Use Support

INDIGENOUS COMMUNITIES

Assembly of First Nations: COVID-19

First Nations Health Authority: Staying Connected during the Pandemic

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

First Peoples Wellness Circle: COVID-19 Resources page
Provides printable Information Sheets for Mental Wellness for Community; Parents and Children; Elders and Seniors; and Health Professionals

Thunderbird Partnership Foundation: Harm Reduction during COVID-19

SUPPORT RESOURCES FOR HEALTHCARE PROVIDERS

Canadian Foundation for Healthcare Improvement (CFHI)
Supports partners to accelerate the identification, spread and scale of proven healthcare innovations.
Webinar Series: Patient Partnership in a Time of COVID-19

Health Canada Subsection 56(1) Class Exemption for Patients, Practitioners and Pharmacists Prescribing and Providing Controlled Substances in Canada during the Coronavirus Pandemic
In response to the evolving health risk due to COVID-19, to maintain Canadians' access to controlled substances for medical treatments (e.g. treatment of substance use disorders and chronic pain), while they adhere to social distancing guidance from public health officials or if they need to self- isolate,

Health Canada has issued exemptions for prescriptions of controlled substances under the Controlled Drugs and Substances Act (CDSA) and its Regulations.

Mental Health Commission of Canada: The Working Mind

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.

The toolkit is available here.

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