

Guidance Document

on the Management
of Substance Use
in Acute Care

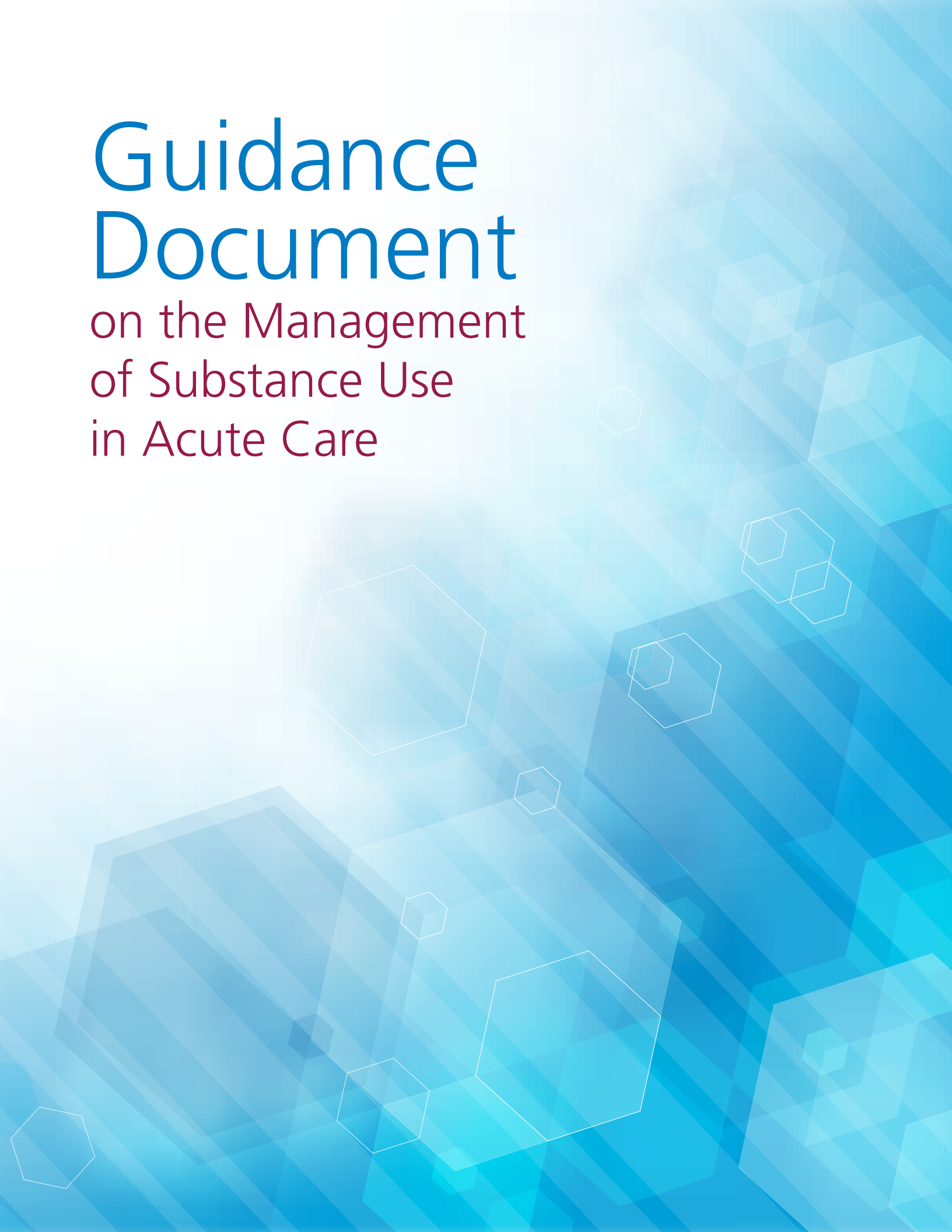
The background of the page is a vibrant blue gradient, transitioning from a lighter, almost white blue at the top left to a deeper, more saturated blue at the bottom right. Overlaid on this gradient are numerous semi-transparent, overlapping hexagonal shapes of various sizes and shades of blue. Some of these hexagons are outlined in a thin white line, while others are filled with different shades of blue, creating a complex, layered geometric pattern that suggests a molecular or crystalline structure.

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Read this first: A letter to the reader

Dear Reader,

Thank you for taking the time to read this document and for all you do to take care of patients. Our hope is this document will be a useful resource to support the care of people who use alcohol and/or drugs who are admitted to hospital. As you will have seen in your practice, we are facing a health, social and human crisis related to substance use. It will take all of us working together, armed with evidence and compassion, to deal with this challenge.

When someone with a substance use disorder presents to hospital, it represents a unique opportunity to help. Many people are willing to access harm reduction services, treatment for their substance use disorder and other health promotion interventions while admitted to hospital. There are effective treatments that save lives by helping people who use drugs and alcohol. We cannot miss a single opportunity to offer lifesaving treatment and supports – your interaction may be the last time someone accesses health care services before significant unintentional harm or a fatal overdose occurs.

While many people are actively trying to reduce their substance use, not everyone can stop using alcohol or drugs while admitted to hospital. When this happens, it is our job to help reduce the harms associated with ongoing use. Patients do not have to be abstinent from alcohol and drugs in order to receive the best possible health care.

The stigma that surrounds substance use must end. Stigma sabotages the therapeutic relationship and prevents people from accessing treatment. All patients are entitled to and deserve the highest quality of care we can provide.

The practices outlined here, when implemented in the best interests of patients, are supported by our regulatory colleges. Working together, in partnership with our patients and those with lived or living experience, we can save lives. There is not a moment to lose.

Thank you for your hard work, compassion and commitment to excellence.

Sincerely,

The Advisory Committee

Executive summary

Patients with substance use disorders (SUDs) admitted to acute care may continue to use substances while in hospital and the associated harms can pose challenges for patients, hospital clinical teams and employees. While patients admitted to acute care may use a variety of legal and illegal substances, this Guidance Document focuses on alcohol, stimulants and opioids.

The purpose of this document is to provide advice and guidance on how to address these challenges while ensuring the best possible outcomes for patients, health professionals and the health care system.

Simply put, harm reduction is about reducing the harms that come with legal or illegal substance use. Harm reduction is about keeping people as safe and healthy as possible, even though they may continue to use psychoactive substances.

A harm reduction approach is a necessary addition to the way we may have treated people who use substances in hospital in the past. Substance use disorders are complex, and may be rooted in a history of abuse, trauma, chronic pain, mental health conditions, poverty, adverse childhood experiences and other factors. Some of these root causes affect how people engage in and experience health care. When combined with negative attitudes towards people who use substances, many patients may find the hospital environment unwelcoming and unsafe. Growing evidence of poor health outcomes has led to urgent calls to improve the acute care hospital experience for patients with SUDs. Evidence-based harm reduction services must be offered to all patients who would benefit from them, regardless of a health care providers' personal views on substance use.

Overcoming stigma, using patient-centered language, employing trauma-informed care and setting clear expectations and boundaries creates a supportive, healing environment for all.

Not everyone who uses drugs meets the criteria for a substance use disorder. Many people who use drugs experience no problems related to their use. The formal diagnosis of a substance use disorder often occurs in consultation with a health care professional with experience in Addiction Medicine.

There is often fear that prescribing opioids for pain and/or withdrawal management will contribute to a patient's opioid use disorder. It should be noted that undertreated pain is also a risk factor for returning to use or ongoing substance use. Pain, withdrawal symptoms and cravings must be adequately and humanely managed in patients with substance use disorders.

Alcohol withdrawal is a life-threatening medical condition. Managed alcohol programs and various medications can help patients stop drinking or drink less.

While many patients are able to abstain from stimulant use while admitted to hospital, some will experience cravings and may continue to use stimulants while in hospital. In these cases, a harm reduction approach is warranted, including inpatient counselling and referral to outpatient supports and treatment programs upon discharge.

Despite optimal substance use disorder management, some patients will continue to use drugs in hospital. Provision of sterile supplies or supervised consumption services have been shown to save lives, engage individuals in treatment and are highly cost effective.

Pregnancy often represents a unique opportunity to engage patients about their substance use, since women may increase their contact with the health care system during pregnancy. This is an opportunity to reduce harm and support women and the children in their care.

Substance use in young adults poses specific challenges for health care providers in both acute care and community settings. In addition to issues associated with substance use, the stage of growth and development of the young adult and co-existing disorders and past traumas must be considered.

It is common for people who use substances to report overwhelming experiences of trauma and violence in their lives. It is also common for them to view their use of substances as a coping mechanism, making them more vulnerable to substance use during periods of stress, such as a hospitalization. This highlights the importance of trauma-informed practice and, in some cases, the need for further education to better understand these concepts.

No matter who the patient is, certification under the *Mental Health Act* should not be used to detain patients who use substances when they have the capacity to understand the risks and benefits of their substance use. There is no consistent evidence to show that coerced substance use treatment is effective.

Patients with an active SUD may approach issues relating to their health in the context of multiple competing priorities. Patients who leave the unit or miss treatments do care about their health and want to get better, and likely have other urgent and competing concerns. It is often reasonable that patients with substance use disorders remain in hospital longer than those without SUDs to facilitate critical outpatient appointments and procedures. People who use drugs are at a higher risk of discharge against medical advice (AMA). Preventing premature discharge is rooted in understanding the reasons why the patient may leave. Working with your patient to strategize ways to address these reasons may support them to stay and continue treatment.

The social determinants of health have a significant impact on a patient's SUD and the achievement of sustainable outcomes. Referral to resources that can address issues such as housing, income, etc. can have a profound impact on the lives of patients.

While there are limited culturally appropriate treatments available, understanding the nuances of

different cultures and groups, including Indigenous people and gender diverse populations, are crucial to successful treatment planning. Peer Support Workers can be an important source of support and advocacy for a patient with a substance use disorder when they are in hospital. Engaging people with lived or living experiences to assist in the design, implementation, evaluation and improvement of acute care services can lead to a safer, more supportive environment for both patients and the health care team.

Integrating a harm reduction approach into patient care does not conflict with expectations of the regulatory colleges when a health professional uses reasonable judgment and makes evidence-informed decisions consistent with desired therapeutic outcomes, best practices and safety standards. Health care professionals are expected to follow applicable legislation, act in the best interests of their patients, provide appropriate treatment and care, and safeguard the well-being of each patient, especially patients who are at risk for poor health outcomes due to systemic, cultural or medical reasons. Health care professionals are also expected to follow the codes of ethics and standards of practice established by their regulatory college. This document was created in partnership with some of the health regulatory colleges in Alberta:

- College of Physicians and Surgeons of Alberta (CPSA)
- College and Association of Registered Nurses of Alberta (CARNA)
- College of Licensed Practical Nurses of Alberta (CLPNA)
- College of Registered Psychiatric Nurses of Alberta (CRPNA)
- Alberta College of Pharmacy (ACP)

Guidance document methodology

Funding and committee membership

The Guidance Document on Substance Use in Acute Care was jointly funded by the College of Physicians and Surgeons of Alberta and Population, Public and Indigenous Health, Alberta Health Services.

An interdisciplinary Advisory Committee of 25 individuals was assembled. Individuals were invited based on their unique areas of relevant expertise and background. The Advisory Committee met four times over a one-year period (from December 2017 to December 2018), and Committee members were regularly and actively engaged through email and phone communications. A smaller Working Group was also created to manage the ongoing development and review of the Guidance Document. This Working Group met 11 times (in-person or via conference call) from December 2017 to October 2019, in addition to regular and frequent email communications. All non-salaried committee members were compensated for their time (including PWLLE, in accordance with best practice).

Evidence selection and review

The content and recommendations in the Guidance Document are based on a structured review of the best available evidence, clinical experience, observational reports and expert opinion.

The Canadian Agency for Drugs and Technologies in Health (CADTH) was engaged to complete a *Rapid Response Report: Summary with Critical Appraisal - Substance Use Disorder Interventions in Acute Care: A Review of Clinical Effectiveness, Cost-Effectiveness and Guidelines*. CADTH is an independent, not-for-profit organization created by the federal, provincial and territorial governments to deliver evidence, analysis, advice and recommendations to inform health policy decisions.

Overall, CADTH's search found limited research on substance use disorder interventions in acute care, with no relevant evidence-based guidelines. CADTH conducted a limited literature search of key

resources, and titles and abstracts of the retrieved publications were reviewed by one reviewer. Full-text publications were evaluated for final article selection according to predetermined selection criteria (population, intervention, comparator, outcomes and study designs). The literature search identified 1,016 citations, of which 61 were identified as potentially relevant. An additional 2 potentially relevant articles were identified from other sources. Of these 63 articles, 17 met the criteria for inclusion in this report — 6 systematic reviews, 3 randomized controlled trials, 6 non-randomized studies and 2 economic evaluations. Please see Appendix E for the selection criteria/search terms used by CADTH.

The Advisory Committee also considered lower grade evidence available through qualitative studies, and the substantial epidemiological evidence on the need for this kind of Guidance Document. Data from Alberta Health Services (AHS) data analytics (DIMR) were also reviewed to better understand the epidemiology of substance use and acute care presentations in Alberta over time.

Librarians at the Canadian Centre on Substance Use and Addiction (CCSA) conducted a supplementary search on additional topics of interest for the Advisory Committee's reference. Please see Appendix E for the search strategy used by the CCSA.

Development, review and approval of the guidance recommendations

After reviewing the results of the literature search and reviewing the epidemiological evidence showing an urgent need to better address substance use in acute care settings, the Advisory Committee made a unanimous decision to proceed with the development of a document to guide practice and to classify the present document as a Guidance Document rather than a Guideline. The clinical expertise of the members of the Advisory Committee and the authors informed the development of the document's sections, content and recommendations, given the limitations of the evidence gathered. The content

outline evolved throughout the development of the document, with the Advisory Committee reviewing and approving section and content additions and changes.

A total of 28 authors (many of whom were Advisory Committee members) researched and wrote the various individual sections of the Guidance Document. Authors were identified based on their expertise and/or relevant clinical experience and training. The working group was responsible for adjudicating the various rounds of edits and for writing new content.

The Guidance Document went through 14 rounds of edits with the Advisory Committee and its Working Group between May 2018 and April 2019. Consensus of Committee and Working Group were sought and secured through in-person meetings, email communication and tracked document review and revision. Feedback and changes were incorporated into a revised draft 14 for external review.

External review and final approval

Following the 14 rounds of review by the Advisory Committee and the Working Group, the Guidance Document was circulated for external review to 36 individual and organizational stakeholders across Canada. External feedback via email communication, an online survey, and/or tracked document review and revision were accepted. The external consultation feedback was reviewed by the Working Group and incorporated into Draft 15 of the Guidance Document, which was distributed to the Advisory Committee for review and comment. Several more rounds of review and edits were completed, culminating in this final version of the Guidance Document (draft 18).

Conflict of interest disclosure

Committee members and authors (a total of 39 individuals) were asked to disclose all sources and amounts of direct and indirect remuneration from industry, for-profit enterprises, and other entities (i.e., direct financial conflicts) that could potentially introduce real or perceived risk of bias. In addition, committee members and authors were asked to report indirect conflicts of interest, such as academic advancement, clinical revenue, and professional or public standing that could potentially influence the interpretation of evidence and the formulation of recommendations.

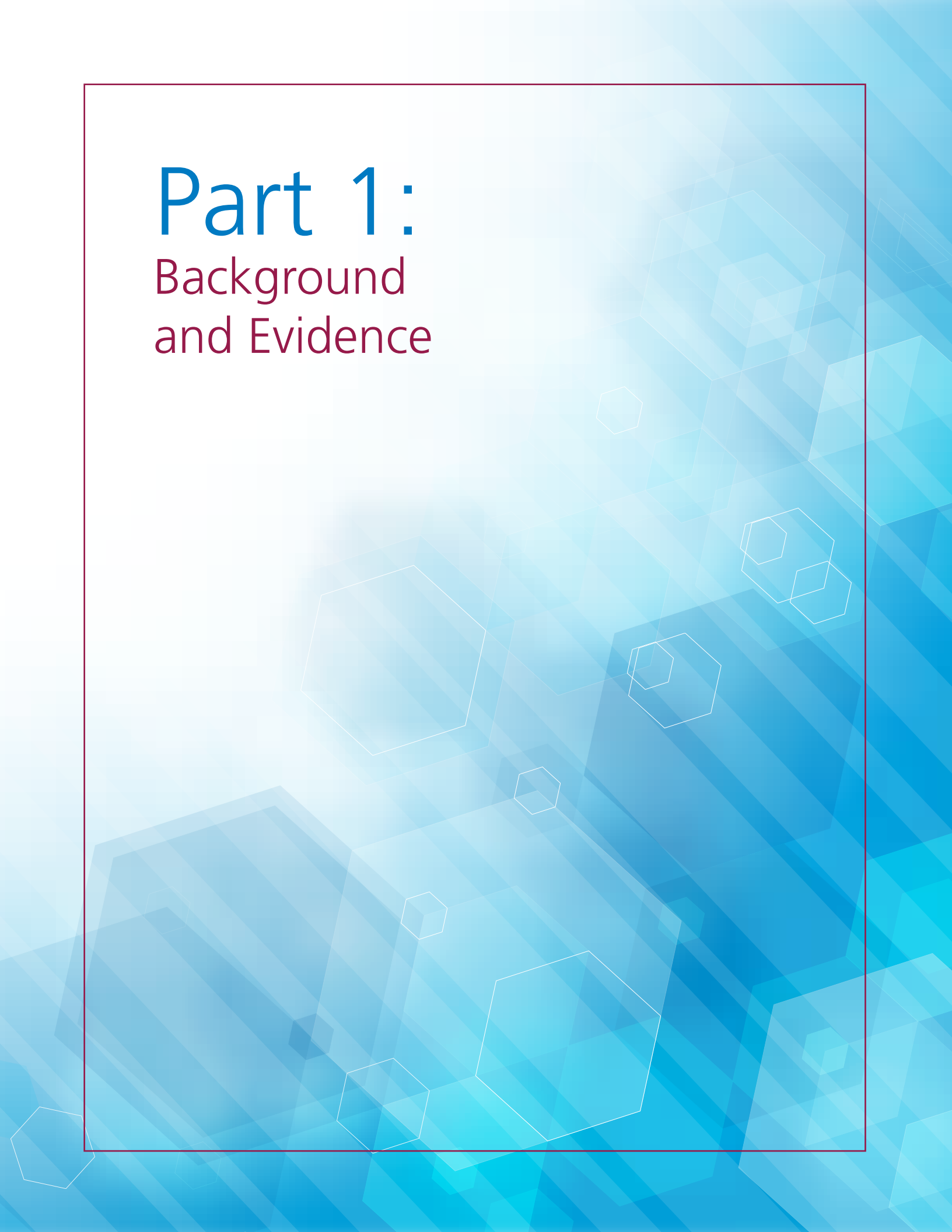
Thirty-two committee members and/or authors disclosed no current nor ongoing direct or indirect conflicts of interest. One individual, who served on the Working Group and as the project Co-Chair, reported a financial partnership in a clinic where fee-for-service Addictions Medicine is provided. This individual did not write any of the sections on OAT or related treatments (Note: fee-for-service is the standard practice in Alberta for remunerating community-based physicians). A total of six other committee members and/or authors reported possible indirect conflicts of interest in the form of funded grants or clinical trials, paid honoraria or fees to speak or present, or serving as a member of an advisory board. None of these disclosed indirect conflicts of interest were related to the Guidance Document project and subject matter.

Risk mitigation

On review, none of the disclosed potential direct nor indirect conflicts of interest or bias were deemed to be of sufficient relevance or weight to warrant exclusion from the committee or serving as a content author.

Part 1:

Background and Evidence



Your top 9 questions (with answers or comments) about caring for patients who use drugs in hospital

A harm reduction approach is a necessary evolution of the way we have treated people who use substances in the past. The change has come about because our understanding of substance use has evolved. *The ethics of health care have not changed.* We still have to balance respect for a patient's autonomy and liberty with our obligation to remove harms in the least restrictive manner.

We've taken common questions or statements from front-line clinicians and provided you with answers and responses:

"Why should we trust patients who use drugs to make decisions about their care?"

Health care places a high value on patient autonomy – the right of patients to determine what happens to their bodies. Like other patients, people who use drugs are generally motivated to engage in care and improve their own health outcomes. Health care professionals will go to great lengths to inform patients about their condition and fully explain all treatment options so patients can make informed decisions. While health care professionals may recommend certain treatments, they have an obligation to respect the informed, voluntary decisions of a capable patient even when it goes against medical advice or one's values and beliefs.

Similar to other patients, there are times when patients with substance use disorders may not be able to make an informed, voluntary choice. This might include times when patients are extremely intoxicated or delirious from severe alcohol withdrawal (Carter and Hall, 2008). Wherever possible, we should strive to enhance patient autonomy by treating conditions causing them distress such as pain, withdrawal and cravings. This respects their right to competent health care regardless of their circumstances.

"Why don't we force patients to stop using substances in hospital?"

To insist that a patient stop using while suffering from an acute illness is a significant barrier to care. Many patients with a substance use disorder present with life threatening illnesses that are secondary to their addiction – endocarditis, cellulitis, spinal abscesses, liver failure, etc. Patients may also present with medical needs unrelated to their substance use disorder. In either case, the patient needs to recover from the life-threatening illness before they can deal with the physical and psychosocial drivers of their substance use. A harm reduction approach allows the patient and health care provider to focus first on acute recovery.

A patient who experiences negative consequences or is forced to stop using substances while being treated in hospital may leave against medical advice (AMA), or they may attempt to continue substance use in hospital without detection from healthcare providers, thus further putting their health at risk. If the health care professional focuses on addressing the harms of substance use without trying to force a change in behaviour, the patient will be much more likely to trust the health care professional and more willing to continue with treatment.

"Why don't we just certify a person with a substance use disorder under the Mental Health Act, for their own good?"

People who use substances are not certifiable simply because they have a substance use disorder. Efforts to hold people with a substance use disorder against their will while we treat them have proven no more effective than voluntary treatment and can lead to increased harms. Patients still have the capacity to make decisions about their care and each situation is

unique. Many will leave care despite restrictions, often with a deeper distrust of care providers, or continue to use with the help of friends or other patients. Furthermore, a forced detoxification for a patient who uses opioids can actually increase the risk of death because of a loss of opioid tolerance due to a reduction in their use in hospital and then a return to use at high or original doses in the community.

There are times when a patient is intoxicated, in severe withdrawal, or experiencing acute mental health symptoms due to their drug use, resulting in the loss of capacity to make informed decisions. If the person is a danger to themselves or others, it may be ethically justified to certify them for a limited defined period of time – and constantly review whether certification is still necessary (please see the section of this Guidance Document, ‘When is it appropriate to certify a patient under the *Mental Health Act*?’). In such cases where certification is necessary, there should be strategies in place to rebuild trust with the patient once the crisis is over and there is an opportunity to explain the choices made and the rationale related to their safety.

*“Why can’t they just stop using?
Why should we treat someone who has
caused harm to themselves?”*

It would be hard to know where to draw the line if care was only given to the “deserving.” Would we refuse care for people who were in a motor vehicle collision because they were driving recklessly? Would we refuse care for a person who broke their leg while knowingly skiing out of bounds? Would we refuse care for someone who did not exercise and ate too much, despite medical advice? We care for all those in need because it is not possible to establish or expect fair and consistent criteria for “deserving care”. Further, there are many reasons why people use drugs. Substance use disorders are often rooted in physical, emotional or sexual abuse; adverse childhood events; previous trauma; mental health conditions; poverty; homelessness or other factors. Thus, in providing patient-centered care to people who use drugs, it is important to exercise compassion and withhold judgment. Cravings for substances can

be emotionally and physically overwhelming and may eliminate or restrict the patient’s ability to choose to stop using the substances. Harm reduction is about reducing harms and helping people to live healthy lives. Stopping the use of the substances is not required to receive care.

*“I have to pay for my insulin, EpiPen etc.
Why do people with substance use disorders
get free medications and supplies?”*

While some might question spending public money to help someone use drugs, it is often far less expensive to help a patient reduce the harms of their drug use than to address the harms of unsafe use (such as overdoses, hospitalizations, and transmission of blood borne viruses like HIV). Furthermore, if providing medications and supplies can increase the chances of engagement into treatment and treatment completion, the patient is less likely to be readmitted with a more severe condition.

*“I feel uncomfortable around people who use drugs.
I will care for them but I don’t have to like them.”*

Many patients who use legal and illegal drugs report feeling judged and marginalized by society and caregivers. It is not just what is said out loud; patients can detect non-verbal indicators that show a lack of respect such as lack of eye contact or touch. Substance use occurs across all sociodemographic segments of society and people who use substances are our friends, family, neighbours and colleagues. We don’t have to like all our patients, but we have a duty to treat them with respect. To treat such patients dismissively, as if they are to blame for their illness, may well reinforce feelings of disempowerment, compound feelings of shame and unworthiness, and contribute to a worsening of the substance use disorder. Negative health care interactions can result in patients leaving against medical advice or not seeking help in the first place. It is important to reflect on your feelings about patients with substance use disorders and seek support from others and education if you feel you are having difficulties fulfilling your professional role.

“Patients who use drugs are a danger to staff and other patients.”

We have a duty to prevent harm to staff and other patients. A harm reduction approach actually improves patient and staff safety. For example, providing sterile syringes and supplies to patients who inject substances prevents patients from having to hide and reuse injection equipment. Providing sharps containers prevents unsafe disposal and reduces the risk of a needle stick to another patient or health care provider. Treating pain and withdrawal and starting patients on evidence-based medications for their substance use disorder reduces the amount of illegal substances that patients purchase, either on or off hospital property. It is important to set respectful boundaries if the patient’s behavior is potentially unsafe for them or others. Honest open conversation with the patient is part of building trust and opening the door to providing the support required to address their needs.

“I want no part of helping someone use illegal drugs. It is just wrong.”

It is important that we respect the moral conscience of staff – especially if we expect them to behave morally. But it is also important that we care for patients who need our help. Balancing this tension between personal convictions and public duty can be challenging.

Providing a patient with sterile needles, alcohol swabs and naloxone kits does not aid and abet illegal activities; it addresses the harms of those activities. It is not dissimilar from another harm reduction strategy,

seatbelts. Seatbelts reduce the harm to drivers who speed and crash; they do not cause people to speed and crash. Providing sterile needles and naloxone kits reduces the harms to people using street drugs; it does not cause them to use.

With controversial issues such as abortion or medical assistance in dying, the courts have very clearly said that care providers don’t have to do something they personally feel is morally objectionable but they need to refer the patient to another provider who is ready, willing and able to help. In the case of harm reduction, the moral objection argument is less compelling and care providers therefore have a stronger ethical obligation to provide care even if they feel uncomfortable. Harm reduction is evidence-based, and the evidence shows harm reduction improves patient outcomes and is highly cost effective. Patients are to be treated based on best practices, no different than any other illness or condition. The Code of Ethics and professional Standards of Practice are available on the website of your regulatory College.

If you or another care provider are struggling to deal with a patient or an issue, seek out assistance from managers, acute care educators, an Addiction Medicine Specialist or a colleague.

“Is it legal or illegal for a nurse to witness self-injection of a prescribed opioid in hospital?”

The self-administration of prescribed medications is considered legal. A Health Canada exemption for supervised consumption is not required for prescription medications.

Why do some people who use substances think the hospital is unsafe?

Substance use disorders (SUDs) are common, disabling health conditions that frequently go untreated. The 2012 Canadian Community Health Survey indicates that more than 1 in 5 Canadians will have a SUD in their lifetime.¹ SUDs account for an increasing proportion of emergency department visits, inpatient admissions and substantial economic costs.²

Patients with SUDs are rarely provided the opportunity to access evidence-based addiction medicine or harm reduction interventions. Canadian hospitals have very few specialized addiction medicine or addiction psychiatry departments, and do not typically designate beds specifically for the care of patients with SUDs.³ Most hospital physicians and nurses encounter patients with SUDs, but few have adequate training on the management of substance use in acute care.^{4,5} Many report challenges addressing patients' substance-related health concerns alongside their acute medical needs.⁶⁻⁸ This lack of knowledge and training may be further compounded by an acute care system that is not well-equipped to address poverty, unstable housing, trauma, discrimination and mental health comorbidities that are frequently contributing factors to patients' SUDs.⁹

These gaps in care, combined with negative attitudes towards people who use drugs, cause many patients to experience the hospital environment as unsafe,^{9,10} rather than as a place of healing. Patients with SUDs frequently describe experiencing stigma or judgment from hospital staff and report that their symptoms of pain or withdrawal are ignored or undertreated.⁹⁻¹² This can result in significant discomfort and distress, undue suffering, and a need to self-manage physical dependence, withdrawal or pain through ongoing substance use.^{10,12,13} Even when patients with SUDs receive specialist addiction treatment and effective pain management, some may have difficulty maintaining abstinence while hospitalized; abstinence has been generally expected as a condition for receiving hospital care. While effective medications exist for treating opioid use disorders, there is a

.....
“Caring for patients with addiction in the hospital is very challenging. The approach of the care team is so varied that the patient is often left in the middle trying to navigate the system. This often leads to distrust, broken promises and patients leaving AMA.”
– Perspective of a frontline Registered Nurse
.....

distinct lack of similar therapies for the long-term treatment of patients with stimulant use disorders.^{5,14}

Ongoing substance use in hospital may violate written or unwritten expectations of abstinence, and lead to conflicts between patients and staff. As a result, patients who use drugs or alcohol while hospitalized and the staff who care for them may face increased risks associated with a patient attempting to conceal their substance use from their clinical care teams. Some may leave the unit and return intoxicated, or consume drugs or alcohol in unsafe conditions that may increase the risk for overdose and infections.^{10,12} These risks are often greater given constrained access to harm reduction services such as sterile syringe distribution, naloxone kits and supervised consumption services—evidence-based strategies that are widely available in many community settings, yet rarely offered to hospital patients.²⁵

Suboptimal acute care experiences may partly explain why patients with SUDs have an increased risk of leaving against medical advice and reoccurring hospital admissions.²⁶⁻²⁹ Recent evidence shows that

.....
“My experience in the hospital is very frustrating. There are few nurses and doctors that understand harm reduction and why it's necessary, usually I just hide my addiction to get care that is free from judgment.”
– Perspective of a patient in hospital
.....

25-30% of patients who inject drugs leave or are discharged from hospital prior to completing medical treatment.²⁸ Patients who leave hospital prematurely are 12 times more likely to be readmitted with a related diagnosis within 14 days, and twice as likely to die.^{28,30,31} Beyond potentially dire impacts on health, this places a substantial burden on the health care system and contributes to escalating economic

costs.³²⁻³⁷ Research from the United States suggests that average costs associated with a readmission within 30-days of leaving against medical advice are approximately 56% higher than the costs associated with completing the initial hospitalization.³⁸

Growing evidence of poor health outcomes has led to urgent calls to improve the acute care hospital experience for patients with SUDs.³⁹⁻⁴⁰

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Why is it important to change things now?

While patients admitted to acute care may use a variety of legal and illegal substances, this Guidance Document focuses on opioids, alcohol and stimulants. Patients with substance use disorders admitted to acute care most commonly use one or more of these three substances, and the harms from their use can pose challenges for hospital clinical teams and employees.

The opioid crisis

Canada's rising rates of opioid-related morbidity and mortality constitute a public health crisis. Opioid-related deaths have increased dramatically, largely driven by an illegal drug supply that has become contaminated with highly toxic synthetic opioids, such as illegally produced fentanyl.

In addition to mortality, the opioid crisis has resulted in high rates of hospitalizations. From 2006-2007 to 2016-2017, hospitalizations for opioid poisoning in Canada increased 53% to a rate of 15.6 per 100,000 population, which corresponds to an average of 16 hospitalizations every day.⁶ Alberta had one of the highest rates of opioid hospitalizations nationally in 2016-2017 with 23.¹ hospitalizations per 100,000 population, which was behind only British Columbia and the territories.⁶ For comparison, the rate of hospitalization related to motor vehicle injuries in Canada is 25 per 100,000 population.⁶

In Alberta, the rate of opioid-related emergency department (ED) visits doubled between 2012-2013 and 2016-2017.⁶ The increased rate of ED visits in Alberta was mainly driven by increases in the number of heroin and fentanyl related ED visits, which both increased 10-fold over this 5-year period.⁶ Opioid-related emergency department visits and deaths have occurred in all communities.

The opioid crisis has disproportionately impacted youth and younger adults. In 2017, the highest number of opioid-related deaths in Canada occurred in the 30-39 age group.⁵ Similarly, youth (15-24) and younger adults (25-44) have experienced fast growing rates of both opioid-related hospitalizations and ED visits.

Hospitals and emergency departments have a long history of providing care in the midst of public health crises. You may recall responding in your role during SARS (44 people died) or H1N1 (428 people died). Between January 2016 and June 2018 more than 9,000 Canadians died; using a reference age of 75, the total PYLL (potential years of life lost) was 58,889 person-years lost due to opioids. The average person who died of an opioid overdose lost 36 years of life.

The most recent data can be found here:

<https://www.alberta.ca/opioid-reports.aspx>

<https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research.html>

What is the number one substance causing harm? Alcohol

Alcohol use directly or indirectly contributes to a substantial proportion of all hospital admissions. In 2015-2016, there were 77,000 hospitalizations entirely caused by alcohol in Canada—i.e. those stays for the treatment of conditions considered to be wholly (100%) caused by the harmful consumption of alcohol.¹ This compares to approximately 75,000 hospitalizations for myocardial infarction in the same year.¹

It is important to note that hospitalizations entirely caused by alcohol represent only a minority of alcohol-related hospitalizations.¹ The majority of alcohol-related hospitalizations are for partially alcohol-attributable conditions, such as motor vehicle injuries, cancer, heart disease and others.¹

How much of a problem are stimulants?

Stimulants are a broad class of substances that increase the level of activity in the central nervous system. The category includes illegal drugs such as cocaine and methamphetamine, and prescription stimulants such as methylphenidate, lisdexamfetamine, dextroamphetamine and other amphetamine-type drugs.

In 2014, there were 1,572 hospitalizations attributable to cocaine and 2,275 attributable to other CNS stimulants in Canada (not including Quebec).² Together, this represented 1.5% of hospital stays attributable to substance use, which was less than tobacco (57.0%), alcohol (34.4%), opioids (2.7%), and other CNS depressants (2.2%).²

Cocaine-related hospitalizations have been decreasing in Canada: from 2006 to 2011, the number of hospitalizations for cocaine-related disorders decreased by 55%.³ These trends may be driven by a substitution effect, in which the use of other stimulants (such as methamphetamine) and opioids is at least partially replacing the use of cocaine.³

In addition to causing hospitalizations, stimulants also contribute to a significant number of substance-related deaths. In 2014, there were an estimated 297 premature deaths attributable to cocaine and 487 premature deaths attributable to other CNS stimulants.² These include deaths directly caused by acute toxicity, as well as indirectly linked deaths such as those caused by drug-attributable hepatitis C and HIV infection.

Although there are relatively few premature deaths caused by stimulants, these deaths have a disproportionate cost to Canadian society because they tend to occur in young people; in 2014 the average age at the time of stimulant-related death was 38.² This resulted in an estimated 34,053 years of life lost due to premature mortality, which was second only to opioids among illegal drugs.²

What do we do now?

For many years, we have ignored or only partially addressed patients' substance use disorders when they were admitted to hospital. This is true even for patients who were admitted with complications directly resulting from their substance use. This has in part contributed to escalating emergency department visits and hospitalizations. In order to reverse these trends and to provide the best care possible for patients, we must begin to view hospitalization as an opportunity to help patients start treatment for their substance use disorder at the same time as we are treating their acute illness.

Resources:

Canadian Substance Use Costs and Harms: <https://csuch.ca/>

CCSA - Methamphetamine (Canadian Drug Summary): <http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Drug-Summary-Methamphetamine-2018-en.pdf>

CCSA - Changes in Stimulant Use and Related Harms: Focus on Methamphetamine and Cocaine: <http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Stimulant-Use-Related-Harms-Bulletin-2019-en.pdf>

Canadian Substance Use Costs and Harms Visualization Table: <https://csuch.ca/explore-the-data/>

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Overcoming stigma that affects patient care

Stigma involves showing discrimination, judgment, and/or isolating and stereotyping others. This may occur in overt ways such as hurtful, derogatory or offensive comments or negative body language such as looking at the floor while in conversation. Stigma can also be based in subtler behaviours, such as ignoring the expressed needs of an individual, withholding care or refusing to make appropriate referrals.⁵

Stigma continues to be a primary barrier faced by people who use drugs, their family members, and those in recovery. Research has shown that the public holds more negative attitudes and are less supportive of policy reform designed to assist individuals with a substance use disorder compared to those experiencing a mental illness.²

The stigma surrounding drug use is further reinforced when it occurs in combination with other discriminatory practices such as gender bias and racism.⁹ Racial biases exhibited by health care providers have been documented^{3,8} and an inquiry into the 2008 death of Brian Sinclair, an Indigenous man waiting to be seen in an emergency department in Canada, highlighted the importance of addressing cultural safety within the health care system.¹⁰

A public health approach to addressing stigma involves “moving away from an emphasis on

criminalization and law enforcement to a focus on promoting the capacity of individuals and communities to increase control over their own health and wellbeing.”⁹

Reducing stigma and improving health outcomes can be effectively embraced by the simple step of eliminating stigmatizing language.

Stigmatizing term	Replace with this alternative
Addicts	People who use substances
Junkies	People living with a substance use disorder
Former drug addict	People in recovery, or People who used drugs in the past
Clean or dirty	People in recovery, or People that use substances
Relapse	Return to use

Advocate for people that use substances and their families when you witness them being spoken to or treated in a disrespectful way, and educate others about substance use and stigma. Stigma can contribute to feelings of shame, blame, isolation and guilt—all of which build barriers to lifesaving supports and prevent people from seeking the help they need.

Resources:

Creating Culturally Safe Care in Hospital Settings for People who use(d) Illicit Drugs, University of Victoria: <https://www.uvic.ca/research/centres/cisur/assets/docs/bulletin11-creating-culturally-safe-care.pdf>

Canadian Public Health Association: <https://learning.cpha.ca/>

CCSA Language of Addiction Words Matter Fact Sheet: <https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Language-of-Addiction-Words-Matter-Fact-Sheet-2017-en.pdf>

CCSA Substance Use Disorder Words Matter Fact Sheet: <https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Substance-Use-Disorders-Words-Matter-Fact-Sheet-2017-en.pdf>

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Change the conversation: Why using patient-centered language is so important

Language is one of the primary ways to stigmatize people who use substances – terms such as ‘junkie’ or ‘drug addict’ continue to perpetuate negative stereotypes. Even more subtle terms have the potential to influence people’s perceptions – to say someone is ‘clean’ when in recovery somehow implies that they are ‘dirty’ when they were using substances. Similarly, referring to methadone or buprenorphine/naloxone as ‘opioid replacement therapy’ or ‘opioid substitution therapy’ instead of ‘opioid agonist treatment’ reinforces misconceptions that a patient is substituting one opioid or addiction for another.

The words we use can affect people’s perceptions. Kelly, Dow and Westerhoff (2010) surveyed over 300 participants (half of whom worked in health care) and measured their perceptions about people who were actively using alcohol or drugs. When people were referred to as a ‘substance abuser’ vs. ‘having a substance use disorder’, they were more likely to be ‘... perceived as engaging in willful misconduct, a greater social threat, and more deserving of punishment’³. Stigmatizing terms may discourage individuals from seeking or remaining in treatment and sometimes can have harmful consequences.

A number of suggestions have been put forth on how to change conversations around substance use:²

1. **Use person-first language** to describe the person prior to their behavior or condition (i.e. use ‘person with an alcohol-use disorder’ instead of ‘alcoholic’).
2. **Recognize substance use disorders are a chronic medical condition** like other chronic diseases as opposed to a moral failing.
3. Use language that **supports recovery and emphasizes individual autonomy** (i.e. “opted not to...” vs. “non-compliant”). Build on the patient’s strengths and use positive language (i.e. ‘taking steps forward together’ or ‘what can I do to support or work with you?’)
4. **Avoid slang terminology**, like ‘junkie’ or ‘clean’.
5. **Speak up** when colleagues, family or friends use derogatory terms, or bring this to the attention of the media when such terms are used in news reports. While some individuals in recovery or currently using (or the organizations that represent them) have chosen to reclaim stigmatized terms such as ‘addict’, health professionals and others have a responsibility to use terminology that is supportive, non-judgmental and which does not discriminate.

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What is harm reduction?

Simply put, harm reduction is about reducing the harms that come with legal or illegal substance use. Harm reduction is about keeping people safe.

That said, the definitions of harm reduction vary.

Harm reduction is a comprehensive, just and science-based approach to substance use. It represents policies, strategies and services that aim to assist people using legal and illegal substances to live safer and healthier lives. Harm reduction recognizes that people use drugs for many reasons. Reduction of substance use and/or abstinence is not required in order to receive respect, compassion or services. Harm reduction enhances the ability of people who use substances to have increased control over their lives and their health, and allows them to take protective and proactive measures for themselves, their families and their communities. – Adapted from Streetworks Edmonton¹

Harm reduction means those policies, programs and practices that aim primarily to reduce the adverse health, social or economic consequences of the use of legal and illegal psychoactive substances without necessarily reducing consumption. A harm reduction approach to substance use accepts that abstinence may or may not be a realistic or desirable goal for an individual patient, and explicitly acknowledges that the cessation of substance use is not a prerequisite for accessing health or social services. Interventions may

be targeted at the individual, the family, community, or society. – Alberta Health Services

Harm reduction is underpinned by four key principles:

1. Some level of substance use in society (and for some individuals) is inevitable (pragmatism).
2. We do not judge people negatively for using drugs. Drug use is neither condemned nor supported (humanistic values).
3. Any harms that come from the patient's use are more important than the fact they are using or the extent of their use (focus on harms).
4. Listen to the patient's wants and needs. The immediate health and social needs of people who use substances takes priority over the goals of the health care system and service provider (hierarchy of goals).²

Contemporary harm reduction mainly developed in response to the spread of HIV/AIDS among people who injected drugs during the 1980s.²⁻⁵ Since then, harm reduction interventions have expanded to include additional services targeting other modes of consumption and a broader range of substances.^{2,3} Some examples of harm reduction services include supervised consumption services, sterile supply distribution, overdose prevention education and naloxone kit distribution, and managed alcohol programs.

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Does my regulatory college support harm reduction?

Health care professionals are expected to follow applicable legislation, act in the best interests of their patients, provide appropriate treatment and care, and safeguard the wellbeing of each patient and in particular, any patient who is vulnerable.

Health professionals must also follow the codes of ethics and standards of practice established by their regulatory college. These foundational documents outline the expected professional responsibilities and accountabilities to support provision of safe, non-judgmental and competent care to all patients.

The regulatory colleges listed below support the principles of harm reduction when best practice clinical interventions are applied after a careful assessment of the individual circumstances of the patient.

A harm reduction approach aligns with a health professional's responsibility to use critical inquiry and evidence-based knowledge to protect and promote a patient's right to autonomy, respect, privacy and dignity. In addition, this approach requires a health professional to interact with a patient without judgment, stigmatizing language or actions, regardless of personal values, beliefs and culture. The patient has a right to make informed choices and decisions and be an active, full partner in their care.

When a health professional uses reasonable judgment and makes evidence-informed decisions consistent with desired therapeutic outcomes, best practices and safety standards, integrating a harm reduction approach into patient care does not conflict with expectations of the regulatory colleges.

As a health professional, you meet the expectations of your regulatory college when you provide care in accordance with the standards and code of ethics of your profession and act as any other reasonable, prudent health professional would in the same situation.

Unfortunately, no document can provide you with all the answers to meet the unique situational needs of a

patient. You and your colleagues may find yourselves in a difficult position if asked to provide treatment before there are well-established protocols in place. However, professional clinical judgment based on knowledge, skills, abilities, experience and evidence can guide your decisions in your practice setting. All health professionals are encouraged to:

- consider the advice offered in this Guidance Document and by peers who have experience managing these potentially difficult clinical situations;
- consult and collaborate with a more experienced colleague and the other health professionals involved in the care of your patient when you do not feel confident in managing the care of a patient;
- refer to the standards of practice, code of ethics and advisory documents available through your regulatory college;
- contact your college if you are unsure about your professional responsibilities or feel uncomfortable about what you are being asked to do;
- document your discussions, plans and decisions to clearly identify that the choice of treatment at the time is based on clinical best practice and for harm reduction purposes.

The following health regulatory colleges participated in the creation of this Guidance Document:

- College of Physicians and Surgeons of Alberta (CPSA)
- College and Association of Registered Nurses of Alberta (CARNA)
- College of Licensed Practical Nurses of Alberta (CLPNA)
- College of Registered Psychiatric Nurses of Alberta (CRPNA)
- Alberta College of Pharmacy (ACP)

Part 2:

Recommendations
for Clinical Practice
in Acute Care
Settings

Creating a safe environment for you and your patients

Patient and staff safety go hand in hand.

Everyone working within health care can participate in the creation of a safe environment for you, your colleagues and patients. Adopting a trauma-informed, culturally-appropriate, harm reduction approach is conducive to both staff and patient safety.

Harm reduction approaches and interventions such as having a non-judgmental attitude, providing harm reduction supplies and safe, monitored spaces for drug use, and adequately treating pain and withdrawal, all contribute to the creation of a safe environment for everyone.

Trauma-informed care (please see the 'Trauma informed care' section and resources of this Guidance Document) creates a safe environment through:

- **Welcoming intake procedures:** "I'm glad you're here today. Let me show you around our unit."
- **Refer to the patient by name:** Ask the patient what name they prefer you to use. "Thanks Tim, I'll refer to you that way from now on."
- **Adapting the physical space to be less threatening and more supportive.** For example, make sure patient care areas contain sharps disposal units and ensure patients know how to dispose of any used injection or other equipment throughout their stay.
- **Providing clear information and expectations,** offering patients choice whenever possible.
- **Ask permission when appropriate:** "I'd like to ask you some questions about alcohol and drug use. Is that okay?"
- **Acting in a transparent, consistent and predictable manner:** "Let me explain why we're doing it this way".

These practices build respectful and trusting relationships, reduce the likelihood of triggering or re-traumatizing patients, and should be offered to all patients in your care. This sense of safety can also be substantially enhanced through implementing peer staffing models.¹

Culturally-relevant services and an openness to learning more about a patient's culture can further enhance therapeutic relationships and safety. When possible, respond to patient requests for translation or suggest translation services even if these services are not requested, and offer patients the opportunity to engage in cultural practices.¹ (please refer to the 'Culturally appropriate care' section of this Guidance Document).

Training on non-violent crisis intervention, trauma-informed care and cultural safety may help you better understand your patients and respond more effectively in difficult situations. Applying these principles and practices will prevent the vast majority of conflicts that can occur between patients and staff. However, it is important to maintain clear boundaries (please refer to the 'Setting boundaries' section of this Guidance Document) and remain familiar with relevant AHS Policies and Procedures if difficulties arise despite the use of the strategies outlined above.²

When to engage Protective Services

Protective Services Officers can be the first and last people patients see when entering or leaving the emergency department or other departments within your hospital. They are uniquely situated to assist with the development of professional relationships that build trust and encourage the use of harm reduction resources. In some health care facilities, protective services distribute Naloxone kits.

When situations cannot be resolved or when there is an urgent threat to patient or staff safety, protective services may need to be called. It is important to remember that for people who have

spent time inside correctional or other institutions, the arrival of individuals in uniform may heighten their distress or cause them to relive past trauma. Being sensitive to this and continuing to maintain a calm environment, as well as explaining the role of protective services in the hospital setting can help. The hospital environment also presents an opportunity to change perspectives. A respectful rapport between officers and patients can alter a patient's view of law enforcement, encourage patients to ask officers for help and create a safe environment for everyone.

No matter what the situation, it is always the goal to leave people in a better state than when we found them.

For Protective Services to be effective at harm reduction, officers must be made aware of the resources available in hospital and receive direction and support from the team that is working closely with the patient. The Officers should be included as a member of the care team to encourage positive communication and understanding of roles and expectations.

References and Resources:

1. BC Centre of Excellent for Women's Health http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf
2. AHS Workplace Violence: Prevention & Response Policy <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-workplace-violence-prevention-response.pdf>

There is an AHS non-violent crisis intervention course on My LearningLink.

Setting boundaries

Harm Reduction does not mean 'anything goes'.

Strong boundaries are an essential component of harm reduction. It is possible (and necessary) to set healthy limits on challenging behaviour while maintaining a compassionate and respectful attitude toward a patient. Try to validate the emotions and experience of the patient: "I can see you're feeling angry right now," while gently and firmly outlining expectations, "but you cannot continue to yell in this space."

In addition to setting boundaries for the patient, it is important to set boundaries for yourself. Many people who use drugs have significant, unmet financial, physical, emotional and social needs. It is important

to remember that you cannot personally address a patient's every need. Some patients live in poverty but that does not make it appropriate for you to financially support them. Similarly, many patients have challenges with childcare, but you should not be babysitting their children.¹

Healthy boundaries also relate to self-care. Set sustainable limits on the amount of time and energy you can give to your patients and know when to refer patients to other services.² Minimize self-disclosure and when possible, avoid providing care to close friends or family members.³

Failure to maintain appropriate boundaries may result in unsafe work environments, provider burnout, inappropriate and unethical relationships between care providers and patients as well as damaged trust.²

Resources and References:

1. CATIE program development resource for community-based organizations:
<https://www.catie.ca/en/pif/fall-2017/practice-guidelines-peer-health-navigation-people-living-hiv-new-program-development-r>
2. CATIE practice guidelines in peer navigation for people living with HIV
<https://www.catie.ca/ga-pdf.php?file=sites/default/files/practice-guidelines-peer-nav-en-02082018.pdf> (pages 50-52)
3. College of Physicians and Surgeons of Alberta Code of Conduct
http://www.cpsa.ca/wp-content/uploads/2015/08/CPSA_Code_of_Conduct_-_Expectations_of_Professionalism.pdf?43144a&43144a
4. Canadian Nurses Association Ethics for Registered Nurses
<https://www.cna-aicc.ca/en/nursing-practice/nursing-ethics>
5. CARNA document: Professional Boundaries for Registered Nurses: Guidelines for the Nurse-Client Relationship
https://nurses.ab.ca/docs/default-source/document-library/guidelines/rn_professional-boundaries.pdf?sfvrsn=cc43bb24_14
6. Code of Ethics for Licenses Practical Nurses in Canada
https://www.clpna.com/wp-content/uploads/2013/02/doc_CCPNR_CLPNA_Code_of_Ethics.pdf
7. College of Registered Psychiatric Nurses of Alberta Code of Ethics and Standards of Practice
https://www.crpna.ab.ca/CRPNAMember/CRPNA_Member/CRPNA_Code_of_Ethics_and_Standards_of_Practice.aspx

How can I take care of myself and my colleagues?

Taking care of patients, and specifically patients who use substances, can sometimes be difficult. Some patients may have experienced past trauma, been incarcerated or had to learn how to survive on the street. The behaviours people use to survive in these tough environments can sometimes create conflict in a hospital setting. It can also be difficult to hear about a person's past trauma. Over time, stress can build up and lead to compassion fatigue, moral distress, vicarious trauma or burnout.

As health care providers, we need to take care of ourselves and each other. Getting enough sleep, exercising regularly and eating healthy food are all important, but can be challenging for shift workers. Practicing mindfulness, journaling and having a strong social support network outside of work have all been shown to be helpful strategies. Working together to create a supportive work environment where difficult issues and complex cases can be discussed is also important.

Managers may also want to consider having self-care topics as part of regular staff meetings. Team wellness

.....
It is impossible for us to take good care of patients if we are not taking good care of ourselves.
.....

meetings can be arranged through an Employee and Family Assistance Program. *Lifespeak* videos and online wellness seminars are also available.

Substance use disorders are common, and many caregivers may have a friend or someone in their family who is living with or has died from a substance use disorder. Reflect on how your personal experiences may affect your care at work and reach out for help to Workplace Health & Safety services, your manager, your primary care provider, colleagues, family and friends if needed.

Physicians, nurses and other caregivers may also develop substance use disorders. You are entitled to the same patient-centered, compassionate and non-judgmental care we provide to our patients. If you are concerned about your own substance use, please contact Workplace Health & Safety, an employee assistance program or the Addiction Helpline for help.

Resources:

Employee and Family Assistance Program: <https://insite.albertahealthservices.ca/hr/Page964.aspx>

Addiction Helpline: 1-866-332-2322 (24/7)

Physician and Family Support Program: 1-877-SOS-4MDS (767-4637)

How do I ask patients about their substance use?

“It’s amazing how often common presenting problems like insomnia, anxiety, or chronic pain end up being attributed to substance use disorders, once you start screening routinely.”

– CUPS Physician

Screening patients entering acute care for substance use is important as the effects of substance use can have a significant impact on their hospitalization and discharge planning.

It may be of value to reassure the patient during assessment that this information is gathered strictly for the purposes of providing best possible health care services. Any information collected is protected under confidentiality standards and legislation such as the *Health Information Act* (HIA) in Alberta.

To screen for alcohol use related harms, there are several validated tools including CAGE, AUDIT, and AUDIT-C (see more information at the end of this section). In 2011, the Canadian Centre on Substance Use and Addiction (CCSA) published Canada’s Low Risk Drinking Guidelines.¹ In order to identify patients who may be at risk of alcohol related harms, it proposes a simple 3-question screening protocol asking the following questions:

- i- Do you drink beer, wine, coolers or other alcoholic beverages?

WHAT IS A STANDARD “DRINK”?

The CCSA Low Risk Drinking Guidelines specify that “a drink” means:

- 1 regular can/bottle of beer (341 ml; 12 oz.)
- 1 regular can/bottle of cider/cooler (341 ml; 12 oz.)
- 1 five-ounce glass of wine (142 ml)
- 1.5 ounces (43 ml) of distilled alcohol (rum, gin, rye, etc.; 40% alcohol content)

SAMPLE SCRIPT

Here is a sample script, drawn from the National Institute on Drug Abuse, you can follow when you have to initiate a conversation with the patient about their substance use:

“Hi, I’m _____, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illegal drug use—but only to better diagnose and treat you.”

- ii- On average how many days per week do you drink alcohol?
- iii- On a typical drinking day, how many drinks do you consume?²

If the daily or weekly amounts of reported alcohol consumption are above the limits set out in the guideline, further evaluation is recommended to help determine whether a diagnosis of an alcohol use disorder is warranted and what further interventions may be needed.

To screen for drug use, screening tools such as DAST-10 can be used. In the US, the National Institute on Drug Abuse (NIDA) recommends a single-question initial screen for substance misuse (“In the past year, how often have you used prescription drugs for nonmedical reasons or illegal drugs?”).³ If an answer other than “never” is obtained, then further assessment with the NIDA-Modified ASSIST survey is recommended.³

It can be helpful to ask permission and ensure you are in an appropriately private setting. Some patients will prefer to answer questions about alcohol and drug use without family or other support persons present.

Whatever the screening tool used, it is important to determine:

- which substances are used;
- how frequently;
- how much;
- the route of administration.

This assessment will help you to properly anticipate any current or future withdrawal symptoms that may present and guide further screening, supports and interventions that may benefit the patient.

Resources and References:

1. Alcohol and Health in Canada: A Summary of Evidence and Guidelines for Low-Risk Drinking. CCSA: <https://ccsa.ca/alcohol-and-health-canada-summary-evidence-and-guidelines-low-risk-drinking>
 2. Resource Guide: Screening for Drug Use in General Medical Setting. National Institute on Drug Abuse: <https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen>
 3. Screening and Assessment Protocol – Alcohol Use. Alcohol Screening, Brief Intervention and Referral: <http://sbir-diba.ca/screening-and-assessment/screening-and-assessment-protocol>
- CAGE-AID: Alcohol and Other Drugs Screening: <https://www.integration.samhsa.gov/images/res/CAGEAID.pdf>
- DAST-10: Drug Abuse Screening Test: [cde.drugabuse.gov](https://www.cde.drugabuse.gov) and: <https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/228>
- AUDIT-C: Alcohol Use Disorders Identification Test: <https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf>
- CRAFFT 2.0: Alcohol and Drug Screening Questionnaire Ages 12-18: <https://sbirt.webs.com/CRAFFT%202.0%20Combined.pdf>

Making the diagnosis of a substance use disorder

Not everyone who uses drugs meets the criteria for a substance use disorder. Most people who use drugs experience no problems related to their use. Even if your patient doesn't meet the criteria for a substance use disorder, they may still benefit from education and interventions. The formal diagnosis of a substance use disorder often occurs in consultation with a health care professional with experience in Addiction Medicine, it may involve additional diagnostic tests like a urine drug screen.

For your reference, below are the criteria for diagnosing a substance use disorder.

The DSM-5 contains the standard criteria to diagnose a substance use disorder. The DSM-5 defines substance-related disorders in two groups:

1. **Substance use disorders:** pattern of symptoms resulting from the use of a substance which an individual continues to take, despite experiencing significant problems as a result; or
2. **Substance-induced disorders:** including intoxication, withdrawal and substance-induced mental health disorders.

Substance Use Disorders which may pertain to the DSM-5 diagnostic criteria include:

- Alcohol Use Disorder
- Cannabis Use Disorder
- Phencyclidine Use Disorder
- Other Hallucinogen Use Disorder*
- Inhalant Use Disorder*
- Opioid Use Disorder*
- Sedative-, Hypnotic-, or Anxiolytic Use Disorder*
- Stimulant Use Disorder*
- Tobacco Use Disorder
- Other (or unknown) Substance-Use Disorder

*The DSM-5 indicates that a specific substance should be used for the diagnosis (e.g. Fentanyl use disorder; or Methamphetamine Use Disorder; Diazepam use disorder; etc.), although commonly this nomenclature is not strictly followed therefore favoring broader terms such as Opioid Use Disorder.

A substance use disorder for the above-noted substances can be diagnosed when there is a "pattern of problematic use... leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period":

Pattern of problematic use	✓
The substance is taken in larger amounts or over a longer period than was intended.	
There is a persistent desire or unsuccessful efforts to cut down or control use of the substance.	
A great amount of time is spent obtaining the substance, using the substance or recovering from its effects.	
Cravings or the strong desire or urge to use the substance.	
Recurrent use results in failure to fulfill major role obligations at work, school or home (such as repeated absences or poor performances related to use of the substance).	
Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (including arguments with spouse about consequences of intoxication; physical fights).	
Important social, occupational or recreational activities are given up or reduced because of the use of the substance.	
Recurrent use of the substance in situations in which it is physically hazardous (such as using a combustible substance in bed).	
Use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by use of the substance.	
Tolerance* as defined by either: a) A need for markedly increased amounts of the substance to achieve the desired effect. b) A markedly diminished effect with continued use of the same amount of the substance.	
Withdrawal* as manifested by either of the following: a) The characteristic withdrawal syndrome for the substance (see DSM-5 for further details). b) The substance is taken to relieve or avoid withdrawal symptoms.	

*Tolerance and Withdrawal criteria are not considered to be met for those taking opioids or sedatives, hypnotics, anxiolytics or stimulants **solely** under **appropriate** medical supervision (p. 484 DSM-5).

The DSM-5 diagnosis should include:

- Severity:
 - o Mild: Presence of 2-3 symptoms
 - o Moderate: Presence of 4-5 symptoms
 - o Severe: Presence of 6 or more symptoms
- Whether in Remission:
 - o Early remission: between 3-12 months where no criteria met except cravings
 - o Sustained remission: no criteria met for 12 or more months, except cravings
 - o Specify whether remission was in a controlled environment where access to the substance was restricted (e.g. incarceration or inpatient treatment).
 - o For opioid use disorder (OUD), specify whether remission occurred while on a prescribed agonist therapy. For OUD, remission is achieved when no criteria are met for the specified period of time, except tolerance to, or withdrawal from, the agonist).

Patients with opioid use disorders

How can I assess for opioid tolerance?

Tolerance is:

- the need for more of an opioid to achieve the same effect,
- diminished effect with the same amount of an opioid.

Since tolerance to opioids develops very rapidly, any patient reporting daily or near daily use of opioids will invariably have developed tolerance. Tolerance can occur without an opioid use disorder (patients taking opioids as prescribed).

In addition to assessing for tolerance using DSM-5 criteria while interviewing patients, reviewing past medical records and provincial prescription drug databases may provide evidence for escalating doses of opioids and tolerance (bearing in mind that prescribed medications could be diverted or used by another individual). Upon cessation of opioid use, the

precise onset of withdrawal symptoms varies based on the individual and will also depend on what type of opioid they are using¹. Short acting formulations (e.g. immediate release oxycodone) and drugs with a short serum half-life are associated with a faster onset of withdrawal symptoms than longer-acting drugs. The table below shows commonly used opioids, their half-lives and examples of their street names.

If patients are using opioids obtained without a prescription, assessment of tolerance can be particularly challenging. Illegal opioids are notorious for variation in dose form and potency, and containing substances different than what individuals believe they are purchasing (e.g. fentanyl sold as heroin; methamphetamine containing fentanyl). Therefore, in situations when tolerance is uncertain, it is typical to start patients on short-acting opioids (e.g. liquid morphine or liquid hydromorphone) and frequently re-evaluate and titrate doses up to control pain and withdrawal.

Examples of commonly used opioids

Generic name	Half-life (hrs)*	Example Brand Names	Street names**
Buprenorphine	3-5 (IV); 26 (patch)	Butrans-Belbuca	Bupe, bute
Buprenorphine/Naloxone	35 (sublingual)	Suboxone	Subby, sobos
Codeine	~3	Tylenol w/codeine – Atasol- Ratio Lenoltec-Calmlylin Codeine syrup- Ratio Cotridin- Coactifed	T1's, T2's, T3's, T4's, Captain cody
Diacetylmorphine	— (very short; rapidly metabolized to morphine)	Heroin	Down, White China, Smack, Black Tar, Brown Sugar, H, one, horse
Fentanyl	2-4 (IV); 20-27 (patch)	Duragesic Patches-Fentanyl citrate injection USP – Teva Fentanyl, Fentora	Down, fent, green apples, shady 80s, fake oxy, greenies
Hydrocodone	2.5-4	Hycodan - Novahistex-DH - Novahistine-DH - PMS Hydrocodone - Tussionex	Hydro, vike
Hydromorphone	2-3	Dilaudid - Hydromorph Contin - Journista - Palladone	Dillies, dust, juice
Meperidine	3-4	Demerol – Meperidine HCl injection	Demy, demmies

Examples of commonly used opioids, concluded

Generic name	Half-life (hrs)*	Example Brand Names	Street names**
Methadone	12-150	Metadol- Methadose	Meth, drink, juice
Morphine	2-3	Morphine Sulfate SR - Doloral - Kadian - M-Eslon - M.O.S. Sulfate - MS Contin - MS-IR - Morphine Epidural - PMS- Morphine Sulfate SR - Statex	Red rockets, morph, M's, reds, grays, peaches
Oxycodone	2-4	Endocet - Endodan - Oxy-IR - OxyNEO - Percocet - Percocet- Demi - Percodan - PMS- Oxycodone-Acetaminophen - Ratio-Oxycocet - Ratio- Oxycodan - Supeudol - Targin	Oxyies, percs, Oxy, hillbilly heroin, Big C
Pentazocine	2-5	Talwin	T's
Tapentadol	~4	Nucynta ER; Nucynta IR	---
Tramadol	5-7	Tramadol/Acet - Ultram - Ralivia - Durela - ZytramXL - Tramacet	Ultras, Chill pills

*Half-lives shown are estimates and can vary from person to person, across disease states and formulation type. Consult the applicable drug monograph for specific situations.

**Extended release formulations may have longer durations of action.

***There are multiple versions of this list in circulation as well as new street names that constantly arise. The names used on the street can vary from one location to the other. Asking the patient for clarification and/or a peer-support worker can be helpful in this context.

References:

1. Vaughan BR, Kleber HD. Opioid detoxification, chap. 20. In: American Psychiatric Press Textbook of Substance Abuse Treatment, 5th ed, Galanter M, Kleber HD, Brady KT (Eds), American Psychiatric Publishing. Washington DC, 2015.
2. Inturrisi CE. Clinical pharmacology of opioids for pain. Clin J Pain. 2002; 18: S3-13.

How do I start someone on OAT: Opioid Agonist Treatment?

For patients with opioid use disorder, Opioid Agonist Treatment (OAT) is the standard of care.

.....
*"This medication saved my life,
thank you so much."*

.....
– Patient
.....

Four medications are used for the treatment of Opioid Use Disorder (OUD):

1. Buprenorphine/Naloxone—Preferred first-line treatment
2. Methadone—Alternative first-line treatment
3. Slow-release oral morphine—Alternative expert-led approach
4. Injectable Opioid Agonist Treatment—Alternative expert-led approach

These medications treat cravings and withdrawal and can provide protection against unintentional overdose. OAT is evidence-based, effective and reduces mortality as well as drug use. It is particularly important to consider OAT for patients who have had a long period of abstinence (for example, those released from incarceration or abstinence-based residential treatment as these patients are particularly high risk of overdose or death if they return to past use and previous high doses of drugs).

Due to the superior safety profile of buprenorphine/naloxone in comparison to methadone, it is now considered the preferred first-line treatment. Buprenorphine/naloxone is essentially as efficacious as methadone, but includes significant advantages including:

- Reduced risk of fatal and non-fatal overdose, due to the reduced risk of respiratory depression;
- Less potential for drug-to-drug interactions;
- The potential for greater treatment flexibility resulting from the improved safety profile (i.e. earlier take-home doses compared to often daily witnessed ingestion at the community pharmacy with methadone).¹

The requirements for practitioners to initiate or maintain patients on OAT are updated regularly on relevant regulatory body websites, which are listed below. Training resources are also included on these websites.

- CPSA: <http://www.cpsa.ca/physician-prescribing-practices/methadone-program/>
- CARNA: https://nurses.ab.ca/docs/default-source/document-library/standards-prescribing-standards-for-nurse-practitioners.pdf?sfvrsn=c02ca1bf_8
- ACP: <https://abpharmacy.ca/sites/default/files/ODTGuidelines.pdf> and their resources page <https://abpharmacy.ca/opioids/resources-tools>

Buprenorphine/Naloxone

While training is recommended, the safety profile of buprenorphine/naloxone is such that there is no specific training requirement for physicians to initiate or maintain patients on this medication and no longer requires the use of a triplicate prescription pad in Alberta. Nurse Practitioners are also able to prescribe buprenorphine/naloxone with the appropriate knowledge and skills (see the CARNA website for details). Physicians and nurse practitioners should access available resources for best practices for dosing and prevention of precipitated withdrawal.

Initiating buprenorphine/naloxone while other opioids are present can result in precipitated withdrawal due to the high affinity and partial agonist effect of buprenorphine compared to full agonists. Precipitated withdrawal is not life threatening but is very uncomfortable. It is important to ensure that a patient is in moderate to severe withdrawal and off of all other opioids for an appropriate period of time, prior to receiving the first dose of buprenorphine. In addition to obtaining broader training, the following is an important tool to assess the degree of opioid withdrawal and thus the appropriate time to initiate buprenorphine/naloxone:

- Clinical Opioid Withdrawal Scale (COWS) <https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf>
- AHS COWS score: <https://insite.albertahealthservices.ca/Main/assets/frm/frm-20900.pdf#search=cows%20score>

Methodone

To initiate or change a methadone dose, the practitioner must consult an initiating prescriber or their delegate.² To maintain a patient on their current dose in acute care, regulatory body approval to prescribe methadone is not required. When planning for patient discharges, it is important to be aware that outside of hospital, specific education and training are required by both CPSA and CARNA, with the CPSA requiring prescribing approval to initiate or maintain a patient on methadone.

In circumstances where a practitioner is maintaining an acute care patient on their current dose, it is critical that the date of the last dose taken prior to admission is verified with the community pharmacy prior to prescribing the maintenance dose. If doses were missed, the dose must be adjusted by, or in

consultation with, a practitioner with full prescribing authorization.

Discharge planning

Regardless of the medication used to treat a patient with an OUD in an acute care setting, it is extremely important that:

- A follow up appointment is arranged with an outpatient prescriber prior to discharge;
- Access to a prescription is in place in the community for the days between discharge and the first appointment with the community prescriber;
- Medication funding is in place.

See Appendix C for a sample admission and discharge checklist for patients with opioid use disorder.

Resources:

Opioid Use Disorder Consultation Service (AHS RAAPID call center): A province-wide telephone and e-Consult service for physicians and nurse practitioners seeking advice regarding the prescribing of opioid agonist therapy (OAT) such as buprenorphine/ naloxone and methadone, when treating individuals with opioid use disorder (OUD). This service for physicians and Nurse Practitioners will allow more patients with opioid dependence to be treated in primary care, emergency, and inpatient settings.

If you are calling NORTH of Red Deer, you can access the service by calling RAAPID North at 1-800-282-9911 or 1-780-735-0811 (from 8 am - 5 pm daily, including weekends and statutory holidays).

If you are calling SOUTH of Red Deer, you can call RAAPID South at 1-800-661-1700 or 403-944-4488 (from 8 am - 5 pm daily, including weekends and statutory holidays).

AHS OAT training <https://www.albertahealthservices.ca/info/Page16083.aspx>
OR <http://ecme.ucalgary.ca/> for the accredited version

Management of opioid use disorder: a national clinical practice guideline. <http://www.cmaj.ca/content/190/9/E247>

A Guideline for the Clinical Management of Opioid Use Disorder. British Columbia Centre on Substance Use. <http://www.bccsu.ca/care-guidance-publications/>

Recommendations at a Glance: <https://i1.wp.com/crism.ca/wp-content/uploads/2018/03/Recommendations-at-a-Glance.png?ssl=1>

Online training opportunities such as the BCCSU online opioid dependency treatment training: <https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/>

CARNA Prescribing Standards for Nurse Practitioners: http://nurses.ab.ca/docs/default-source/document-library/standards/prescribing-standards-for-nurse-practitioners.pdf?sfvrsn=c02ca1bf_8

References:

1. Management of opioid use disorders: a national clinical practice guideline, CMAJ. March 5, 2018, Vol 190, Issue 9, E249-E252.
2. College of Physicians and Surgeons of Alberta website: www.cpsa.ca

What are other treatment options for opioid use disorder? (SROM, iOAT, diacetylmorphine, opioid replacement as a harm reduction approach)

Not all patients will respond to conventional treatments for opioid use disorder, such as methadone and buprenorphine. Reasons for treatment non-response can include intolerable side effects, ongoing symptoms of cravings despite optimal dosing, and ongoing use despite optimal dosing, possibly leading to destabilization and stopping treatment.

Slow Release Oral Morphine (SROM)

The recommendation of the CRISM National Guideline for the Clinical Management of Opioid Use Disorder is that SROM should be considered for use in patients who are intolerant to or have not responded to buprenorphine/naloxone or methadone, and who remain at high risk of opioid-related harms.⁴ SROM is considered a specialist-led approach and should only be prescribed by, or in consultation with, an Addiction Medicine specialist with authorization to initiate methadone.

The treatment model for SROM is similar to treatment with conventional opioid agonist treatments in that the patient presents daily to a community pharmacy to receive the morphine dose. To minimize risks of diversion, all doses are witnessed with the capsules opened and slow release beads swallowed, typically with a glass of water. Carry or take-home doses are not permitted.

Clinical guidelines:

- BC's Guidelines for the Clinical Management of Opioid Use Disorder has SROM dosing and titration recommendations.⁵ Available at: <http://www.bccsu.ca/care-guidance-publications/>

Regulatory standards:

- The CRISM National Guideline for the Clinical Management of Opioid Use Disorder

recommends that any provider who does not have experience prescribing SROM for treatment of opioid use disorders, seek specialist consultation prior to initiating treatment.⁴

- The College of Physicians and Surgeons of Alberta's recommendations on required prescriber competencies should be checked prior to prescribing SROM.

While hospitalized, if a patient has a contraindication to or declines conventional OAT, with appropriate expertise they could be offered stabilization on SROM as an alternative. If the 24-hour formulation is not on the hospital formulary, an alternative product can be used in the inpatient setting (e.g. 12-hour formulations with bid dosing). Doses should be converted to the 24-hour formulation on discharge with the capsule opened and daily witnessed ingestion in a community pharmacy. During hospitalization, take the time to connect the patient with a community provider with experience prescribing SROM to ensure a smooth handover of care on discharge.

If your patient is already on SROM, it is important to confirm when the last dose was ingested in the community prior to prescribing a dose in hospital, since tolerance can be rapidly lost if doses are missed. Similar to methadone or buprenorphine/naloxone, this information can be confirmed by calling the community pharmacy and verifying when the last witnessed dose occurred. Similar to how the medication is administered in the community, all doses should be witnessed and capsules should be opened and the beads observed to be swallowed in the hospital setting, explaining to the patient how medications will be administered and the rationale, to prevent misunderstandings. This ensures a consistent approach across both hospital and community settings, and minimizes the risk of medication diversion.

References:

1. Beck T, Haasen C, Verthein U, et al. Maintenance treatment for opioid dependence with slow-release oral morphine: a randomized cross-over, non-inferiority study versus methadone. *Addiction*. 2014;109(4):617-626.
2. Jegu J, Gallini A, Soler P, Montastruc J-L, Lapeyre-Mestre M. Slow-release oral morphine for opioid maintenance treatment: a systematic review. *British Journal of Clinical Pharmacology*. 2011;71(6):832-843.
3. Haemmig R, Koehler W, Bonorden-Kleij K, et al. Safety and tolerability of slow-release oral morphine versus methadone in the treatment of opioid dependence. *Journal of Substance Abuse Treatment*. 2014;47(4):275-281.
4. Bruneau J, Ahamad K, Goyer M-É, et al. Management of opioid use disorders: a national clinical practice guideline. *CMAJ : Canadian Medical Association Journal*. 2018;190(9):E247-E257. doi:10.1503/cmaj.170958.
5. British Columbia Centre on Substance Use and B.C. Ministry of Health. A Guideline for the Clinical Management of Opioid Use Disorder. Published June 5, 2017. Available at: <http://www.bccsu.ca/care-guidance-publications/>

Injectable Opioid Agonist Treatment (iOAT)

Alberta Health Services is now offering treatment with prescribed injectable hydromorphone in clinics in Edmonton and Calgary for patients with treatment refractory, severe opioid use disorders, for those who use injectable opioids and have not been able to stabilize on conventional treatments.

In some European countries and Vancouver, BC, treatment with injectable diacetylmorphine (prescribed heroin) under direct clinical supervision is a well-established treatment for severe, refractory opioid use disorder. Patients in Vancouver are additionally able to access treatment with injectable hydromorphone in a variety of treatment settings, including stand-alone treatment centers, community health clinics with embedded programs, and a pharmacy dispensing model. In all models, patients are required to attend two to three times daily to self-administer doses under medical or direct supervision by a health care professional.

Reviews have concluded there is value in offering prescribed injectable hydromorphone or diacetylmorphine (pharmaceutical-grade heroin) for people with long-term refractory opioid disorder. This approach has demonstrated decreased use of illegal substances, decreased involvement in criminal activity and incarceration, increased retention in treatment, and greater reductions in illegal heroin use compared to those who received methadone only.^{1,2}

Hydromorphone has several advantages over diacetylmorphine in that it is a readily available pharmaceutical product without the current barriers in obtaining and prescribing that diacetylmorphine involves. A Canadian trial looked at treating OUD with injectable diacetylmorphine versus injectable

hydromorphone. This study showed that injectable hydromorphone is comparable to injectable diacetylmorphine in terms of decreasing illegal diacetylmorphine use. There were also significantly less adverse events in the hydromorphone group than in the diacetylmorphine group³.

It is important to note that iOAT in the community involves the self-administration of I.V. or I.M. hydromorphone or diacetylmorphine (heroin). Patients typically also take methadone or a slow release oral morphine to help prevent withdrawal overnight. Acute care environments must be prepared to manage iOAT patients if they require admission to hospital and should contact the iOAT clinic the patient has been attending to discuss current dosing and individual patient responses. It is important to note that the dosing for hydromorphone for patients in the iOAT program may seem unusually high compared to dosing in an acute care setting.

Consideration could be given to initiating patients with severe, refractory injection opioid use disorders on iOAT while admitted to hospital. Appropriate clinical expertise and protocols must be in place to properly monitor for potential side effects of high dose IV hydromorphone administration (e.g. overdose, seizure). This should be done in collaboration with community providers with expertise in addiction medicine to support transfer of care and maintenance of treatment after discharge from hospital. The self-administration of doses and the post-dose observation period should be supervised by health care professionals with training and expertise to respond to potential side effects and with access to prescribers that can adjust the doses as needed.

Resources:

Opioid Use Disorder Consultation Service (AHS RAAPID call center): a province-wide telephone and e-Consult service for physicians and nurse practitioners seeking advice regarding the prescribing of opioid agonist therapy (OAT) such as buprenorphine/ naloxone and methadone, when treating individuals with opioid use disorder (OUD). This service for physicians and Nurse Practitioners will allow more patients with opioid dependence to be treated in primary care, emergency, and inpatient settings.

If you are calling NORTH of Red Deer, you can access the service by calling RAAPID North at 1-800-282-9911 or 1-780-735-0811 (from 8 am - 5 pm daily, including weekends and statutory holidays).

If you are calling SOUTH of Red Deer, you can call RAAPID South at 1-800-661-1700 or 403-944-4488 (from 8 am - 5 pm daily, including weekends and statutory holidays).

Edmonton iOAT Clinic: 780-342-7810

Calgary iOAT Clinic: 403-955-3390

Clinical guidelines:

- BC's Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder has iOAT dosing and titration recommendations⁴. Available at: <http://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf>

Regulatory standards:

- BC's Guidance document recommends as a minimum that prescribers have experience in conventional OAT prescribing, complete the BCCSU online training module on iOAT, and seek expert consultation for at least the first five patients initiated⁴.
- The College of Physicians and Surgeons of Alberta's recommendations on required prescriber competencies should be checked prior to prescribing iOAT.

Provincial Clinical Knowledge Topic: Opioid Use Disorder and Opioid Agonist Therapy, Adult and Young Adult – Alberta Health Services

References:

1. Ferri M, Davoli M, Perucci CA. Heroin maintenance for chronic heroin-dependent individuals. The Cochrane database of systematic reviews. 2011;12.
2. Strang J, Groshkova T, Uchtenhagen A, et al. Heroin on trial: systematic review and meta-analysis of randomised trial of diamorphine-prescribing as treatment for refractory heroin addiction. The British Journal of Psychiatry. 2015;207(1):5-14.
3. Oviedo-Joekes E, Guh D, Brissette S, et al. Hydromorphone compared with diacetylmorphine for long-term opioid dependence: A randomized clinical trial. JAMA Psychiatry. 2016;73(5):447-455.
4. British Columbia Centre on Substance Use and B.C. Ministry of Health. Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder. Published October 11, 2017. Available at: <http://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf>

Opioid replacement as a harm reduction approach

Hospitalized patients with an opioid use disorder may decline available conventional treatments (methadone, buprenorphine/naloxone) and alternative treatments such as SROM or iOAT. It is important to note that motivation for treatment and understanding of treatment options can change during a hospital stay and can continue to be explored as appropriate. Patients may decline conventional treatments for a number of reasons including past negative side effects or stigma they have experienced in the past when in treatment. Autonomy to make an informed decision about their own care must be respected, as with treatment decisions for any other medical condition.

If all forms of OAT are declined, or the dose of OAT is suboptimal, these patients will still require treatment for their withdrawal and cravings during hospitalization. Given that withdrawal management or detoxification alone is not an effective or safe treatment for OUD¹, this may mean providing opioids while the patient is hospitalized for the purpose of reducing the harms associated with ongoing use of illegal opioids. Sustained release formulations can be used to provide baseline coverage for withdrawal but short acting opioids may still be required for breakthrough symptoms.

CLINICAL TIP:

- *If unsure of the patient's opioid tolerance, start with frequent (2-3h) dosing of a short-acting opioid as needed. Consider using an oral liquid formulation or subcutaneous injection to minimize the risk of diversion.*
- *After 24-48 hours, convert in the range of 50-75% of the amount of opioid required to a long-acting formulation with twice to three times daily dosing and leave the remainder as a prn option for breakthrough symptoms.*
- *Frequent reassessment of dosing will be required.*

Instruction should be given to assess how safe it is for the patient to receive opioid doses. If the patient appears significantly sedated or respirations are

depressed, then the dose should be held until the patient is more alert. All patients with an active opioid use disorder should have a prn naloxone order so nurses can respond promptly to any unintentional opioid overdoses due to ongoing drug use in hospital.

If a more specific assessment scale is required, the Pasero Opioid-induced Sedation Scale (POSS)² can be used. For example, a modified version of the one used in the BC document, Guidance for Injectable Opioid Agonist Treatment³, is as follows:

POSS Scale

Level of Sedation	Appropriate Action
S – Sleep, easy to arouse	Acceptable; no action necessary; may continue with opioid dose
1 - Awake and alert	Acceptable; no action necessary; may continue with opioid dose
2 - Slightly drowsy, easily rousable	Acceptable; no action necessary; may continue with opioid dose
3 - Frequently drowsy, rousable, drifts off to sleep during conversation	Unacceptable; hold opioid until improved; monitor respiratory status and sedation closely until sedation level is stable at less than 3 and respiratory status is satisfactory
4 - Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable; hold opioid and notify prescriber; consider administering naloxone; monitor respiratory status and sedation closely until sedation level is stable at less than 3 and respiratory status is satisfactory

The above approach using prescribed oral opioids will work for the vast majority of patients not willing to receive OAT.

In exceptional situations, other specialist-led approaches may be considered to mitigate a substantial risk of illicit fentanyl-related poisoning/death during hospital admission and to facilitate

completion of hospital treatment. An example of such an approach is prescription of IM/IV opioids for nurse administration or, in rare cases, witnessed self-administration. These approaches require extensive consultation with an Addiction Medicine specialist and involve the entire care team. Medication administration must occur in a supervised setting with frequent monitoring for sedation or other adverse events. The following must be discussed with the patient prior to initiation:

- 1) There is currently no clear evidence base to support the provision of opioids for self-administration for the purposes of a safe opioid supply (outside of a structured OAT/ iOAT treatment program). Rather, it is a pragmatic approach based on an assessment of risks and benefits in the context of ongoing IV drug use that is not modifiable with other available therapies.
- 2) In settings where iOAT programs are not available in the community, ongoing treatment with IV or IM opioids will not be possible upon discharge. Oral OAT should continue to be offered throughout the admission.

- 3) There is a risk of overdose, particularly with rapid administration of opioids.
- 4) An informed consent discussion must occur with the patient and be documented in their chart.

The self-administration of prescribed medications is considered legal and therefore a Health Canada exemption for supervised consumption is not required.

On discharge, connection with community providers experienced in the management of opioid use disorders should again be offered. Opioids can be prescribed as a bridge to follow up for initiation of OAT, but should be converted to a safer form for community treatment such as daily dispensing with witnessed ingestion in a community pharmacy of a 24-hour morphine formulation. A written plan for discharge, follow-up and treatment should be developed with the patient's input.

See Appendix A for a sample triplicate prescription.

References:

1. Bruneau J, Ahamad K, Goyer M-È, et al. Management of opioid use disorders: a national clinical practice guideline. CMAJ: Canadian Medical Association Journal. 2018;190(9):E247-E257. doi:10.1503/cmaj.170958.
2. Pasero C. Assessment of Sedation During Opioid Administration for Pain Management. Journal of PeriAnesthesia Nursing.24(3):186-190.

British Columbia Centre on Substance Use and B.C. Ministry of Health. Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder. Published October 11, 2017. Available at: <http://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf>

BCCSU Heroin Compassion Clubs: <http://www.bccsu.ca/wp-content/uploads/2019/02/Report-Heroin-Compassion-Clubs.pdf>

How do I manage acute pain for someone with an opioid use disorder?

All patients require appropriate and humane management of acute pain. There is often provider fear that prescribing opioids will contribute to a patient's opioid use disorder. It should be noted that undertreated acute pain is also a risk factor for returning to use or ongoing use. Treating acute pain for patients with a pre-existing opioid use disorder can be challenging given underlying issues of opioid tolerance and withdrawal. Non-opioid pharmacotherapies such as acetaminophen, NSAIDs, and anticonvulsants for neuropathic pain, and specialist interventions such as nerve blocks if available, should always be trialed, but where there is severe acute pain or a significant traumatic injury, opioid analgesics are likely going to be required.

For patients already receiving opioid agonist treatment, common misconceptions can lead to the under treatment of acute pain. These misconceptions can include:

- **Myth 1:** The maintenance opioid agonist (for example, daily dosed methadone or buprenorphine) provides analgesia.
Reality: When used for maintenance, these medications treat withdrawal and cravings but are not adequate for acute pain management.
- **Myth 2:** The use of opioids for analgesia will result in addiction relapse.
Reality: Opioids can be safely used in patients with a history of opioid use disorder but should be carefully managed.
- **Myth 3:** The additive effects of opioid analgesics and OAT will cause respiratory and central nervous system depression.
Reality: While this is a risk, it should not preclude adequate pain management and with careful monitoring, opioids can still be used. Please see the section, 'What are the other treatment options for opioid use disorder', in this Guidance Document for the POSS scale.
- **Myth 4:** The pain complaint is a manipulation to obtain opioid medications or drug seeking, because of an opioid addiction.¹

Reality: Most patients can obtain opioids more easily outside of hospital. A patient's presenting concerns, including pain, should be taken seriously.

Acute Pain Management for Patients Stabilized on OAT

Patients already on methadone will require a continuation of their methadone dose with the addition of treatment for acute pain. If opioid analgesia is required, greater than usual doses may be required due to tolerance.²

For patients on buprenorphine/naloxone, acute pain management can be challenging given that buprenorphine binds tightly to opioid receptors (thus blocking, or partially blocking, the binding of other opioids), but only partially activates them. Opioid analgesia can be given to treat acute pain though aggressive titration of higher affinity opioids may be required (e.g. hydromorphone).¹ If adequate analgesia cannot be achieved for patients on buprenorphine/naloxone with this method, then another option may be to split their buprenorphine dose into twice daily or three times daily dosing or even decrease their buprenorphine dose in order to allow other opioid analgesia to better access to the mu receptor. When treating acute pain, buprenorphine/naloxone and Suboxone should not be discontinued, except in rare, exceptional cases. It is challenging to reinstate Suboxone following the resolution of acute pain and the risk of relapse increases if Suboxone is discontinued. Consult an Addiction Medicine Specialist or call the AHS RAAPID call center if an Addiction Medicine Specialist is not available (see Resources below).

Changes to a previously stable dose of either methadone or buprenorphine/naloxone should only be done with patient involvement and discussion with their treating prescriber and the input of an Addiction Medicine specialist as well as acute pain service experts, when available. Given the risk of destabilizing the opioid use disorder, and the requirement to generally go into moderate to severe withdrawal in order to re-initiate buprenorphine/naloxone, buprenorphine should only be discontinued if absolutely necessary. It is often easier to taper down

the full agonist opioid when full dose buprenorphine/naloxone is maintained.

For patients with an untreated opioid use disorder, stabilization of their opioid use disorder with opioid agonist treatment at the same time as managing their acute pain could result in better pain management

and outcomes. If OAT is declined, please see the section of this Guidance Document, 'What are other treatment options for opioid use disorder? Opioid replacement as a harm reduction approach' for suggestions.

Resources:

Opioid Use Disorder Consultation Service (AHS RAAPID call center): a province-wide telephone and e-Consult service for physicians and nurse practitioners seeking advice regarding the prescribing of opioid agonist therapy (OAT) such as buprenorphine/naloxone and methadone, when treating individuals with opioid use disorder (OUD). This service for physicians and Nurse Practitioners will allow more patients with opioid dependence to be treated in primary care, emergency, and inpatient settings.

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If you are calling SOUTH of Red Deer, you can call RAAPID South at 1-800-661-1700 or 403-944-4488 (from 8 am - 5 pm daily, including weekends and statutory holidays).

References:

1. Alford, D., Compton, P., Samet, J. Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy. *Ann Intern Med.* 2006 Jan 17; 144(2): 127-134.
2. Ries, R., In Miller, S. C., In Saitz, R., In Fiellin, D. A., & American Society of Addiction Medicine, (2014). The ASAM principles of addiction medicine.

Naloxone – orders and early provision of overdose response kits (i.e. Take Home Naloxone kits)

In March 2016, Health Canada removed naloxone from the Prescription Drug List for emergency use outside hospital settings¹. Take home naloxone kits are indicated for anyone at risk of witnessing an opioid use disorder. Please note that this includes those taking prescription or non-prescription opioids, and also their families, friends or people who live in areas where opioid overdoses are common.

Anyone using illegal drugs is at risk and should be offered a kit given the high rates of contamination with fentanyl. Naloxone kits are currently available, free of charge and without prescription, in community pharmacies and from other agencies across Alberta. A list of locations that distribute naloxone kits can be found at: <https://www.albertahealthservices.ca/info/page12491.aspx>.

In order to prevent a delay in administering a dose of naloxone in an emergent situation, for patients at risk of experiencing an opioid overdose in hospital, an order can be written at the start of the admission for naloxone as needed. An example would be: “naloxone 0.4mg IV/IM x1 dose prn for signs of opioid overdose such as pinpoint pupils and decreased LOC or decreased respiratory rate and decreased LOC. Call the physician or NP to reassess the patient”.

Given that hospitals remain high risk environments for people who use drugs² and much of the ongoing drug use is done in isolated unsafe areas such as hospital bathrooms³, it is important that patients who use opioids carry their own naloxone kit. In the emergency department or on admission, patients with a history of opioid use should be asked if they have a naloxone kit and if not, one should be provided with education on its use and overdose prevention.

Resources:

AHS Community Based Naloxone Program: <https://www.albertahealthservices.ca/info/Page13663.aspx>

References:

1. Government of Canada: Notice: Prescription Drug List (PDL): Naloxone. <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/prescription-drug-list/notice-naloxone.html>
2. McNeil R, Small W, Wood E, Kerr T. Hospitals as a `risk environment: An ethno-epidemiological study of voluntary and involuntary discharge from hospital against medical advice among people who inject drugs. *Social science & medicine* (1982). 2014;105:59-66.
3. Grewal HK, Ti L, Hayashi K, Dobrer S, Wood E, Kerr T. Illicit Drug Use In Acute Care Settings. *Drug and alcohol review*. 2015;34(5):499-502.

Should I prescribe opioids for chronic pain?

Current guidelines suggest that a trial of opioids may be considered for patients with chronic non-cancer pain after non-opioid medications have been fully trialed and titrated, and non-medication approaches have proven unsuccessful in *patients with no history of a substance use disorder or current mental illness*.

In opioid naïve patients, it is suggested to avoid offering opioid therapy to those with a history of substance use disorders or a current mental illness, and is advised against in patients with an active substance use disorder. Please note this refers specifically to chronic pain. For treatment of acute pain in someone with an opioid use disorder, please refer to the section ‘How do I manage acute pain for someone with an opioid use disorder?’ in this Guidance Document. In a patient with a current psychiatric disorder whose non-opioids are optimized but has persistent problematic pain, it is recommended to stabilize the psychiatric disorder prior to a trial of opioids. (2017 Canadian Opioid Prescribing Guideline: <http://www.cmaj.ca/content/189/18/E659#sec-25>)

It can be difficult for patients and clinicians alike to determine whether an individual has solely chronic

pain, solely an opioid use disorder, or a combination of the two. It can be helpful to note that when using the DSM-5 criteria to diagnose an opioid use disorder in a patient with comorbid chronic pain, the criteria of Tolerance and Withdrawal are not considered met for those taking opioids “solely under appropriate medical supervision”. OAT should be offered to all individuals with an opioid use disorder including those with comorbid chronic pain, whether in hospital or in the community.

Tapering of opioids for chronic pain to the lowest effective dose or discontinuation, particularly at doses ≥ 90 mg OME (oral morphine equivalent) should be considered with a patient’s consent and done over a period of weeks and in conjunction with the patient’s primary care provider or community-based support. Forced tapers are not recommended, neither in acute nor community settings. Functional benefit and improvement are critical factors in the ongoing use of prescription opioids for chronic non-cancer pain. In situations where patients experience serious challenges in tapering opioids for chronic non-cancer pain, consultation with a multidisciplinary team, including an Addiction Medicine specialist, may be warranted (2017 Canadian Opioid Prescribing Guideline).

Resources:

CMAJ: Guideline for opioid therapy and chronic non-cancer pain: <http://www.cmaj.ca/content/189/18/E659>

Patients with alcohol use disorders

How do I manage alcohol withdrawal?

The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) can be used to help identify which patients may be most at risk of developing severe alcohol withdrawal syndrome. Alcohol withdrawal typically starts within 6-24 hours after a patient's last drink and symptoms can start to appear while there is still alcohol in the bloodstream. Alcohol withdrawal can be life threatening and every effort should be made to identify patients at risk and to initiate treatment early. Alcohol withdrawal seizures typically occur in the first 24 hours after alcohol cessation. Delirium tremens usually occurs 72-96 hours after the last drink and is characterized by autonomic instability, tremors, diaphoresis and hallucinations. If these symptoms are left untreated it can lead to patient death.

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Alcohol withdrawal is a life-threatening medical condition.
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Benzodiazepines are the standard of care for withdrawal management and whenever possible, a symptom-triggered approach should be used to guide medication administration. This approach (as opposed to giving doses on a fixed schedule or a set

taper) results in a quicker resolution of symptoms, a shorter period of hospitalization and the use of less benzodiazepines overall.

The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) tool is a validated tool that can be used to guide when benzodiazepines are indicated.

NOTE: This tool must only be used in patients who are awake and alert, able to answer questions, and those that have a normal cognitive status at baseline; if used incorrectly, patients could receive benzodiazepines for symptoms unrelated to their alcohol withdrawal and thus be at risk for unnecessary sedation.

Elderly patients, those with respiratory disease and/or liver disease should be treated with benzodiazepines (e.g. lorazepam) that do not have active secondary metabolites (e.g. diazepam) so as to avoid over sedation. For patients in whom CIWA-Ar is felt to be contraindicated, an objective scoring system can be considered.¹

There is early evidence to suggest that gabapentin may be effective in treating hospitalized patients with mild to moderate alcohol withdrawal.² This treatment option could be considered, particularly if gabapentin is likely to be continued for its anti-craving effects after the acute withdrawal period and/or if benzodiazepines are relatively contraindicated.

Resources:

Alcohol Intoxication Withdrawal, Adult: Emergency Department – Alberta Health Services: <https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-alcohol-intoxication-withdrawal-adult.pdf>

Alcohol Withdrawal, Adult: Inpatient – Alberta Health Services: <https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-alcohol-withdrawal-adult-inpatient.pdf>

Alcohol Withdrawal, Adult Inpatient Orders – Alberta Health Services: <https://www.albertahealthservices.ca/frm-21050.pdf>

References:

1. Knight E, Lappalainen L. "Clinical Institute Withdrawal Assessment for Alcohol-Revised might be an unreliable tool in the management of alcohol withdrawal" *Canadian Family Physician* 2017; 63: 691-695.
2. Leung JG, Rakocevic DB, Allen ND et al. "Use of a Gabapentin Protocol for Management of Alcohol Withdrawal: A Preliminary Experience Expanding From the Consultation-Liaison Psychiatry Service" *Psychosomatics* 2018 (e-pub ahead of print).
3. Wood E, Albarqouni L, Tkachuk S et al. "Will this Hospitalized Patient Develop Severe Alcohol Withdrawal Syndrome? The Rational Clinical Examination Systematic Review" *JAMA* 2018.

Which medications can I use to help patients stop drinking or to drink less?

Many patients in acute care are motivated to reduce their alcohol intake or to attempt abstinence. Thus, acute care admission represents a key opportunity to initiate treatment. It is important to understand that simply managing alcohol withdrawal is not treating the underlying alcohol use disorder. Pharmacotherapy should be considered along with additional approaches including psychosocial treatment and support groups. There is evidence supporting the use of medication to assist those with alcohol use disorder to:

- reduce intake;
- support abstinence, and/or;
- delay time to first relapse.

Medications to treat alcohol use disorder are historically underutilized.² Pharmacotherapy should be considered for all patients with moderate or severe AUD.^{1,3,4,5,6}

The strongest evidence supports the use of naltrexone and acamprosate as initial options, and both are approved by Health Canada for the treatment of alcohol use disorder, unlike other options which are 'off label' for this indication. Naltrexone should not be used in those with severe liver disease or who are on opioids (whether prescribed or illegally obtained). Treatment with acamprosate is contingent on sufficient renal function. See Appendix D of key considerations for these medications, and see the product monograph for full details.

The relative cost of these medications is also an important factor. Since criteria for medication

funding may change, updates on drug coverage and additional coverage details can be found on the Alberta Health Benefit List <http://www.health.alberta.ca/services/drug-benefit-list.html>. For NIHB coverage see <https://www.canada.ca/en/services/health/aboriginal-health.html>

In addition to the two medications approved by Health Canada for alcohol use disorder, the following 'off-label' medications, with less supporting evidence, may be considered in situations where naltrexone or acamprosate are not suitable.

- Gabapentin at dose of 600mg TID⁷
- Topiramate¹
- Valproic acid¹
- Disulfiram—the limited evidence only supports its use in a structured treatment environment with daily witnessed ingestion; (not a benefit under NIHB, Income Support, Alberta Adult Health Benefit, or AISH).^{1,5}

These medications are funded via NIHB, Income Support, Alberta Adult Health Benefit, and AISH.

While there is good evidence for naltrexone and acamprosate, it should be noted that the recommendation for gabapentin stems primarily from a well-designed, but small, single-centre study.⁷ Given that this medication is well-tolerated with few contraindications and a low side-effect profile, it may be quite useful when naltrexone and acamprosate are not suitable. However, it should be noted that the evidence is limited and that there is the potential for sedation and the non-medical use of this medication.

See Appendix D for a table on Pharmacotherapy for AUD.

References:

1. Jonas D, Amick H, Feltner C, Bobashev G, Thomas K, Wines R et al. Pharmacology for adults with alcohol use disorder in outpatient settings: a systematic review and meta-analysis. *JAMA* 2014; 311(18):1889-1900.
2. Rehm J, Shield K, Gmel G, Rehm M, Frick U. Modeling the impact of alcohol dependence on mortality burden and the effect of available treatment interventions in the European Union. *Eur Neuropsychopharmacol*. 2013. 23(2): 89-97.
3. Spithoff S, Kahan M. Primary care management of alcohol use disorder and at-risk drinking. *Can Fam Physician*. 2015;61:515-521.
4. Uptodate. Pharmacotherapy in alcohol use disorder. 2015
5. Jorgensen C, Pedersen B, Tonnesen H. The efficacy of disulfiram for the treatment of alcohol use disorder. *Alcohol Clin Exp Res*. 2011;35(10):1749-1758.
6. Substance Abuse and Mental Health Services Administration and National Institute on Alcohol Abuse and Alcoholism. Medication for the treatment of alcohol use disorder: a brief guide. HHS Publication No. (SMA) 15-4907. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.
7. Mason B, Quello S, Goodell V, et al. Gabapentin treatment for alcohol dependence: a randomized clinical trial. *JAMA Intern Med*. 2014;174:70.

How can I help patients who continue to use alcohol in hospital?

Alcohol use disorder is a known risk factor for leaving hospital against medical advice and readmission within 15 days.^{1,2} Managed alcohol programs (MAPs) are a harm reduction approach for people with severe alcohol use disorders for whom abstinence from alcohol is not desired by the patient nor feasible in the short term. Community MAPs provide participants with regulated, scheduled doses of alcohol. They have been shown to stabilize alcohol use patterns and have demonstrated health, social and economic benefits.^{3,4} Despite their effectiveness in community settings and the risks for those admitted to hospital with alcohol use disorders, MAPs have not been systematically implemented in acute care.

The provision of beverage alcohol can be considered when patients decline an abstinence-based management plan while hospitalized, have

continued to use alcohol while in hospital (or are likely to continue to use alcohol), and whose ongoing alcohol use has interfered with their ability to address their health concerns, putting their ongoing hospitalization and medical care at risk. The goals of providing managed alcohol are to prevent premature discharges, decrease consumption of non-beverage alcohol (e.g. hand sanitizer) in hospital, and to better engage patients in their care.

An acute care MAP would entail dispensing a standardized amount of alcohol at set dispensing intervals, to be consumed under supervision. MAP eligibility criteria, a patient agreement and a pre-dose intoxication assessment tool can guide the provision of alcohol in the inpatient setting. At the time of writing, MAP are available in a few acute care sites in Alberta (Peter Lougheed Centre and the Royal Alexandra Hospital).

Please see Appendix B for a sample alcohol order.

References:

1. Alfandre DJ. "I'm Going Home": Discharges Against Medical Advice. *Mayo Clinic Proceedings*. 2009;84(3):255-260.
2. Hwang SW, Li J, Gupta R, Chien V, Martin RE. What happens to patients who leave hospital against medical advice? *CMAJ: Canadian Medical Association Journal*. 2003;168(4):417-420.
3. Pauly, B, Gray, E, Perkin, K, Chow, C, Vallance, K, Krysowaty, B, and Stockwell, T. (2016). Finding safety: a pilot study of managed alcohol program participants' perceptions of housing and quality of life. *Harm Reduction Journal*. 2016; 13:15.
4. Vallance K, Stockwell T, Pauly B, Chow C, Gray E, Krysowaty B, et al. (2016). Do managed alcohol programs change patterns of alcohol consumption and reduce related harm? A pilot study. *Harm Reduction Journal*. 2016; 13:13.
5. Brooks, H. L., Kassam, S., Salvalaggio, G., and Hyshka, E. (2018). Implementing managed alcohol programs in hospital settings: A review of academic and grey literature. *Drug Alcohol Review*. 37: S145-S155.

Patients with stimulant use disorders

How do I manage stimulant use disorders?

Stimulant Withdrawal

Patients who use stimulants on a daily basis may experience some withdrawal symptoms when admitted to hospital. This may present as fatigue, anxiety, low mood, difficulty concentrating, irritability and agitation. At times, patients can appear quite sedated and/or may sleep excessively for the first few days of hospitalization. Withdrawal is typically mild and can be managed symptomatically. Low dose antipsychotics are typically used for agitation and mild psychosis.

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Did you know that 'pint' is another name for methamphetamine?
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Stimulant Intoxication

While many patients are able to abstain from stimulant use while admitted, some will experience cravings and may continue to use stimulants while in hospital. In these cases, a harm reduction approach is warranted. Patients who return to the unit with agitation or other features of stimulant intoxication should be assessed for medical stability. Patients with severe agitation, hypertension (blood pressure greater than 160/100 mmHg), tachycardia (heart rate greater than 170 beats per minute), muscle rigidity and/or respiratory distress need urgent medical assessment. Physical restraint can increase CNS stimulation and lead to cardiovascular collapse and death. Staff may benefit from learning various de-escalation strategies to reduce the stimulation in the environment (e.g.

reduce lighting and number of caregivers) with the goal of creating a calmer setting.

Once other causes are excluded, benzodiazepines and/or antipsychotics can be used for symptom management if needed. Patients with chest pain should have a full cardiac work up completed to exclude a myocardial infarction, aortic dissection and/or an arrhythmia. Beta-blockers are contraindicated in these patients due to the risk of unopposed alpha-adrenergic effects.¹

Treatment

There are currently no pharmacotherapies that have been shown to be effective for the treatment of stimulant use disorders. Patients may benefit from inpatient counselling including motivational techniques and relapse prevention discussions. Contingency management programs, such as those that offer small rewards for periods of abstinence, have been shown to be effective in reducing stimulant use and hospitalizations, as well as cost effective. Connection to outpatient contingency management programs from hospital, when available, should be strongly considered.^{2,3} For patients suspected of having undiagnosed attention deficit hyperactivity disorder (ADHD), an outpatient psychiatric consultation should be considered. Addressing social determinants of health such as housing and finances prior to discharge or referral to agencies that can support the patient in the community can be effective to help the patient reduce stimulant use based on coping or survival strategies in the community (e.g. staying awake to avoid violence or theft of possessions).

Resources:

United Nations Office on Drugs and Crime: Treatment of Stimulant Use Disorders: Current Practices and Promising Perspectives: http://www.unodc.org/documents/drug-prevention-and-treatment/Treatment_of_PSUD_for_print_1X_09.03.19.pdf

References:

1. Gist RS, Sullivan M, Serianni RP. "Management of Substance Abuse in the Hospital Setting" *International Anesthesiology Clinics* 2011;40(1): 15-30.
2. McDonnell MG, Srebnik D, Angelo F et al. "Randomized Controlled Trial of Contingency Management for Stimulant Use in Community Mental Health Patients With Serious Mental Illness" *Am J of Psychiatry* 2013;170(1): 94-101.
3. Murphy SM, McDonnell MG, McPherson S et al. "An economic evaluation of a contingency-management intervention for stimulant use among community mental health patients with serious mental illness" *Drug and Alcohol Dependence* 2015; 153: 293-299.

Management of ongoing substance use in hospital

What do I need to know about providing sterile supplies for drug use?

Many patients will continue to use drugs while in hospital. There is compelling evidence that programs which provide sterile syringes and other clean supplies substantially reduce rates of HIV transmission, have no significant unintended consequences and are cost effective. These programs are based on the fundamental principles of harm reduction and have been shown to engage individuals in primary care and substance use treatment programs, and reduce the frequency of injection drug use and other complications (e.g. abscesses).

.....
“You’re trying to get better when you come to the hospital so having a needle exchange takes away the risk for having another [infection] or making it worse.”

– Acute care patient in an Edmonton hospital
.....

Patients who are admitted to hospital should have easy access to sterile injection equipment, including syringes, alcohol swabs, tourniquets, filters, cookers, sterile water and vitamin C (to break down any tablets). Harm reduction education about safer drug use, including avoidance of groin and neck veins, and any peripherally or centrally inserted catheters, should also be provided. It is important to provide ready access to sharps containers and instruction on

how to dispose of used equipment. This could include the installation of sharps containers into patient and public washrooms, needle drop boxes on hospital property, the provision of discreet personal sharps containers and/or the placement of a bedside sharps disposal unit for patients with limited mobility. A combination of all the above approaches is likely to result in the lowest incidence of improperly disposed syringes. Ideally, patients should be provided with a safe space to use drugs (please see the section in the Guidance Document, ‘What do I need to know about supervised consumption services?’). The provision of supplies and harm reduction education should be a collaborative effort between all members of the health care team.

There are a number of different ways to provide access to supplies and the approach should be tailored to each individual hospital. Emergency departments are open 24/7 and are a potential venue for anonymous supply distribution. Regular hospital visits by harm reduction programs or an outreach model with access to patients in the hospital could also be considered. A bedside model that relies on patients to self-identify or disclose ongoing drug use to their care team may not reach all the patients in need of supplies. Provision of sterile supplies may help to build trust in the health care team and open the door for effective communication and potential access to treatment.

Resources:

CATIE guidelines: <https://www.catie.ca/en/home>

What do I need to know about supervised consumption services?

Supervised consumption services provide access to sterile injection equipment and medical supervision. This ensures any adverse reactions (i.e. opioid poisoning) are immediately identified and treatment is provided. Such services have been shown to save lives, engage individuals in treatment and are highly cost effective. These services do not increase drug use or crime. Needle debris has been shown to

decrease in the immediate area (i.e. patient rooms and public washrooms) surrounding the locations where these services are offered. Drug use in hospital typically occurs in high risk locations, and research demonstrates that patients would access such services while in hospital. Canadian guidelines are now recommending the integration of supervised consumption services into acute care settings.¹

Hospitals that regularly provide care to people who use drugs should consider the integration of supervised consumption services into their hospital setting, a successful example of which is located at the Royal Alexandra Hospital in Edmonton, Alberta. Overdose prevention sites are also an option in Alberta. An exemption from the Controlled Drugs and Substances Act is required to operate such a service in Canada. For more information, email:

harm.reduction@ahs.ca

hc.exemption.sc@canada.ca

.....
“Taking a harm reduction approach and providing supervised consumption services within acute care settings has the potential to reduce the identified risks and harms related to drug use among PWUD [people who use drugs] who require acute care.”

– *Supervised Consumption Service:
Operational Guidelines, BCCSU*
.....

Resources:

Health Canada: Supervised Consumption Sites:
<https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites.html>

BCCSU Supervised Consumption Services: Operational Guidance:
<http://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf>

References:

1. British Columbia Centre on Substance Use “Supervised Consumption Services: Operational Guidance” [<http://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf>].
2. Potier C et al. “Supervised injection services: What has been demonstrated? A systematic literature review”. 2014 Elsevier Ireland Ltd.

Many patients continue to use drugs in hospital

It is important to recognize that many patients will continue to use drugs in hospital. Hospitals are typically unsafe places for people who use drugs. In many cases, it is unrealistic to expect a patient with a substance use disorder to stop using drugs during one of the most stressful times in their lives, in an unfamiliar environment and when they have been cut off from their usual social supports.

The best way to approach a conversation about a patient's drug use is nonjudgmentally, with curiosity and openness. Ask them how their drug use serves them: "What is your drug use helping you with?" or "What are the good things you are experiencing with your drug use?" Frame your concern around safety: "How can we keep you safe while you're here?" Key points to cover from a harm reduction perspective include:

- use where you feel safe;
- make sure that someone else is around in case you overdose;
- carry a naloxone kit;

- overdose prevention: consider sampling/testing your drugs (half or quarter dose) to see how the drug affects you (in a new environment, overdoses are more likely, as well as after a period of abstinence or if they come from a new dealer), don't mix drugs, use via snorting/smoking/orally rather than injecting;
- vein care: use sterile supplies (e.g. syringes, waters, cookers, filters), use a new needle each time, dispose of your sharps safely, clean the site with an alcohol swab, rotate sites, save one vein for medical emergencies (in the arm), don't use the neck (easier to OD, abscesses in this area are dangerous) or the groin (you could hit an artery and cause bleeding or lose your leg) or in the inside of the wrist (full of arteries and nerves that are close to the veins).

Resources:

CATIE Harm Reduction Info for Safer Drug Use - <http://librarypdf.catie.ca/PDF/ATI-70000s/70095.pdf>

How can I minimize the diversion of prescribed medications?

Patients with identified or unidentified substance use disorders may attempt to use their oral medications via another route, or less commonly, sell or trade their medications. Drug diversion is the transfer of regulated pharmaceuticals from an authorized individual to an unauthorized one, or to the illegal market.

While it may not be possible to eliminate diversion entirely, several steps can be taken to minimize the risk. Having a standard hospital approach to minimize diversion is helpful and can avoid the conflict that can arise when medication administration is changed after an episode of diversion is suspected. It is also reasonable to provide medications in a similar fashion to the standard of care expected in the community, particularly for the care of patients with opioid use disorders.

Keep in mind the following considerations:

- Patients are very sensitive to changes in medication, so it is important to be open and transparent, explaining any changes and why they are being made.
- If a patient is suspected of diverting medications, have a non-judgmental conversation framed around patient safety to help identify hidden issues.
- Ensure oral medications are directly observed to be taken by the patient (i.e. not left at the bedside).
- If short acting opioids (e.g. morphine and hydromorphone) are prescribed, provide doses in liquid formulations.
- For patients taking long acting capsule formulations of an opioid for an opioid use disorder, open capsules and have the patient swallow the beads from a cup with water.
- If the long acting formulation the patient is taking in the community is not available in hospital (e.g. Kadian®), using another long acting formulation (e.g. M-Eslon®). Splitting the dose into two or three times daily dosing is an option.

After the patient is discharged, it may be necessary to provide a short-term bridging prescription until the patient can be seen by their new or regular prescriber. In these cases, the following should be considered:

- Triplicate prescriptions should be faxed to a community pharmacy open 7 days per week. After faxing, the prescription should be struck or marked through and indicated as 'faxed' to avoid altering or re-use of the prescription.
- Doses can be dispensed daily and/or directly observed. This can occur once or multiple times per day depending on the risk of diversion.
- For patients on slow release oral morphine for the treatment of an opioid use disorder, capsules should be opened and observed to be taken.
- Carries (or take home doses) should only be considered after reassessment by their community prescriber.
- The community pharmacy should be able to reach the prescriber, or their delegate, seven days a week for advice about missed doses and/or other patient concerns if needed.

IV and central line management

Patients using IV drugs often have poor intravenous access. Intravenous drug use is not a contraindication to starting an IV or central line that is medically indicated. Patients should be advised to avoid using these indwelling lines for non-medical purposes due to the risk of the lines themselves becoming contaminated with bacteria and causing a systemic infection. To minimize risk, it is also critical that patients have access to sterile supplies in the event they continue to use drugs in hospital.

The following points should be considered:

- Avoid accusing patients of drug use simply because their IV or central line becomes blocked. Most patients are aware that they should not use their medical catheters and try to avoid these sites.
- Tamper proof catheters may be helpful² in patients needing midline or PICC lines.
- The most pragmatic way to reduce substance use through a central line is to provide appropriate medical management of pain, withdrawal and cravings; and/or to have a supervised consumption site (SCS) available

at the acute care facility. Patients often report using their lines when they are in a rush and in fear of getting caught.

- In very select cases where various forms of OAT have been declined or ineffective, adequate analgesia has been attempted, and an appropriate Addiction Medicine specialist consultation has been obtained, it may be appropriate to provide patients with other options. Please see the section of this Guidance Document on 'opioid replacement as harm reduction'.
 - o Documenting informed consent and the patient's decision to decline safer OAT treatments are crucial in these situations as is emphasizing that this is a harm reduction approach rather than evidence-based treatment of substance use disorder. An example of such an intervention would be starting a peripheral IV for the patient to use for intravenous drug use in order to preserve their central line and to reduce the harms (abscesses, sores) associated with the patient's multiple attempts to find a vein.

References:

1. Infection Control Today: "Midline Catheters: An Essential Tool in CLABSI Reduction". <https://www.infectioncontroltoday.com/clabsi/midline-catheters-essential-tool-clabsi-reduction>
2. J Antimicrob Chemother. Safe and successful treatment of intravenous drug users with a peripherally inserted central catheter in an outpatient parenteral antibiotic treatment service. 2010; 65: 2641.

When is it appropriate to certify a patient under the *Mental Health Act*?

The criteria for certification or involuntary detention under the *Mental Health Act* states¹:

“When a physician examines a person and is of the opinion that the person is:

- a. suffering from a mental health disorder
- mental health disorder is defined as “a substantial disorder of thought, mood, perception, orientation or memory that **grossly** impairs: judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life”
- b. likely to cause **harm** to themselves or others or to suffer substantial mental or physical deterioration or serious physical impairment, and
- c. unsuitable for admission to a facility other than as a formal patient.”

Patients who are intoxicated, delirious or otherwise impaired may qualify for an involuntary detention. Patients with severe manic or psychotic symptoms as a result of their substance use may also qualify for involuntary detention if they are confirmed a risk to

themselves or others. For example, a patient who has developed psychosis with hallucinations and delusions of harming others due to methamphetamine use could be considered for involuntary detention.

Certification under the *Mental Health Act* **should not** be used to detain patients who choose to use substances when they have the capacity to understand the risks and benefits of their substance use.

Case: A patient who has been using methamphetamines and is in hospital for treatment of an infection, but wants to leave hospital to use methamphetamines should be encouraged to stay but not be detained.

Case: A patient with a PICC line in place who injects into their PICC, but is aware of the risks of injection use including worsened infection and death, should not be detained. If the patient is leaving against medical advice, the PICC line should be removed prior to discharge if possible.

There is no consistent evidence to show that coerced substance use treatment is effective.

References:

1. Alberta Health Services. Guide to the Alberta Mental Health Act and Community Treatment Order Legislation. September 2010.
2. McCarty et al. Substance Abuse Intensive Outpatient Programs: Assessing the Evidence. *Psychiatry Services*. Vol 65 No. 6 (718-726) June 2014.

Special populations

Pregnant patients

Pregnancy may result in increased motivation to seek treatment for substance use disorders. Routine screening for substance use disorders is recommended for all pregnant women, as early in the pregnancy as possible and at each antenatal visit¹.

Pregnant women with an opioid use disorder should be offered opioid agonist therapy, and discouraged from opioid detoxification due to the significant risks to the fetus (BCCSU 2018; CMAJ 2018; WHO 2014). Methadone has been the gold standard for the past several decades, however, initiation of buprenorphine/naloxone during pregnancy on a case-by-case basis is considered a viable option. Recent guidelines recommend continuing buprenorphine/naloxone if stability is achieved prior to the identification of a pregnancy, and highlight that transition to buprenorphine alone is not necessary.

Consultation with an Addiction Medicine specialist is recommended.²

An important safety consideration is that although withdrawal from opioids should be generally avoided in pregnancy due to the risk of fetal harms, in circumstances where a pregnant woman exhibits signs of opioid overdose, naloxone should be used as with any other patient.

Pregnant patients may also have admissions where non-opioid substance use disorders are identified. Detoxification is indicated for all non-opioid substances. Care must be taken to ensure that the medications used to assist with detoxification are safe during pregnancy.

NOTE: Seeking consultation from an Addiction Medicine specialist with experience in detoxification of pregnant women with SUDs is generally warranted.

Resources and References:

1. Guidelines for the identification and management of substance use and substance use disorders in pregnancy. World Health Organization, 2014.
http://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731_eng.pdf;jsessionid=184B38427FA0F07F90767BD623372587?sequence=1
2. Treatment of opioid use disorders during pregnancy guideline supplement. British Columbia Centre on Substance Use, B.C. Ministry of Health and Addictions, & Perinatal Services BC. A Guideline for the Clinical Management of Opioid Use Disorder—Pregnancy Supplement. June 1, 2018. <http://www.bccsu.ca/care-guidance-publications/>
3. Finnegan, Loretta, Canadian Centre on Substance Abuse. "Licit and Illicit Drug Use during Pregnancy: Maternal, Neonatal and Early Childhood Consequences". <https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Drug-Use-during-Pregnancy-Report-2013-en.pdf>

Patients who are young adults

Substance use in young adults poses specific challenges for health care providers in both acute care and community settings. In addition to existing health issues associated with substance use, the stage of growth and development of the young adult must be considered. Experimentation and risk taking behaviours are common in adolescents/young adults, with potentially negative outcomes. Rejection of authority (including health care providers), striving for autonomy in their decision making and complex social circumstances must be considered when establishing relationships with young adults.

OAT should be offered to this population: BCCSU <http://www.bccsu.ca/wp-content/uploads/2018/06/ODU-Youth.pdf>

Co-occurring mental health disorders such as attention deficit hyperactivity disorder (ADHD), major depressive disorder (MDD), bipolar disorder, post-traumatic stress disorder (PTSD), anxiety, schizophrenia, and conduct disorder are prevalent (61-88%) in young adults with substance use disorders (SUD) which adds to the complexity of providing care.³

Motivational interviewing strategies are effective when working with young adults with SUDs.¹ If there are time constraints, conducting a brief intervention for alcohol or drug use can be beneficial in reducing

the harms associated with substance use. Meeting young adults/adolescents “where they are at” with a non-judgmental attitude, and involving them in decisions regarding their health can have a positive effect as young adults typically identify care providers as credible sources of information pertaining to their health.¹ Clear messaging about the effect of substance use on their bodies may help the young adult perceive the harm as relevant and realistic, and allows health care providers to deliver important messages about reducing risk.² Health care providers are in an optimal position to provide much needed support and care for young adults with SUD. Acceptance, continuity of care and a genuine interest in the young adult may have a life changing impact.

All young adults and adolescents should be offered OAT to treat their OUD. Age should not be a barrier to treatment and reducing harm and promoting health are the goals.

Substance use in young adults also affects families. Consideration should be given to providing family members with support. There may also be gaps in services as young adults pass the age of 18 and enter the adult system.

There are special implications about obtaining consent from minors. In addition, some minors may have a Permanent Guardianship Order if they are in the care of Children’s Services. Please refer to your institution’s policies and resources as below.

Resources:

AHS Summary Sheet: Consent to Treatment/Procedures(s) Minors/Mature Minors:

<https://www.albertahealthservices.ca/assets/about/policies/ahs-clp-consent-summary-sheet-minors-mature-minors.pdf>

AHS Consent to Treatment/Procedure(s) Policy:

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-consent-to-treatment-prr-01-policy.pdf>

Motivational interviewing: <http://www.ccsa.ca/Resource%20Library/CCSA-Motivational-Interviewing-Summary-2017-en.pdf>

Newton et al. “Instruments to Detect Alcohol and Other Drug Misuse in the Emergency Department: A Systematic Review” *Pediatrics* 2011; <https://www.niaaa.nih.gov/publications/clinical-guides-and-manuals/alcohol-screening-and-brief-intervention-youth>

The CFRAFT Screening Tool: <http://ceasar.childrenshospital.org/crafft/>

CCSA Cannabis Communication Guide:

https://www.ccsa.ca/sites/default/files/2019-03/CCSA-Cannabis-Communication-Guide-2018-en_0.pdf

References:

1. KM Leslie (2008); Canadian Paediatric Society Child Health 2008;13(1):53-6 Reaffirmed 2016.
2. Canadian Centre on Substance Abuse, 2017. Canadian Youth Perceptions on Cannabis. Ottawa, ON.
3. Bukstein, O. (2017) Substance use disorder in adolescents: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis. UPtoDate.

Patients with co-existing mental health conditions

Post-Traumatic Stress Disorder (PTSD)

It is common for people who use substances to report overwhelming experiences of trauma and violence. It is also common for them to view their use of substances as a coping mechanism, making them more vulnerable to substance use during periods of stress, such as a hospitalization.

Common symptoms of PTSD include intrusive memories of past traumas, flashbacks or re-experiencing of past traumas, nightmares, hypervigilance, dissociations, anxiety including panic attacks and labile mood. These symptoms can often be exacerbated when patients are experiencing intoxication, withdrawal and/or when in the hospital environment.

Psychosis

Many substances can cause psychosis either during intoxication or during withdrawal. Amphetamine induced psychosis is often seen in the acute care setting and can progress through three stages of severity: increased curiosity and repetitive examining, searching and sorting behaviors; increasing paranoia; and finally paranoid and persecutory delusions, auditory, visual and tactile hallucinations, grandiosity, racing thoughts and pressured speech.

An approach to managing acute methamphetamine induced psychosis is to utilize the ART approach.

- *Acceptance* of the patient's immediate needs, such as pain relief or need to use the washroom.

- *Reassurance* that what they are experiencing is due to the drug and will get better with time.
- *Talking down* to provide reality orientation and to avoid hostility.

In addition to the ART approach, placing the patient in a quiet dark room with limited sensory stimulation is recommended.

In terms of pharmacological management of acute psychosis, physical restraints should be avoided unless absolutely necessary as this increases the risk of hyperthermia and rhabdomyolysis. If medication is needed, benzodiazepines are preferred over antipsychotics as antipsychotics may worsen cardiovascular effects, lower seizure threshold, increase the risk of hyperthermia and/or precipitate extrapyramidal reactions. If an antipsychotic is needed to control the psychosis, haloperidol is preferred.

Seeking advice from an Addiction Medicine Specialist is recommended if you are unsure how to treat the patient.

Depression

Mood symptoms are extremely common among patients using substances, especially when using alcohol and sedatives or when withdrawing from stimulants. It is important to both concurrently treat the substance use disorder, evaluate for a depressive disorder and if present, treat the depressive disorder. In severe cases which are not likely to be substance-induced, you may consider consulting psychiatry for support with evaluation and treatment.

References and Resources:

1. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: https://www.nasmhpd.org/sites/default/files/SAMHSA_Concept_of_Trauma_and_Guidance.pdf
2. Fallot, Harris. A trauma-informed approach to screening and assessment. *New Directions for Mental Health Services*. (89)23-31. 2001.
3. Ries, R., In Miller, S. C., In Saitz, R., In Fiellin, D. A., & American Society of Addiction Medicine. (2014). *The ASAM principles of addiction medicine*.

CCSA Concurrent Disorders: <https://www.ccsa.ca/sites/default/files/2019-04/ccsa-011811-2010.pdf>

Patients with co-existing brain injury/developmental disability

Individuals with substance use disorder in acute care sometimes appear to have fluctuating levels of functioning. However, some of these patients face challenges with their functioning or cognition even when not using substances.

Due to the stigma associated with substance use, a patient's condition may be dismissed as being associated with their substance use or lifestyle. Further investigation of the causes for poor levels of functioning and screening for potential brain injuries and/or developmental disabilities may be warranted. When concerns are raised about a patient who is failing to manage independently in a number of areas, an assessment into cognitive impairment, decline in functional ability or both, can be initiated. An Occupational Therapist may be consulted who can perform investigative tests such as Mini-Mental State Examination (MMSE), Montreal Cognitive Assessment (MOCA), Executive Interview (EXIT), Independent Living Scales (ILS), etc. The results of these assessments can determine the area and severity of impairment and, subsequently, health professionals can then start to identify types of supports that may be most beneficial to the patient such as supportive housing/ALC and/or connecting patients to community agencies and programs. In some cases, a

formal capacity assessment may be required however the health care team should look at least intrusive measures first.

It is important to determine whether individuals may have suffered from any brain or head injuries, infections such as meningitis, and to inquire whether they had ever attended special classes or had assessments completed when they were children. Whether patients are aware of having any diagnoses such as fetal alcohol spectrum disorder (FASD) may also help with securing specialized services or programs to help support their needs. The PDD (Persons with Developmental Disabilities) program may help them get into group homes, support homes, or even to provide workers to help them manage independently. This may also help with securing AISH (Assured Income for the Severely Handicapped) benefits. Specialized programs and services for FASD may be appropriate as well.

Significant investigative work may be necessary by the team including the involvement of social workers to look into past histories, referrals, assessments and consultations completed during early childhood to support potential developmental delays that may not have been followed up during adulthood. Issues surrounding decision-making capacity may also need to be explored for this population to reduce risk of harms and increase supports.

Hospitalization can be an opportunity to meet other health needs

Screening for sexually transmitted and blood borne infections

Some patients that have substance use disorders may be at high risk for sexually transmitted and/or blood borne infections. Patients with substance use disorders identify significant barriers to accessing mainstream health services, and despite being one of the populations at highest risk, they are also likely to not to access screening on a regular basis. Screening when patients are seen in an emergency department or admitted to hospital should be strongly considered.

.....
Offering screening helps identify patients with untreated infection and reduces the risk of ongoing spread in the community.
.....

Individuals considered to be at high risk include the following:¹

- Sexually active youth < 25 years' old
- Sexual contacts of individuals known/suspected to have a sexually transmitted infection
- Sex workers and their sexual partners
- Individuals with new sexual partners or > 2 sexual partners in the past year
- Serially monogamous individuals who have had a series of one partner relationships over time

- Individuals not using contraception or using only non-barrier methods
- Those using injection drugs
- Those using substances in association with sex or those engaging in other unsafe sexual practices
- Individuals who trade sex for housing, food or other items
- Homeless populations or those with street involvement
- Individuals engaged in anonymous sexual partnering
- Victims of sexual assault or abuse
- Those who have had previous sexually transmitted infections

Screening should include HIV, Hepatitis B, Hepatitis C, syphilis, chlamydia and gonorrhea. Screening should be offered at least annually and possibly more frequently depending on the clinical risk. When offering and ordering screening, obtaining contact information and/or developing a plan on how to reconnect to review the test results is important. When clinically appropriate, treatment can be initiated in acute care with community follow up at the time of discharge.

All patients should be offered condoms and education on the risk of sexually transmitted infections.

Resources:

Treatment guidelines can be found in the Alberta Health Services "Provincial Clinical Knowledge Topic: *Sexually Transmitted Infection, Adult – Acute Care*" document.

References:

- 1 The College of Family Physicians of Canada. Explanations for the Preventive Care Checklist Form: http://www.cfpc.ca/uploadedFiles/Health_Policy/PDFs/PreventiveCareChecklistExplanation2011.pdf

Immunizations

Many serious infections that are relevant to individuals who use substances can be prevented by vaccination. These include Hepatitis A, Hepatitis B, pneumococcal infections, tetanus and others. Immunizations are one of the most important, effective and cost-effective interventions in public health. An admission to hospital is an opportune time to review an individual's vaccination status and offer missing vaccinations.

RNs, RPNs and LPNs (with Immunization Specialty) are authorized to administer vaccines to adults with access to the appropriate information and a prescriber's order.

The patient's prior vaccinations should be reviewed with Public Health and immunization recommendations tailored to their clinical context and serology. A partnership with Alberta Health Services Communicable Disease Control can be helpful to

ensure recommendations are appropriate and to facilitate access to vaccines. All vaccines that are administered need to be tracked and reported.

On longer admissions, it may be possible to deliver the first two doses in a vaccination series (e.g. Hepatitis B which requires the first two doses be spaced 30 days apart). Ideally, the timing of subsequent doses is tracked in the hospital information system so that these can be administered during a subsequent admission, should the patient not have already received them in the community.

For a vaccination series requiring additional doses after hospital, the patient should be referred to local primary care or public health offices that are easily accessible. All patients should receive a card indicating the vaccinations received in hospital for their personal records. Report the vaccinations administered to ensure timely access to a full and complete record of immunization.

Resources:

More information about vaccination, as well as links to provincial and national standards can be found here:
<https://insite.albertahealthservices.ca/cdc/Page11322.aspx>

<https://insite.albertahealthservices.ca/tools/policy/Page14947.aspx>

NACI recommendations: <https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-3-vaccination-specific-populations.html?page=2>

Canadian Immunization Guide
<https://www.canada.ca/en/public-health/services/canadian-immunization-guide.html>

Discussing contraception with your patient

In taking a sexual health history, it may become apparent that some patients are at risk of an unwanted pregnancy. Hospitalization can be a great time to talk about and initiate contraception. All patients at risk should also have a beta-human chorionic gonadotropin (BhCG) level sent as part of their routine admission bloodwork.

Various options for contraception are available including oral hormonal contraceptives that require daily dosing, vaginal rings and transdermal patches that are replaced monthly, injectable forms that are dosed quarterly, intrauterine devices (IUD) that can be left in place for a number of years, and reversible and non-reversible surgical procedures. Of the non-surgical options, intra-uterine devices have the lowest failure rate after typical use (0.2% -0.6%) followed by intramuscular progesterone injection (3-6%).

As mentioned above, IUDs are a reversible form of birth control that once inserted can typically be left for in place 3-5 years or longer, depending on the form used. IUDs not only provide longer term

protection against pregnancy but also require minimal up keep as there is no daily pill burden while being highly efficacious at preventing pregnancy¹. From a patient perspective, an acute care admission can be an ideal time to have an IUD inserted, particularly for those who are typically disconnected from health services while in the community. IUDs can also be inserted post-partum for women wanting to avoid an immediate subsequent pregnancy.

Another option is the Depo-Provera injection. It also has no daily pill burden but does require an injection every 3 months. The initial injection can be offered and administered in hospital and subsequent injections can be administered at the patient's community pharmacy on an ongoing basis. Depo-Provera should not be used in females with active thrombophlebitis or a history of thromboembolic disorders or cerebrovascular disease, those with known or suspected breast cancers, significant liver disease or patients with undiagnosed vaginal bleeding.

All patients should be offered education about how to prevent unwanted pregnancy and sexually transmitted infections and given access to free condoms.

References:

1. Curtis, K. M., & Peipert, J. F. (2017). Long-acting reversible contraception. *New England Journal of Medicine*, 376(5), 461-468. DOI: 10.1056/NEJMc1608736.
2. Dehlendorf, C., Krajewski, C., & Borrero, S. (2014). Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. *Clinical obstetrics and gynecology*, 57(4), 659. DOI: 10.1097/GRF.0000000000000059.
3. Forray, A. (2016). Substance use during pregnancy. *F1000Research*, 5. DOI: 10.12688/f1000research.7645.1.

How can I help my patient successfully complete their inpatient stay?

Patients with an active substance use disorder may approach issues relating to their health in the context of multiple competing priorities. Patients who leave the unit often or miss treatments do care about their health and want to get better. There are likely other urgent and competing concerns that the patient is addressing. Some of these could include:

- Risk of eviction or loss of housing;
- A pressing legal matter, court date or child custody hearing;
- Loss of their personal items or the need to safely store belongings;
- The need to support a loved one in the community either by being there in person (e.g. a partner who cannot inject themselves and is at risk of victimization or severe withdrawal without assistance) or by continuing to work while admitted (e.g. a woman who is supporting both her and her boyfriend's opioid use disorders by working in the sex trade).

One way to address these issues is to start the conversation when patients are first admitted. Saying something like, "I really want to help you stay in

.....
"I lost my housing because I was in the hospital and I couldn't take my rent money to my landlord. My landlord didn't know how to accept an e-transfer. The hospital was small and didn't have a social worker or anyone who could help me with this. I moved to Calgary and started using fentanyl and meth instead of the prescription morphine I'd been using the same dose of for 25 years."
- Patient recently initiated on iOAT in Calgary
.....

hospital so that you can get all your medications and get better. Is there anything you need to deal with in the community that will make it hard for you to stay?" Advocating for patients to have passes if needed between medication doses and/or having peer support workers who can accompany patients to help address some of these competing priorities can be very helpful for supporting patients to get their full treatment. Social work involvement to assist with moving court dates, dealing with housing issues and tracking down lost belongings is also critical.

Supporting patients to take their prescribed medication

The following strategies can be used to support a patient taking their medications while they are admitted to an acute care setting:

- To minimize interruption to the patient's sleep cycle and recovery activities (such as evening peer support meetings or day time counseling), the nurse can facilitate adjusting the timing of medication to better meet the patient's needs or involve the team pharmacist (if available) to make decisions on the patient's medications that facilitate the following:
 - o Try to choose medications that require **low frequency dosing**.
 - o **Time doses** of medications to coincide with patients' regular sleep schedule.
 - o **Time antibiotics with other medications** the patient may be motivated to take which requires them to be present on the unit (e.g. opioids or medications for sleep).
 - o When medically appropriate, **work with patients to provide passes** in between medication doses.

Certification is not recommended for patients with substance use disorders for the purpose of improving medication adherence. This can threaten the therapeutic relationship with the patient and prevent return visits in the setting of crisis. (Please see 'When is it appropriate to certify a patient under the *Mental Health Act?*' section of this Guidance Document)

It is often reasonable that patients with substance use disorders (SUDs) remain in hospital longer than those without SUDs. This could be to facilitate critical appointments and procedures, or to support the completion of prolonged courses of IV antibiotic therapy where sub-acute or home treatment options may not be available nor appropriate. This is particularly true for those patients who have poor support systems. A longer hospital stay may ensure a patient receives care that will ultimately reduce morbidity, readmission and overall cost to the health care system and improve the patient's health and well-being. It is also important to connect patients to care in the community in order to reduce re-admission rates. This can take time and creative strategies (e.g. access to transportation, peer support) that address the unique needs of the patient.

Resources:

Mutual Mistrust in the Medical Care of Drug Users: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495051/>

Patient Experience Journal – What are the most important dimensions of quality for addition and mental health services from the perspective of its users?: <https://pxjournal.org/cgi/viewcontent.cgi?article=1244&context=journal>

Patients who require prolonged IV therapy

Not all patients with substance use disorders (SUD) are the same. There is a vast continuum between active substance use disorder and recovery. Factors such as whether the disorder is in remission, strength of the sustained recovery, route of drug use (oral/snorting versus intravenous use), and degree of social support all affect a patient's likelihood of being able to manage with a Home Parenteral Therapy Program (HPTP) program.

Many are successful at completing outpatient courses of intravenous therapy, with one study showing 28 out of 29 selected SUD patients who injected drugs successfully completed outpatient treatment with IV antibiotics with very few adverse effects¹. Close collaboration between the attending service, infectious diseases and addiction medicine, together with community-based support services is crucial to make a case-by-case decision.

To assist you in determining whether inpatient or outpatient treatment is appropriate, consider the following:

Factors favoring outpatient treatment include:

- strong social support and connections
- housing
- stable medical condition
- low likelihood of medical complications if treatment is adhered to
- non intravenous drug use related addiction
- the opportunity for timely low threshold access to SUD treatment in the community

Factors favoring inpatient treatment include:

- high degree of impulsivity
- recurrent presentations for the same issue
- impaired cognition
- medical instability or significant medical complexity
- homelessness
- diminished or absent recognition of their SUD

For recommendations on longer inpatient stays, please see 'Managing ongoing substance use in hospital' in this Guidance Document.

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What to do when you have a patient who can't be discharged

There are situations where an appropriate level of care required by someone with a substance use disorder is not available in the community. These patients can stay in hospital for a prolonged period of time, even years.

Strategies that can make prolonged hospital stays easier and positive for the patient include:

- outings with peer support workers;
- help patients rediscover hobbies and connect with social supports;
- rotation of units to prevent caregiver burnout and disengagement with the patient;
- give the patient a private room, when possible.

Ultimately, more harm reduction focused sub-acute care and supportive housing are required to improve the experience of these patients and to reduce their dependence on the acute care system. Systematic tracking of such cases and comprehensive case management may assist in the identification of care gaps in the community and support advocacy for needed resources.

When it becomes apparent that patient behaviours are complicating a medical stay (such as missed antibiotic doses, conflicts with staff, issues with visitors, etc.), collaboratively developing a written care plan together with patients and their supports can be effective. It is important that the care plan have mutual accountability (i.e. things that the patient commits to and things that the care team commits to).

Social determinants of health

Social workers are an integral part of the multi-disciplinary team in acute care settings that treat people with substance use disorders and help the team to address the social determinants of health that are impacting the patient's lives.

Social determinants of health are the economic and social conditions in which people are born, grow, live, work and age. They are shaped by disparities in the distribution of resources. This results in health inequities among different populations.¹ These conditions contribute to problematic substance use.¹

Determinants of health are conditions often beyond an individual's control and include factors such as²:

- Income and social status
- Education
- Physical environment
- Social support networks
- Genetics
- Health services
- Gender

Socioeconomic determinants of health also lead to adverse states that impact mental health and substance use as illustrated in the table below³.

Table 1. Adverse Health Effects of the Socioeconomic Determinants of Health

Determinant	Adverse State	Examples of Adverse Health Effects
Aboriginal status	Marginalization, exclusion, poverty	Addiction, lower life expectancy
Early life/Childhood	Poverty and deprivation	Blunted coping skills
Education	Lower achievement	Learned helplessness
Working conditions	High demands, low control	Workplace stress
Food security	Food insecurity and hunger	Guilt, shame
Gender	Lack of gender equity for women and LGBTQ2S+ populations	Dependency
Health care services	Lack of access or economic resources	Lack of treatment
Housing	Housing insecurity, homelessness	Stress, anxiety
Income	Low income and poverty	Lack of control, stress, depression, anxiety, hopelessness, more disease, earlier death
Social safety net	Lack of responsive services	Isolation
Social exclusion	Lack of participation	Alienation, anomie, discrimination, racism, violence
Employment	No paid income, job insecurity, lack of meaning and identity	Hopelessness

Improving the social determinants of health may reduce future admissions and improve substance-related outcomes. As such, during admissions it is important to address a patient's housing situation, financial supports, identification and health care coverage.

Housing

Evidence shows that the homeless population has significantly higher rates of problematic substance use⁴ which may be both a consequence of homelessness or result in homelessness.⁵

Homelessness is extremely detrimental with significant costs to both the individual and society. Individuals who are homeless have been shown to have higher rates of physical disease, mental illness, increased risk of infections as well as substance use disorders. This is not only costly to the health care system but also leads to mortality rates similar to those found in developing countries.⁶

The increased morbidity and mortality rates amongst this population is reflected in their higher acute care usage compared to their housed counterparts.⁷ Homeless individuals have much higher readmission rates and have been shown to be 4 times more likely to be readmitted within 30-days⁸ and in some cases in less than a week, often for the same or similar condition for which they had been initially discharged.⁹

As homeless individuals often have more severe medical problems and increased morbidity and mortality, it is important to arrange housing or linkages to community providers who can assist with housing applications prior to discharge. This ensures patients are not homeless, are discharged to unsuitable accommodations or become homeless as a result of their stay in hospital. Early involvement of social workers should be prioritized so that housing options and interventions can be explored as soon as possible. It is also important to plan for discharge and provide as much notice as possible to the patient on the date and time of discharge as this impacts access to available resources as well (i.e. transportation, meals, furniture, shelter, etc.).

Hospital discharge models that incorporate housing coordinators, outreach workers and not-for-profit organizations to assist specifically with raising awareness and education for hospital staff surrounding homelessness, while also securing safe and supportive housing for patients on discharge, have had promising results. These models have shown

a substantial decrease in inadequate and unsafe discharges of patients which led to a decrease in re-admissions to hospitals, reduction in length of stay of homeless patients and reduction in spending for hospital care and emergency department visits.¹⁰

Key approaches to addressing homelessness include early identification and interventions, connection to support agencies and ensuring safe discharge. It is important to identify the patient's current housing situation whether they are sleeping rough (outdoors), 'couch surfing', utilizing shelters, if they are precariously housed which may include temporary accommodations, unsafe or hazardous environments or at risk of eviction.

Interventions include exploring housing options based on a 'housing first' philosophy which focuses on providing safe and stable housing first and foremost and that housing is not contingent upon 'readiness' or abstinence from substance use.¹¹ To address issues surrounding substance use, housing options such as Permanent Supportive Housing, Assertive Community Treatment (ACT) teams and other harm reduction programs and services that reduce harms associated with problematic substance use (i.e. managed alcohol programs) may need to be explored. Interventions to address unsafe or hazardous environments may include risk and safety assessments and the involvement of Environmental Health Officers through AHS.

As housing resources differ in each community, it is beneficial to connect with the hospital social worker to explore what housing options are available in your area. Local not-for-profit agencies, community groups, shelters, health clinics or government agencies may also have resources for housing as well. Alberta's seven cities involved with housing and homelessness may be able to provide information and resources for the cities of Calgary, Grande Prairie, Lethbridge, Edmonton, Medicine Hat, Red Deer and the Municipality of Wood Buffalo and can be accessed through: <https://www.7cities.ca/>.

Financial supports

Income and income distribution is one of the most important social determinants of health. Various

studies have shown how higher income is generally associated with better health outcomes. Poverty also negatively impacts other social determinants of health such as food security, housing, transportation and the ability to cover the costs of treatment.

People who use substances often face challenges in achieving financial security, including employer discrimination, past legal history, unstable housing and more. The alternative source of income is social assistance which is often insufficient to cover all of an individual's needs. While high risk income generation (i.e.: involvement in the sex or drug trade) has been shown to lead to increased high risk drug consumption, the receipt of social assistance has been linked only to changes in patterns of consumption and not to overall drug use.¹² It is important to explore and maximize the amount of funding for which an individual is eligible. This will help them meet their basic needs and better improve their health outcomes, improve their uptake of health promoting behaviors, and reduce high risk behaviors and risks associated with their substance use.

Where possible, involve the hospital social worker to complete screenings and assessments for what funding, benefits and supports a patient may be eligible to receive.

To support a patient's application for income support, a medical note is often required to demonstrate the individual is unable to work for a specified amount of time. It is important to indicate the medical reason for why an individual is unable to work, the length of time they are unable to work, and the date on which this will be reviewed by a physician. The length of time an individual is unable to work may impact the amount of benefits they receive.

Another approach to addressing poverty is to look for opportunities to reduce a patient's financial burden. This may include exploring medication and health coverage for individuals that may be paying out of pocket for medications and health services that could be covered. Opioid agonist treatments have also been proven to reduce financial burden and high risk income generation behaviors. It would be beneficial to involve social work services to explore and problem solve approaches to addressing financial hardships.¹⁴

Identification and health care coverage

Often in the context of health services, the importance of identification is forgotten. Formal government identification such as birth certificates, SIN numbers, health care cards and/or government photo identification cards are key to accessing a range of services imperative to overall health and wellbeing. They allow for access to health care, housing, employment, bank accounts and various programs and services. A research study in Edmonton noted that securing identification (ID) is difficult without a permanent address, social supports and adequate funds.¹⁵ A pilot project in Calgary noted that ID was necessary for individuals to open a bank account, secure employment, access health care and secure housing.¹⁶

Barriers to accessing ID included the costs associated with securing the ID as well as not having the required documents to support their applications. These barriers are particularly challenging for individuals who struggle with homelessness, poverty, substance use and their physical and/or mental health. It substantially limits their choices and opportunities, limiting their ability to attain financial stability and improve their overall health and wellness. As described by Gordon (2012), "Without ID a person has effectively lost their 'membership card' to participating in society."¹⁷

Health care coverage is another issue that impacts the health and wellness of patients. Individuals will come to an acute care facility as they are not able to access care elsewhere due to not having provincial health care coverage. It may be that they have not applied for provincial health care or have not had their health care coverage transferred from another province. No matter the circumstance, individuals need to provide ID and proof of residency to receive provincial health care coverage. The barriers to securing identification are now the same barriers that exclude the individual from accessing health care services. Many individuals access health care services from hospitals and urgent care centers but will be left with unpaid bills and debts that will need to be addressed.

For individuals needing access to opioid dependency programs, it may be necessary to determine whether these programs accept individuals with out-of-

province health care coverage or whether they would accept patients who have no health care coverage. Individuals who are being discharged from acute care without a primary care provider will require one. For patients without health care coverage, it is important to determine which providers in the community will see patients without health care coverage. It is important to ensure follow up services are accessible to the individual while they are working towards securing provincial health care coverage.

Medication Coverage

Long before you provide a discharge prescription to a patient, it is important to ensure they have adequate coverage or resources to fill the prescription. Identify patients without medication coverage and work to secure coverage during hospital admission to prevent discharge delays. Work with the hospital pharmacist or social worker to determine and secure coverage for your patient.

Resources:

Various programs are now available to help address identification and health care coverage issues. These include ID projects such as the AHS ID program: <https://www.albertahealthservices.ca/about/page13445.aspx> where individuals can get help to secure ID, AHCIIP Coverage as well as utilize the site as a repository to store their ID and use as their mailing address.

ID certifiers at various community agencies also are able to assist with securing identification and AHCIIP coverage for individuals and some sites also have ID storage available to keep their documents safe.

Government of Alberta – About Homelessness: <http://www.humanservices.alberta.ca/homelessness/14632.html>

Canadian Council on the Social Determinants of Health: <http://ccsdh.ca>

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Holistic care of patients with substance use disorders

Culturally appropriate care

There is limited availability of culturally appropriate treatment for patients with substance use disorders (SUD). Although the principles of treatment are the same irrespective of culture, understanding the nuances of different cultures is crucial to successful treatment planning.

For patients with a SUD, it is important to assess fluency with English and the degree of self-identification with western culture. Where patients identify with non-western cultures, the following considerations may be beneficial:

- Substance use as a moral failing is a common misunderstanding in all cultures, but it is especially entrenched in non-western cultures. It may be helpful to spend time educating patients and their families, with translation services if necessary, on the organic nature of SUD and how various behaviors are symptoms of this disorder.
- With the patient's consent, consider actively recruiting the support of families in the holistic treatment plan. Family plays a substantial, supportive role in many patients' lives, and are key in framing and reinforcing messages from treatment providers. Building awareness about the importance of boundaries and harm reduction is key.
- Maintaining confidentiality is important, and must be balanced against a greater desire by family and social supports to be involved in the circle of care. Taking the time to delineate with the patient what information can be shared is important to keeping families engaged while respecting patient confidentiality. Generally, but not always, greater transparency with the family, with patient consent, will allow for more effective treatment.
- Spirituality can be important to these patients. When a patient feels shame because of their

SUD and feelings of moral inadequacy, this shame can sabotage recovery. Encouragement by a spiritual professional may help patients overcome these barriers.

- If peer support workers that understand a specific culture are available, involve them early in care as it can greatly improve the chances of the patient's recovery or engagement into therapy.
- Professional translation services are preferred over family-based translation. Resistance may be encountered if the community is small (and if the patient knows the translator), but nonetheless proper translation of information is important.

Culture should not be thought of as a static, coherent amalgam of ideas and values that determine what individuals think and do. More contemporary definitions view culture as "a set of malleable and changing cognitive options, a 'tool kit' from which individuals and groups choose in order to accomplish specific goals."²

The DSM-5 has defined culture as:

Culture refers to systems of knowledge, concepts, rules and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals and customs, as well as moral and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience.

The Cultural Formulation Interview included in the DSM-5 suggests 16 open-ended questions that help the clinician get some insight into how the patient is defining their problem and what they expect from treatment.

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Indigenous approaches to harm reduction

Indigenous approaches to harm reduction reach beyond addressing physical dependence on substances.¹⁻⁵ In general, they emphasize holistic and trauma-informed care and education. They call attention to mental, emotional, spiritual, and physical impacts of colonization to heal the whole human being,⁶⁻⁸ including family and community relationships. Indigenous advocates have highlighted within Alberta that harm reduction strategies may produce inadvertent or even adverse outcomes when inattentive to social determinants (e.g., poverty, multi-generational trauma), structural determinants (e.g., racism, stigma, lateral violence) and political determinants (e.g., service funding gaps, limited access to or inappropriate care) that drive disparities in mental health and addiction.

In Alberta, disparities impacting Indigenous people are evident in rates of opioid dispensation, opioid-related emergency department visits and associated hospitalizations that are significantly higher for First Nations (FN) patients than among non-FN people.^{9,10} A 2017 report indicates that rates of apparent accidental opioid drug toxicity deaths among FN people is as much as three times higher than among non-FN people in Alberta.¹¹

Part of a trauma-informed approach for Indigenous patients is to recognize the role of historical and ongoing adversities perpetuated at systems levels that undermine healing from multi-generational trauma. Research across many disease entities and especially in addiction consistently indicates that social connectedness and culturally congruent care are protective of health and healing.¹²⁻¹⁵ This highlights the relevance of Indigenous liaisons as core members of care teams and the value in engaging with rather than restricting the presence of family and community supports.¹⁶

Historical context

Historical perspective is an important resource for harm reduction advocates, so as to not assume that the same educational strategies are appropriate with Indigenous providers or community partners.

This perspective also contextualizes hesitations around harm reduction that are informed by specific experiences of the colonial legacy of health care¹², stigma¹⁹ and social inequities. Indigenous communities have a long experience with the misuse of addictive substances via colonization. This often shapes mistrust expressed by some Indigenous people that common harm reduction strategies (e.g., safe injection spaces, OAT, and syringe exchange programs) are incomplete¹⁶ and do not address the larger task of healing the whole human being from a multi-generational history of violence.¹⁷ More familiar within First Nations in Canada are prohibitionist and abstinence-based models for restricting substance misuse.¹⁸ At minimum, recognition of historical and systemic factors²⁰ that continue to drive addictions among Indigenous communities is a starting point for working with Indigenous partners to improve care.

In Alberta, whiskey traders in the nineteenth century followed Blackfoot camps around with toxic alcohol-based concoctions laced with other poisons that in some instances killed whole clans. Fort Whoop-Up's name in Lethbridge²¹ is testament to the systematic disruption of traditional social and cultural systems through the perpetuation of addiction by outside entities. In the mid-twentieth century, the prohibition of alcohol on reservations was lifted just as the residential schools system gave way to the Sixties' Scoop.²² For more than a century now, residential schools and child welfare systems have forcibly removed many Indigenous children from their families and communities, deepening family disruption and historical trauma. Today, large segments of some communities may have concealed substance misuse issues; this may increase stigma within communities and families, discouraging those struggling privately with addiction to seek help. Additionally, the largely abstinence-based approaches advocated by the National Native Alcohol and Drug Abuse Program (NNADAP) movement, which emerged in the 1970s and 1980s, remain central to many community-based addictions initiatives.

Integrating holistic approaches

From a holistic approach attention to healing from multi-generational trauma, increasing access to OAT

through hospital-based inductions may open a person to emotional crisis, especially if unresolved grief driving substance misuse remains unsupported.²³ This highlights added risk to hospital-based OAT inductions that occur in the absence of established transitions to community-based or primary care settings that may be better positioned for longitudinal and integrated care. It also strengthens rationale for an enhanced role attributed to Indigenous liaisons as core members of acute care teams when they can connect clients to mental, emotional and spiritual supports, and serve as advocates for improved transitions to community-based resources.

Transitions for Indigenous clientele are not just between levels (i.e., primary/tertiary) or jurisdictions (i.e., federal/provincial) of health care. Given disproportionate representation and mortality of Indigenous people in child welfare²⁴ and criminal justice systems²⁵, effective transitions require consideration for coordination with providers across systems. Examples of multi-agency, community-driven committees to collaborate in supporting acute cases have been modeled for reducing crime and victimization. These emphasize the need for cross-sector collaboration for appropriate transitional support. Hospital-based staff should recognize and interface with peers practicing under similar licenses within diverse community settings and remote geographic settings. While patient privacy is important, refusal to attempt to coordinate after care can leave Indigenous clients isolated, disconnected and in a revolving door of detox and rehabilitation services. Additionally, a narrow understanding of nuclear families as the only appropriate care supports permitted in hospital settings or for discharge planning can further constrain community supports available for Indigenous clients.

Providers are encouraged to be inclusive and responsive to patient-identified resources within family and community networks. It is important to recognize the challenges of remote rural settings and the

barriers to access to pharmacies, nursing and medical care when prescribing OAT for Indigenous patients. Finally, an Indigenous approach to treating neo-natal abstinence syndrome highlights the relevance of encouraging mother-child bonding through breast feeding and regular contact, rather than further separating families and rupturing the potential for supportive bonds during a delicate time of healing, ideally for mothers and newborns alike.²⁶

What can we do in acute care?

The following recommendations are aligned with key external directives for equity-based institutional transformation, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)²⁷ and Truth and Reconciliation Commission of Canada calls to action²⁸. In acute care settings, providers are encouraged to:

- Provide trauma-informed care that recognizes that disparities in substance use among Indigenous people have social and historical roots.
- Recognize social and historical factors that influence why not all patients with substance use issues exhibit trauma-driven addiction in the same way.
- Engage with rather than restrict social and cultural resources supportive of healing among Indigenous people, including creating inclusive spaces for family supports.
- Mobilize Indigenous liaisons as possible members of core care teams and resources for effective transitions out of acute care settings.
- Enhance understanding of Indigenous determinants of health through AHS Indigenous health training modules (<https://www.albertahealthservices.ca/info/page7634.aspx>) and similar resources elsewhere (<http://www.sanyas.ca>).

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Culturally sensitive care for sexual and gender minority (LGBTQ2S+) patients

There is limited availability of culturally sensitive treatment for patients who identify as a sexual and gender minority (LGBTQ2S+) with substance use disorders (SUD). People who identify as a sexual and gender minority are overrepresented among patients with substance use disorders, in large part due to stigma and discrimination. Although the principles of treatment are the same, understanding the nuances of people who identify as a sexual and gender minority is crucial to successful treatment planning.

The following considerations may be beneficial:

- Self-identification is key. This includes using the name a person goes by, which might be different than what is on government issued ID.
 - Names are important to all of us regardless of gender identity. Our name is part of our identity, our story and our history. When we use the name people go by, we are telling them, “We respect and care about you. You are welcome here.” Not validating someone’s identity, their name and pronouns may present a triggering situation, raising old trauma which could encourage past behaviors and substance use.
 - Pronouns are words we use to talk about people when we don’t use their name. Next to a person’s name, the pronouns we use when talking about others are an important and meaningful way of showing respect and dignity. Most often, we will use “he” or “she” when addressing people who identify as male or female respectively and who use those pronouns. However, not everyone identifies as male or female. “They” may be used by some people who do not identify with one gender. Everyone has the right to be addressed by their chosen pronouns that align with their gender identity, and/or gender expression.
- It can be helpful to practice what to say when you are going to introduce yourself. Consider using your pronouns when you introduce yourself and don’t assume a patient’s gender based on their physical appearance. For example, you could say:
“Hi, my name is _____, I use _____ pronouns (He/Him; She/Her; They/Them).”
 - If you use the wrong pronouns when addressing a patient, a simple apology will do. Acknowledge the mistake, apologize and move on.

Confidentiality

- When someone discloses their sexual orientation or gender identity, they have shared something very personal. This information is confidential and should only be shared with the patient’s permission, if it is relevant to their care.
- Sharing information about an individual’s sexual orientation or gender identity that is not known by others is commonly referred to as “outing.” “Outing” someone is not only disrespectful, in many cases, it could put the person at significant risk of discrimination, harassment and violence.
- Consider how a person’s social identities (e.g., race, gender, orientation, income, ability, etc.) intersect and how this impacts their health. An example of intersectionality would be for people who identify as Two-Spirit (2S). Two-Spirit is a cultural term used by some Indigenous people to mean a person who has both male and female spirit and many include concepts of spirituality, sexual orientation and gender identity.

Trauma informed care

It is very common for people accessing substance use treatment and mental health services to report experiences of trauma and violence. “Trauma is defined as experience that overwhelms an individual’s capacity to cope.”¹ It is important to recognize the distinction between trauma, post-traumatic stress disorder (PTSD) and violence. While terms such as PTSD, violence and trauma have been used interchangeably, Stephanie Covington (2003) provides a distinction: “Trauma is both an event and a particular response to an event; PTSD is one type of disorder that results from trauma.”

Trauma Informed vs. Trauma Specific

Trauma informed services recognize how a patient’s experiences can influence their self-perception,

behaviors and their ability to create and maintain a clinical relationship with a service provider. Providing trauma informed services does not require a patient to disclose specifics about their trauma history or experiences. It is a patient-centered approach, promoting freedom of choice, safety and empowerment for the patient.

Alternately, trauma specific services seek to address the specific traumatic events in a patient’s past, through the use of evidenced based clinical interventions. It is a very specific form of counselling/ support and should not be undertaken or attempted unless a service provider is clinically competent to provide the service. A well-meaning service provider risks re-traumatization, or harm to the patient, should they attempt to provide service outside their scope of practice.

Resources:

Trauma Informed Practice: <https://insite.albertahealthservices.ca/Main/assets/tms/amh/tms-amh-trauma-informed-practice.pdf#search=trauma%20informed%20care%20learning%20modules>

Three e-learning modules (which form a series) are available on MyLearning Link:

- What is trauma informed care?
- What is trauma?
- Disaster response: introduction to key concepts related to psychological preparation for and psychological response after a disaster. The purpose of this module is to increase knowledge about psychological trauma that may result after a disaster and improve practice to be more trauma informed and patient/family centered.

Becoming Trauma Informed – CAMH – Edited by Nancy Poole and Lorraine Greaves

Seeking Safety – Lisa M. Najavits

Manitoba Trauma Information Centre: <http://trauma-informed.ca/>

Stephanie Covington: www.stephaniecovington.com

References:

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Addiction counselling

An addiction counsellor uses patient-centered, holistic and evidenced-based approaches to support individuals experiencing psychosocial issues as a result of alcohol use, substance use and/or gambling.

As part of an acute care-interdisciplinary team, an addiction counsellor provides individual support, referral to outpatient resources and connection to

allied health professionals, such as psychiatry or mental health practitioners. Addiction counsellors can also improve patient outcomes by acting as an advocate or liaison between the patient and other members of their inpatient care team. Ti L, Ti L (2015) concluded that patient advocates, mental health and addiction consultants, “may serve to build stronger relationships between physicians and patients...and minimize discharges against medical advice”.¹

Resources:

All Alberta Health Services Addictions Counsellors are trauma informed, and concurrent capable. A comprehensive directory of addiction and mental health supports can be accessed at <https://www.albertahealthservices.ca/amh/amh.aspx>

The Addiction Helpline is a confidential telephone service, staffed by information and referral specialists, and provides alcohol, tobacco, other drugs and problem gambling support, information and referral to services. It operates 24/7 and is available free of charge to all Albertans. It can be accessed by calling 1-866-332-2322

Alberta Health Services has also created learning modules geared towards enhancing the understanding of addiction and mental health issues, and increasing capacity, regardless of discipline. These modules are available to staff and to the general public and can be accessed at <https://www.albertahealthservices.ca/info/Page11536.aspx>

Practice Standards: <https://insite.albertahealthservices.ca/Main/assets/Policy/clp-prov-practice-standard-addiction-counsellors-hcs-225-01.pdf#search=addictions%20counsellor>

References:

1. Ti L, Ti L. Leaving the Hospital Against Medical Advice Among People Who Use Illicit Drugs: A Systematic Review. *Am J Public Health*. 2015 Oct 15;105(12): e53–9.)

How Peer Support Workers can help

Peer support is “an emotional and practical support between two people who share a common experience, such as a mental health challenge or illness. A Peer Support Worker has lived through that similar experience, and is trained to support others”.

Peer Support Workers are certified through Peer Support Canada and the Canadian Mental Health Association, and adhere to standards of practice and competencies. By using their own lived expertise as a bridge, Peer Support Workers are often perceived as trustworthy and can readily relate to patients. They can instill hope by being a living example of someone who has overcome adversity. Patients often feel a strong connection to a Peer Support Worker, as the patient feels understood. This may allow a patient to feel more comfortable in disclosing personal details, which will ultimately assist individuals in accessing the medical and substance-related care they wish to accept.

Peer Support Workers can provide both formal and informal support. Services and support can include:

- Serving as a liaison between patient and the clinical team, helping hospital staff understand the perspective of the patient;
- Listening and sharing lived experiences with the patient;

- Accompanying and supporting patients at their medical, income support, bank, housing or other appointments;
- Providing positive distractions including watching TV, using coloring books, journals, art supplies, books and obtaining seasonal items (clothing for summer and winter);
- Accompanying a patient as they access leisure activities including movies, games, art and taking them to mall;
- Helping a patient access community programs and resources;
- Supporting a patient with in-hospital services and supports, including grooming supplies, access to the library, chapel, smudge room, computer room and pet therapy;
- Obtaining government identification and an Alberta Health Care card.

Peer Support Workers can best be supported themselves by being included as part of both the care and management teams in the hospital. As for all health care workers, it is important to have a workplace environment supportive of self-care and to check in with Peer Support Workers from time to time to see how they are doing with their own self-care.

Resources:

More information regarding peer support workers can be found at <http://peersupportcanada.ca/>

Involvement of the patient's key support people

Recognizing the importance of including the patient's support people in care is key to managing a patient's visitors. Many of the patient's identified support people will have greater knowledge and experience in dealing with the patient's substance use than the health care team. Hospitalization can be a very stressful, often a triggering experience for patients. Recognizing the appropriate social supports that may assist the patient is important.

In situations where there are more visitors than would be reasonable for any patient, consider discussing with your patient who the key support people will be during their hospitalization. This conversation should be phrased in a way that is supportive of the patient and is not further stigmatizing.

It is also important to understand any organizational or site-specific policies or guidelines pertaining to visitors and support for patients and their families. The Harm Reduction for Psychoactive Substance Use policy states that patients and families are integral members of the health care team. Health care providers should

adopt a patient- and family-centered approach to the care and services provided and include the family, as appropriate, in a respectful, non-judgmental manner. Family is defined in broad terms and means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Consider including the patient's supports in conversations with the patient, especially when setting expectations of what will happen while in hospital, ensuring the patient has provided their informed consent to involve these people and that this consent is documented. Establishing a clear, consistent understanding at the outset of a hospital stay of what is appropriate and any specific rules that visitors are expected to follow can help prevent future negative interactions. In situations where the patient's visitors are not following established expectations or behaving in a respectful way, address the behavior in a fair, clear way. In these instances, re-establishing expectations with both the patient and the visitor in a timely manner is important.

References:

Alberta Health Services (2018) Engagement and Patient Experience: <https://insite.albertahealthservices.ca/qhi/Page171117.aspx>

Workshop Summary Report: A Family-Centered Approach to Substance Use in Alberta. Report Date: July 4, 2017; Meeting Date: March 9, 2017. Dr. Elaine Hyshka & Heather Morris (University of Alberta), Dr. Rebecca Haines-Saah (University of Calgary), Dr. Emily Jenkins (University of British Columbia)

Discharge planning

Minimizing discharges against medical advice

People who use drugs are at a higher risk of discharge against medical advice (AMA), with some studies indicating prevalence as high as 30%.¹ Strategies to minimize the risk of patients leaving begins at admission with a comprehensive assessment. This includes open, judgment-free conversation around:

- Understanding where your patient is at with their substance use, including patterns of use, history of withdrawal, history of overdose;
- Any previous unsuccessful hospital admissions.

Preventing discharge against medical advice is best served by understanding the reason the patient may leave and working with your patient to strategize ways to address these reasons. Unmanaged pain, active substance use and withdrawal are all high risk factors that contribute to patients leaving early. In situations where a patient is experiencing unmanaged pain or withdrawal, it is important to inform the patient's physician and/or an Addiction Medicine specialist.

For patients who are actively using substances in hospital, incorporating harm reduction principles into

the patient's care plan is one strategy that should be considered. This can include providing education on safer use, offering harm reduction supplies, providing information on supervised consumption services available, offering an overdose response kit and connecting with other support services such as Peer Support Workers (if available) or community supports. When a patient is struggling to adhere to the typical hospital schedule and rules, you may consider adjusting their care whenever possible.

In situations where despite best efforts, the patient remains at high risk to discharge AMA, proactive discharge planning should be considered. This could include ensuring required prescriptions are available on the chart or faxed to the patient's community pharmacy, arranging follow-up if and when possible, addressing immediate safety concerns and communicating with community resources. Finally, in situations where patients are leaving against medical advice, the health care team has an obligation to provide as much education and support as the patient will accept.

Some planned or unplanned discharges may raise some ethical concerns. Consult with your Clinical Ethics Service.

References:

1. Lingping Ti, & Lianlian Ti. (2015). Leaving the hospital against medical advice among people who use illicit drugs: A systematic review. *American Journal of Public Health*, 105(12).
2. McNeil, R., Small, W., Wood, E., & Kerr, T. (2014). Hospitals as a 'risk environment': An ethno-epidemiological study of voluntary and involuntary discharge from hospital against medical advice among people who inject drugs. *Social Science & Medicine*, 105, 59-66.

Successful transitions to primary and community-based care

Individuals with co-occurring disorders, mental illness or substance use disorders (SUD) are more likely to experience chronic homelessness and less likely to engage in treatment, making it difficult to recover from their diseases.⁸ Fragmentation of health care services, which can be difficult to navigate, also present a substantial barrier to the continuity of care at discharge.¹ As a result, individuals experiencing homelessness, mental illness or substance use disorders are a small subset of the population but have very high usage rates of emergency departments and acute care resources.⁵

Discharging from hospital is a critical moment in arranging appropriate ongoing care for individuals with SUD. Proper transitional care into the community is vital to good patient care and ultimately reducing homelessness.⁸ To improve outcomes for patients experiencing homelessness, mental illness or substance use disorders, it is important for the care team to foster relationships within the community, communicate with community agencies and coordinate management plans to optimize continuity of care.³

For community primary care providers receiving patients from hospital, it is important for the hospital to provide adequate information and notification about the discharge plan. In a study by Robelia, Kashiwagi, Jenkins, Newman, and Sorita (2017), the authors noted that more than 25% of community providers did not have a discharge summary or relevant information to manage a patient in the community. Community providers should be provided with relevant documents to ensure continuity of therapy and management plans that include follow up appointments, medications administered while in hospital, and changes in management (including its rationale) that are to continue once a patient is transitioned into the community. It is important for the community provider to be given the patient's discharge summary and information so they can continue any therapies and redirect a patient back to hospital if required. For patients who choose to leave against medical advice, it is critical that a community

provider receive a patient's documents in a timely manner to ensure patient safety in prescribing, particularly when the patient has a substance use disorder.

Involving a team pharmacist or, if you do not have one, consulting with a hospital pharmacist, can help with transition of care for your patient upon discharge.² A hospital pharmacist can assist in identifying concerns such as supply shortages and medication coverage issues early on. By coordinating with the community pharmacy directly, they can resolve many of these issues before discharge. This supports the patient and will minimize calls to the unit post-discharge. Pharmacists may also provide guidance to the patient or be able to direct them to resources to facilitate enrolment with a drug assistance program they may qualify for. Where the patient has a drug plan but the medication selected is not covered, the pharmacist may be able to suggest an alternate that is a benefit on the most recent formulary listing or be able to initiate a special authorization request under the plan, as applicable. As a number of steps may be involved, it is advisable to engage with a pharmacist at an early stage.

You may want to consider communicating with community providers throughout a patient's hospital admission. In one survey, patients agreed that they received better care from someone they trust more and have known for a long time and that community providers are better suited to disclose a diagnosis and treatment options.⁴ The community provider can provide background history and valuable input into discharge planning. Community providers can also convey what goals have been set when the patient was in the community and support the hospital team in furthering these goals while in hospital. Inclusion of the community provider can also maximize the efficient use of resources.

Some patients may be discharged into the care of a correctional facility. In these cases, the same principles about communicating with the care team taking over the medical and medication management of the patient should be followed. In particular, working with the correctional health care team to ensure patients are able to continue on opioid agonist treatment

while incarcerated is critical and can require some coordination. Having a follow up plan in place should the patient be abruptly discharged from corrections can also help to prevent patients from unintentionally discontinuing treatment.

Please see Appendix C for a sample discharge checklist.

References:

1. Backer, T.E., Howard, E.A., Moran, G.E. (2007). The role of effective discharge planning in preventing homelessness. *Journal of Primary Prevention*, 28, 229-243.
2. Balling L., Erstad BL, Weibel K. Impact of a transition-of-care pharmacist during hospital discharge. *J Am Pharm Assoc*. 2015;55(4):444–448.
3. Biringer, E., Hartveit, M., Sundfor, B., Ruud, T., Borg, M. (2017). Continuity of care experienced by mental health service users - a qualitative study. *BMC Health Services Research*, 17, 63.
4. Hruby, M., Pantilat, S.Z., Lo, B. (2002). How do patients view the role of the primary care physician in inpatient care? *Disease-a-month*, 48(4), 230-238.
5. Kahan, D., Leszcz, M., O'Campo, P., Hwang, S.W., Wasylenki, D.A., Kurdyak, P., Harris, D.W., Gozdzik, A., Stergiopoulos, V. (2016). Integrating care for frequent users of the emergency departments: implementation evaluation of a brief multi-organizational intensive case management intervention. *BMC Health Services Research*, 16, 156.
6. Poremski, D., Harris, D.W., Kahan, D., Pauly, D., Leszcz, M., O'Campo, P., Wasylenki, D., Stergiopoulos, V. (2016). Improving continuity of care for frequent users of emergency departments: Service user and provider perspectives.
7. Robelia, P.M., Kashiwagi, D.T., Jenkins, S.M., Newman, J.S., Sorita, A. (2017). Summary: National primary care provider perspective of challenges and opportunities. *Journal of the American Board of Family Medicine*, 30(6), 758-765.
8. Sun, A-P. (2012). Helping homeless individuals with co-occurring disorders: The four components. *Social Work*, 57(1), 23-37.

Part 3:

How our health
system can be
more supportive

Creating hospital environments that maximize patient and staff safety

A harm reduction approach is about providing safe care or a 'sense of safety' with respect and without judgment. This means that the health care professional and the patients work as partners with compassion and kindness to address care decisions and issues around safety. The patient's perceptions and the health care professional's perceptions are both valued and shared with honesty and respect. This approach promotes both staff and patient safety.

It is essential that clinical practice environments support health care professionals in their ability to provide safe, competent care to their patients when applying a harm reduction approach. Many factors can play into what is considered a safe environment and how managers, staff, physicians and patients perceive and respond to the environment and the interactions that take place. Some of these factors include:

- leadership support to facilitate changes to create an environment of harm reduction, respect, dignity and safety;

- the presence of mentorship and support for less experienced professionals in taking steps to implement a harm reduction approach;
- one's personal values can positively or negatively influence judgment, decisions and actions towards a safe quality environment for both staff and patients. One needs to take the opportunity for self-reflection on personal values towards substance use, abstinence and harm reduction principles and explore opportunities to hear and reflect on the stories and experiences of persons with lived experience and their families.

Managers, staff and physicians need to be aware of what is available to support safe, competent practices in their work setting, and resolve personal situations that can impact the care provided. Managers, staff and physicians should also be encouraged to seek assistance and support without fear of judgment or reprisal. The creation of a psychologically safe environment is essential to health promotion in all settings.

Resources:

Staff may experience moral distress in some practice situations and AHS Clinical Ethics is available for consultation and support.

The Employee and Family Assistance Program (EFAP) is available for counselling support following a traumatic event or loss, or to address a personal life crisis.

The AHS Harm Reduction Services Team is available to advise managers and staff on opportunities for harm reduction practices in their work setting. Please email harm.reduction@ahs.ca.

AHS Harm Reduction for Psychoactive Substance Use Policy: <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-harm-reduction-for-psychoactive-substance-use-policy.pdf#search=harm%20reduction%20policy>

Involving people with lived and living experience in designing health systems

Advisory models

The health system benefits greatly from patient and community engagement to inform the design, implementation, evaluation and improvement of services. Acute care teams should include and involve people with lived and living experience (PWLE) not only within individual patient encounters, but also in creating patient-centered services for PWLE. The involvement of PWLE in an advisory capacity is an opportunity to build trust, address PWLE needs and preferences, and create the capacity to involve PWLE as team members within acute care. PWLE acting in an advisory capacity can help identify current community trends, design services and their evaluation, recruit and train competent staff and troubleshoot challenges.

This trust-building opportunity must be used wisely. With individual patient encounters, involving PWLE as advisors requires a person-first, trauma-informed and culturally safe lens. Keep in mind the following:

- Set clear expectations and roles for all stakeholders—remember who is asking whom for guidance.
- Set meetings at a time and place that is acceptable to PWLE, providing sufficient notice and remuneration for travel expenses.
- Compensate people with lived and living experiences for their time and expertise, ideally in cash given the structural challenges with other forms of remuneration.

- Recognize that technology access, health issues and other considerations may require flexible response times.
- Involve several individuals, ideally nominated by a PWLE organization, to share the advisory responsibility.
- Provide training and other supports including honoraria.
- A PWLE's word means a lot to other PWLE; for this reason, describe projects fully to ensure PWLE understand the implications and can support an initiative with confidence.
- Ensure confidentiality for participants.
- Value and respect all PWLE voices.
- Follow through promptly on active issues to avoid disappointment and re-traumatization.

PWLE can also play a valuable role in Peer Support Worker positions, assisting with intake/paperwork, spending time with patients who might otherwise be alone and bringing a patient from one room/ appointment to another. This can be a relief for hospital staff and added support to the patient. This can be done in hospital and extended into the community to assist with follow up appointments, medication reminders and referrals to other organizations or health care specialists. PWLE who are hired into these formal positions will require training and support to thrive in the health care workplace. Please see the section in this Guidance Document on 'Peer Support Workers'.

Resources:

"Nothing About Us Without Us" guidance on involving PWLE:

<http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Greater+Involvement+-+Bklt+-+Drug+Policy+-+ENG.pdf>

"Peerology" document by and for PWLE on what should be reasonably expected when choosing to engage:

<http://librarypdf.catie.ca/PDF/ATI-20000s/26521E.pdf>

12 tips for interacting with PWLE during service co-design: http://www.orgcode.com/input_from_persons_with_lived_experience

Compensating people with lived and living experience

Compensating people with lived and living experience (PWLE) for their time and expertise in helping to design and evaluate health services is a best practice supported by academic research and endorsed by the British Columbia Centre for Disease Control (BCCDC), the Canadian Mental Health Association, The Canadian HIV/AIDS Legal Network, The Pacific AIDS Network and the Canadian AIDS Society.^{1,2,3,4,5,6,7} This practice is ethical, supports inclusion and equitable participation and helps address power dynamics.^{4,6}

When remunerating PWLE, remember the following:

- Provide fair compensation/stipend for the services provided (including parking, meals, etc.) and ensure flexibility with payment options, including cash (preferably in small bills). Where appropriate, hire PWLE on a full-time or long-term contract basis.^{1,2,4,7}

- Establish expectations early in the collaborative process regarding the work to be performed as well as payment amount, frequency and method. It is helpful to have clear organizational policies and processes in this regard.^{1,2,4}
- Before agreeing on payment, be sure to understand the implications for PWLE with respect to social assistance, pension plans or disability payments.^{1,2,4}
- “When in doubt, ask.”²

The BCCDC has an excellent and practical peer payment guide (for short term payment) that includes recommended payment amounts based on the role performed.¹ Appendix A of the BCCDC document contains a helpful checklist. Appendix B of the BCCDC document provides an example of a payment process at a large Canadian regional health authority.

Resources:

- BCCDC, Peer Payment Guide 2018, http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/peer_payment-guide_2018.pdf
- BCCDC, Engagement Principles and Best Practices, <http://towardtheheart.com/assets/uploads/1516141269o4KkCMkq2ytmhxVyGjcQ9DSWtUo1d8FLnzYdlv.pdf>

References:

1. BCCDC, Peer Payment Guide 2018, http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/peer_payment-guide_2018.pdf
2. BCCDC, Engagement Principles and Best Practices, <http://towardtheheart.com/assets/uploads/1516141269o4KkCMkq2ytmhxVyGjcQ9DSWtUo1d8FLnzYdlv.pdf>
3. Canadian HIV/AIDS Legal Network, ‘Nothing About Us Without Us’ <http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Greater+Involvement+-+Bklt+-+Drug+Policy+-+ENG.pdf>
4. Pacific AIDS Network, Compensating Peer Researchers, <https://pacificaidnetwork.org/files/2014/06/CBR-Tips-Compensating-Peer-Researchers-Pacific-AIDS-Network-Final.pdf>
5. Canadian AIDS Society, Peerology, <http://www.cdn aids.ca/wp-content/uploads/Peerology-Final-PDF-with-Image.pdf>
6. Greer AM, Luchenski SA, Amlani AA et al. Peer Engagement in Harm Reduction Strategies and Services: a Critical Case Study and Evaluation Framework from British Columbia, Canada. BMC Public Health 2016; 16:452. Available at: <https://bmcpublihealth.biomedcentral.com/track/pdf/10.1186/s12889-016-3136-4>
7. Canadian Mental Health Association, ‘Care Not Corrections’, April 2018. https://cmha.ca/wp-content/uploads/2018/04/CMHA-Opioid-Policy-Full-Report_Final_EN.pdf

Reducing systemic barriers to accessing care

Low-threshold and culturally safe service delivery models

Low threshold service models aim to make minimal demands, do not require individuals to be abstinent in order to receive services, and strive to reduce other barriers to access as much as possible. This means being accessible, accommodating, affordable, welcoming and supportive. This may pertain to the location of the service site, hours of operation, low- or no-cost care, rules and policies, and approaches that are positive and patient-centered. In an acute care setting, this may be collaboratively outlining the needs of care with the client, identifying concerns and looking to resolve them (e.g., needing to go off-site to smoke, need for OAT, or access to harm reduction supplies and services) in a manner that encourages continuing care and attempts to bridge gaps in care.

Staff may consider discussing with the patient mutually established times where they will remain on the unit (e.g., for medications, dressings, or consult with physician), unit expectations/policies and referral options to support services (e.g., social work, peer navigator/support, spiritual care, harm reduction supplies, supervised consumption services). Methods to socially control, regulate or prevent substance use have been found to be ineffective in the hospital setting and can increase substance use-related risks, and the likelihood of patients being discharged against medical advice.² Hospital-based harm reduction interventions promote patient-centered

care by prioritizing access to care and focusing on reducing risks over enforcement of abstinence-based policies. The Alberta Health Services Harm Reduction for Psychoactive Substances Use (2019) policy does not expect abstinence to receive health care services. To ensure patients will access such supports, they need to be provided in a safe but flexible manner with a recognition that what works for one patient may not work for another. Be sure to identify a pharmacy of the patient's choice that is suitable for follow-up with treatment and medication management in the community.

Culturally safe care approaches are based on the premise that patients have the right to determine what safe or unsafe care is, and that people's lived or living experience impacts their perception and response to care.⁴ It's an approach of recognizing and respecting differences, and seeking knowledge about patients in a compassionate way. Staff maintain an environment of trust, respect, compassion, dignity and collaboration. It is about openness, acceptance, being present and actively listening to the patient's story and needs. Staff should strive to make the patient feel safe, respected and heard when they interact with care providers and accept care. Accommodations can be made (based on a patient's consent) to refer to cultural or spiritual care/support providers and involving cultural tradition/ceremony where appropriate.

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How to effectively communicate with the patient and other health professionals

To effectively implement a harm reduction approach in a clinical practice setting, it is essential there is respectful, consistent and effective communication between all members of the health care team, including patients. Collaborative relationships where differences are recognized, appreciated and used for the betterment of all members of the health care team are typically positive, encourage participation and facilitate a range of views to be discussed, debated and compared. Relationships that have power differentials and negative attitudes often enforce conformity and mistrust and leave individuals silenced, afraid to voice concerns and with disturbing frequency, bullied or mistreated. A harm reduction approach requires a respectful, safe and encouraging clinical environment based on trust, compassion, goodwill and effective collaborative relationships and communication and promotes patient and family-centered care.

A non-judgmental attitude towards patients and health care colleagues is the best approach when working with persons with substance use disorders. It is also the way to help the patients avoid harm from their use and achieve the highest level of health

possible. Negative attitudes towards the patient and within the health care team can result in poor patient self-esteem and negative clinical outcomes. When working with a harm reduction approach, it is essential that leaders and the team stay alert and attuned to their language, behaviors and attitudes and take steps to respectfully address negative behaviors and viewpoints with honesty, kindness and compassion. Research has shown over time that positive communication, trust, compassion and respect within the health team will have a positive impact on the quality of care provided and received by the patients and their families.

The Health Quality Council of Alberta (March 2013) developed a number of resources including a tool kit to support effective communication and to help leaders, staff and physicians address behaviors and communication that could be disruptive, discriminatory and potentially impede quality safe patient care. The web site below provides a link to these resources:

<http://hqca.ca/health-care-provider-resources/frameworks/managing-disruptive-behavior-in-the-healthcare-workplace-provincial-framework/>

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Appendix A: Sample triplicate prescription

Using TPP Alberta's secure 2-part form for Type 1 TPP drugs:

- The dispenser **MUST** be presented with the top copy of the TPP secure form (i.e. the Pharmacy/TPP copy). The prescriber should retain the second copy. *If the prescription is faxed directly to the pharmacy, the prescriber keeps both original copies, voiding the top one. The pharmacy uses the faxed copy for dispensing and submits a photocopy to TPP Alberta for compounds, office use and veterinarians and Yukon prescriptions.*
- Prescribers should **NOT** leave their copy in the TPP pad to protect patient confidentiality (e.g., if a pad is lost or stolen). Keep the prescription with the patient record.
- Prescriptions are valid **ONLY** for 72 hours. A dispenser **MUST** log or fill the prescription within 72 hours of issuance. A secure prescription form **CANNOT** be honored after midnight on the third day.
- A healthcare number, Personal Health Number (PHN) is **REQUIRED** for patient identification. For out of province patients, enter their provincial healthcare number and indicate the province. *If the patient is an animal this field is left blank.*
- Provide **ALL** given names to reduce duplication of patient profiles in the TPP database. *If the prescription is for an animal, the form should include the animal name followed by the owner's name in brackets.*
- Provide patient date of birth. *If the prescription is written for an animal, enter the animal's date of birth here.*
- Provide the patient's address to help further verify their identity.
- A separate form is **REQUIRED** for each TPP medication. Different strengths of the same medications are acceptable on the same form **ONLY** if the orders are legible, and clearly indicate the prescribed dosage & quantity. *Refills are not allowed, but interval dispense protocols are permitted (e.g., release 14 tablets every Monday).*
- Indicate total prescribed quantity **BOTH** numerically and alphabetically.
- The Prescriber **MUST** provide the intended indication for therapy. This information is useful for assessing appropriateness of therapy and optimizing safe patient care. *The Check-boxes MUST NOT be interpreted as a list of valid indications for TPP Medications. Prescribers and dispensers MUST individually verify the validity of each indication within the context of the clinical care being provided and the history for each patient.*
- Directions for use **MUST** be as complete as possible to allow for verifying quantities. Part-fills are acceptable IF instructions are provided in this section about the amount to release each time as well as the interval between dispenses.
- Prescriber address and contact information. *Locums MUST manually enter on the form the medical clinic or hospital name, address and a contact number (telephone or pager).*
- TPP Tracking Number is a sequential number assigned to each form within the pad. Prescribers **MUST** report this number(s) if the form(s) is lost or stolen.
- ID Number is the unique prescriber registration number. For Alberta prescribers, this is the same number as assigned by their regulatory body. For Yukon prescribers, their TPP number appears here. Prescribers **MUST** use their own personalized TPP forms with their printed ID number. *Pharmacists & pharmacy technicians should ensure the correct prescriber is identified for the prescription record. Misattributions significantly impede PIN data quality and TPP Alberta efficiency.*
- The dispenser compares the date dispensed to the date issued. If the prescription is to be put on hold, the date it was logged should be documented here.
- Pharmacy assigned prescription number is entered here. *Not applicable when the dispenser is a veterinary practice.*
- If the prescription is compounded, the drug identification number (DIN) of the TPP medication component is identified here. *If the compounding agent does NOT have a DIN number, indicate the name of the agent here (do not use pseudo DIN 999999). If the compound contains more than one TPP medication, provide the DIN for each one.*

TPP Alberta		Void after 3 days Tracked Prescription. Take to a pharmacy PLEASE PRINT CLEARLY	
Health care number		Date Issued	DD MMM YYYY
Patient full name (First, Initial, Last)		Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth DD MMM YYYY
Patient address		City/Town	Province
Only one drug & strength per form Part-fills allowed if interval specified			
Drug name & dosage		Quantity Numeric	Quantity Alpha
Indication for therapy:	<input type="checkbox"/> Post-operative pain <input type="checkbox"/> Acute musculoskeletal pain <input type="checkbox"/> Chronic musculoskeletal pain	<input type="checkbox"/> ADHD <input type="checkbox"/> Neuropathic pain <input type="checkbox"/> Cancer/Palliative <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Headache/Migraine <input type="checkbox"/> Opioid Agonist Therapy (OAT/OOT)
Direction for use:			
DR. SMITH, MD ANYTOWN CLINIC 10000 WYE RD NW EDMONTON AB T0T 0A1 780-888-9797			
TPP Tracking #:	ID #:	Prescriber's Signature	
PHARMACY USE ONLY: Rx #	DIN	Quantity	Date Dispersed DD MMM YYYY
Pharmacist Sign. & Reg. #	Pharmacy LIC #		Medication received by

- The quantity dispensed is verified against the quantity ordered. Document part-fills as the amount dispensed over the total quantity (e.g. 30/90 or 0/90 for a prescription placed on hold for later dispense).
- Pharmacy license number is used to identify the pharmacy in the database. *When the dispenser is a veterinary practice this does not apply.*
- The pharmacist responsible for assessing the prescription for appropriateness is identified by their practice permit number. *When the dispenser is a veterinary practice, the license number of the veterinarian should be indicated here.*
- The patient, patient's agent (or animal owner) should sign for the TPP medication upon the receipt of the medication. Dispensers should **NOT** ask the patient to sign for the medication before it is dispensed. For a prescription put on hold, write 'deferred' in this section.

Appendix B: Sample alcohol order

Ethanol 40% 45ml po q3h prn.

Maximum ___ drinks / 24H, no ethanol to be provided between ___ and ___ (hours as per liquor license and/or clinical scenario)

Provide ethanol undiluted.

All doses to be consumed in the patient room.

Witnessed ingestion.

Intoxication assessment tool to be administered prior to each dose.

Appendix C:

Checklist for patients with opioid use disorder admitted to acute care

Admission:

- If patient on opioid agonist treatment or any prescribed opioids in the community, confirm last dose(s) provided with the community pharmacy and put all community opioid prescriptions ON HOLD
- For patients on methadone: order an ECG to evaluate QTc, avoid other QTc prolonging meds during admission
- Write naloxone order in case of unintentional overdose while admitted
- Provide take home naloxone kit to patient on admission
- If indicated, provide harm reduction supplies on an ongoing basis, sharps container for safe disposal of syringes, direct to in-hospital or nearby supervised consumption services (if available)
- Social Work consult if concerns about housing, medication or provincial medical coverage, income, or photo identification
- If OAT is being initiated in hospital, ensure patient signs an appropriate treatment agreement and understands the full implications of treatment both in hospital and after discharge to the community

Discharge:

- Ensure medication coverage in place for all discharge prescriptions
- Ensure community pharmacy has prescribed medications available, especially for weekend and late evening discharges
- Ensure safe housing / location for discharge
- Fax triplicate prescription to the community pharmacy for any ongoing opioid prescriptions – prescription should cover until the confirmed follow up date; void prescription after faxing (all new opioid agonist treatment starts should have doses witnessed daily in the community pharmacy).
- Communicate the following items to the community pharmacist:
 - o Dose and date/time of last dose of medication administered in the hospital
 - o Who will be taking over prescribing and date & time of next appointment
 - o Who to notify of any missed doses of medication
 - o When to hold doses
 - o Specific instructions on how to handle missed doses (if appropriate)
- Ensure primary care or other specialist appointment arranged for ongoing prescribing
- Ensure patient has take home naloxone kit
- All follow up plans provided verbally and in writing to patient and any support people as requested by the patient

Appendix D:

Considerations – Medications for the treatment of alcohol use disorder

Medication:	Dose:	Contraindications:	Considerations:	Side Effects:**	Monitoring:	Health Canada Status for AUD:	Coverage:	Est. cost with no coverage:
Naltrexone	50mg po daily; must stop opioids 7-10 days before initiating; 25mg x3d then 50mg to decrease side effects; May be initiated while drinking or at end of detox;	Current/anticipated use of opioids; Opioid withdrawal; Acute hepatitis or liver failure; Liver enzymes 3x upper limit of normal**	Pregnancy risk category 'C'; Used more than others due to absence of known harms; Adverse fetal effects in animal models, but no data from well-controlled studies; Consider in pregnant women if potential benefit outweighs risk;	GI Upset; nausea, vomiting, headache, dizziness, anorexia, fatigue, somnolence, anxiety, precipitation of opioid withdrawal, hepatotoxic effects at high doses;	Liver enzymes at baseline, at 1 mo, then Q3/12; Initial close weekly follow-up may be helpful; Discontinue if liver enzymes rise >3x ULM	Approved	General benefit for those with funding under NIHB, Income Support, AISH, and AB Adult Health Benefit.	\$220/mo. +/-
Acamprosate	666mg po TID; 333mg po TID if renal impairment or <60kg; Generally abstinence for >3 days before initiation, although studies show reduction in heavy drinking days even when initiated prior to abstinence;	Creatinine clearance <30ml/min;	Pregnancy risk category 'C'; As above, consider in pregnant women if potential benefit outweighs risk; Although TID dosing is cumbersome, it may be useful for patients who cannot take naltrexone due to liver disease or taking opioids, or with polypharmacy because no significant interactions with other drugs; Caution if depression or suicidal ideation;	GI upset; somnolence, rarely suicidality;	Initial close weekly follow-up may be helpful; Monitor renal function and adjust dose if CrCl 30-50ml/min	Approved	For those with funding under Income Support, AISH, and AB Adult Health Benefit, can apply for funding via AB Blue Cross Special Authorization form. For those with NIHB coverage it is a Limited use Benefit (prior approval required), "for patients who have been abstinent from alcohol for at least 4 days, and where available, are currently enrolled in a alcohol addiction treatment program".	\$200/mo. +/-

Considerations – Medications for the treatment of alcohol use disorder, continued

Medication:	Dose:	Contraindications:	Considerations:	Side Effects:**	Monitoring:	Health Canada Status for AUD:	Coverage:	Est. cost with no coverage:
Gabapentin	300mg po day one, 300mg BID day 2; 300mg TID day 3; increasing by 300mg each day up to 600mg TID on day 6, as tolerated; abstinence at 12 wks 4.1% placebo group; 11.1% gabapentin 900mg/day; 17% for 1,800mg/day;	Decrease dose with renal impairment;	Risk of dependence in post-marketing database; Increased risk of CNS depression esp. with opioids and other CNS depressants; Pregnancy risk category 'C'; As above, consider in pregnant women if potential benefit outweighs risk;	Somnolence, dizziness, ataxia, fatigue, nystagmus, tremor;	Routine monitoring not required; consider if renal impairment;	Not approved	Drug benefit under AB Works, AISH, CPP, NIHB	\$30/mo. +/-; partial coverage by many drug plans
Topiramate	Generally initiated at 50mg daily, gradually titrated over several weeks to 150mg BID as tolerated; taper gradually to go off; most trials initiate after 3 or more days of abstinence;	Caution with renal or hepatic impairment; metabolic acidosis risk, hypokalemia, respiratory disease,	Higher rates side effects compared to other options; requires taper to achieve therapeutic dose or to go off; Pregnancy risk category 'D'; increased risk of cleft palate and/or palate, although occurrence rare;	Cognitive dysfunction, paresthesia, taste abnormalities, weight loss, headache, fatigue, dizziness, depression; Slow titration may mitigate side effects;	Creatinine at baseline, bicarb at baseline, then periodically; signs/symptoms of depression, behaviour changes, suicidality;	Not approved	Drug benefit under AB Works, AISH, CPP, NIHB	\$75/mo. +/-; partial coverage by many drug plans
Valproic acid	Studies used range of dosing including 750mg daily, and initiation at 750mg daily titrated to serum level 50-100mcg/mL; most trials initiate after 3 or more days of abstinence;	Hepatic disease or significant dysfunction, known mitochondrial disorders caused by mutations in mitochondrial DNA polymerase gamma, known hypersensitivity, or urea cycle disorders;	May have added benefits for patients with bipolar I disorder and alcohol use disorder; Pregnancy risk category 'D';	CNS depression, HA, somnolence, dizziness, GI, thrombocytopenia, tremor, diplopia, blurred vision, flu-like symptoms,	Liver enzymes, CBC, platelets, INR, serum amonia if lethargy, mental status changes, serum valproate level; suicidality;	Not approved	Drug benefit under AB Works, AISH, CPP, NIHB	\$30/mo. +/-; partial drug coverage by many drug plans

Considerations – Medications for the treatment of alcohol use disorder, concluded

Medication:	Dose:	Contraindications:	Considerations:	Side Effects:**	Monitoring:	Health Canada Status for AUD:	Coverage:	Est. cost with no coverage:
Disulfiram	250mg po daily; range 125mg-500mg daily; Abstinent for 48 hrs or more before initiation; Disulfiram reaction may occur up to 14 days after last dose;	Inability to understand consequences of using ETOH while taking disulfiram; Use of alcohol or alcohol-containing preparations; Metronidazole use; CAD or severe myocardial disease; Rubber sensitivity; End-stage liver disease;	May be suitable where supervised consumption is available, to increase likelihood patient continues to take medication; Use caution if patients has cirrhosis, cerebrovascular disease, psychosis, diabetes, epilepsy, hypothyroidism, renal impairment, takes isoniazid, anticoagulants, or phenytoin; Pregnancy risk category 'C'; As above, consider in pregnant women if potential benefit outweighs risk;	Metallic taste; dermatitis, transient mild drowsiness, hepatotoxic effects, optic neuritis, peripheral neuropathy, psychotic reaction;	Liver enzymes at baseline, 2 weeks, Q 3/12; Discontinue if liver enzymes >3x ULN.	Approved	Not covered by AB Works, AISH, CPP, or NIHB;	Not manufactured in Canada, but can be obtained at compounding pharmacies; \$50/mo. +/-

*See product monograph for additional prescribing details

**SAMHSA consensus panel suggests avoiding if baseline aminotransferase levels >5xULM "except where benefits outweigh the risks".

DynaMed. Alcohol use disorder. Updated June 3,2018; 49-62

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Appendix E:

CADTH search selection criteria and CCSA search strategy

The following search criteria was used the Canadian Agency for Drugs and Technologies in Health (CADTH) was engaged to complete a *Rapid Response Report: Summary with Critical Appraisal - Substance Use Disorder Interventions in Acute Care: A Review of Clinical Effectiveness, Cost-Effectiveness and Guidelines*.

Table 1: Selection Criteria

Population	Patients with a substance use disorder (i.e., alcohol, opioid, stimulants) in the acute care setting (i.e., ED, ICU, tertiary, hospital-based care)
Intervention	Interventions for the management of substance use disorders (e.g., withdrawal management and detoxification, pharmacological and non-pharmacological therapies for the treatment of substance use disorders)
Comparator	Standard care (e.g., undertreated withdrawal, abstinence-based approach, including benzodiazepine), no treatment
Outcomes	<p>Q1: Clinical effectiveness i.e., benefit (e.g. treatment outcomes; length of stay; readmission; survival; patient satisfaction) and/or safety/harm (e.g., patient safety; patient compliance; leaving against medical advice)</p> <p>Q2: Cost-effectiveness (e.g., ICER/ ICUR, cost per QALY or other health benefit)</p> <p>Q3: Guidelines</p>

The following search strategy was employed by the Canadian Centre on Substance Use and Addiction (CCSA) in their complementary research for this Guidance Document:

Search summary:

The PubMed search was limited to English peer-reviewed articles published in the last 10 years. Variations of search terms related to substance use or harm reduction and acute care were used. 4493 articles were initially retrieved. The information specialist screened the results and removed duplicates and any articles that were clearly outside of the scope of the project based on titles and abstracts. The remaining 231 articles were sorted and passed on for additional screening.

Detailed search strategy:

PubMed

For reviews:

(((((("Harm Reduction"[Mesh]) OR "Needle-Exchange Programs"[Mesh]) OR "Methadone"[Mesh]) OR ("Buprenorphine"[Mesh] OR "Buprenorphine, Naloxone Drug Combination"[Mesh])) OR "Hydromorphone"[Mesh]) OR "Opiate Substitution Treatment"[Mesh]) OR "Naloxone"[Mesh])) OR (((((substance[Title/Abstract]) OR stimulant*[Title/Abstract]) OR opioid*[Title/Abstract]) OR opiate*[Title/Abstract]) OR alcohol*[Title/Abstract])) OR (((("Substance-Related Disorders"[Mesh]) OR "Alcohol Drinking"[Mesh]) OR "Opioid-Related Disorders"[Mesh]) OR "Substance Abuse, Intravenous"[Mesh]) OR "Alcoholism"[Mesh])))) AND ((("acute care"[Title/Abstract]) OR ((("Emergency Service, Hospital"[Mesh]) OR "Hospitals"[Mesh]) OR "Hospital Units"[Mesh])) Filters: Meta-Analysis; Review; Systematic Reviews; published in the last 10 years; English; MEDLINE

March 5, 2018 (360 results)

Withdrawal and management in acute care reviews: kept 60

Pain in acute care reviews: kept 3

Integration of harm reduction in acute care reviews: kept 4

Other articles:

(((((("Harm Reduction"[Mesh]) OR "Needle-Exchange Programs"[Mesh]) OR "Methadone"[Mesh]) OR ("Buprenorphine"[Mesh] OR "Buprenorphine, Naloxone Drug Combination"[Mesh])) OR "Hydromorphone"[Mesh]) OR "Opiate Substitution Treatment"[Mesh]) OR "Naloxone"[Mesh])) OR ((((((substance[Title/Abstract]) OR stimulant*[Title/Abstract]) OR opioid*[Title/Abstract]) OR opiate*[Title/Abstract]) OR alcohol*[Title/Abstract]) OR (((("Substance-Related Disorders"[Mesh]) OR "Alcohol Drinking"[Mesh]) OR "Opioid-Related Disorders"[Mesh]) OR "Substance Abuse, Intravenous"[Mesh]) OR "Alcoholism"[Mesh]))) AND ("acute care"[Title/Abstract]) OR (((("Emergency Service, Hospital"[Mesh]) OR "Hospitals"[Mesh]) OR

"Hospital Units"[Mesh])) Filters: published in the last 10 years; English; MEDLINE

March 8, 2018 (4493 results, kept 164)

Integration of HR single: kept 14

Withdrawal single: kept 131

Pain acute care single: kept 9

Barriers for harm reduction single: kept 10

Grey lit search summary

The grey literature was identified through targeted database searches and website scanning and Google searches conducted over four days. Refer to the chart below for a listing of databases and websites that were consulted and search terms used.

Chart of grey lit databases searched

Database name	URL for website + search terms + no. of results	Date searched	No. of relevant results
Trip	https://www.tripdatabase.com ("acute care" OR "critical care" OR "emergency room") AND (addiction OR "Substance use disorder" OR "opioid use disorder" OR alcohol* OR "drug dependence") + All secondary evidence [filter]= 113 (2008 to 2018)	March 7, 2018	3
National Guideline Clearinghouse (NGC)	http://www.guideline.gov ("acute care" OR hospital* OR "critical care" OR emergency) AND (addiction OR "Substance use disorder" OR "opioid use disorder" OR alcohol* OR "drug dependence") = 90 (2008 – 2018)	March 7, 2018	6
Canadian Research Information System (CRIS)	Research grants and awards funded by CIHR http://webapps.cihr-irsc.gc.ca/funding/Search?p_language=E&p_version=CIHR (hospital OR acute care OR emergency room OR critical care) AND (substance use OR addiction OR drug use OR drug dependence) = 55	March 7, 2018	3
National Institute for Health and Care Excellence (NICE)	http://www.evidence.nhs.uk/ Evidence search, Health and Social Care "emergency room" "substance use" intervention + filters = Guidance and Evidence Summaries = 69 "acute care" "substance use" intervention + Guidance and Evidence Summaries = 79	March 8 & 9, 2018	4

Chart of websites scanned

Org name	URL for website	Date scanned	No. of relevant results
Canadian			
Alberta Health Services	https://www.albertahealthservices.ca/amh/amh.aspx Addiction & Mental Health; Health Professionals Scanned the Research & Reports and Resources sections; Scanned the section on Health Information and Tools, Substance Use Problems	March 8, 2018	0
Health Quality Council of Alberta	http://www.hqca.ca/about Healthcare Provider Resources Studies and Reviews	March 8, 2018	
Health Quality Ontario	http://www.hqontario.ca/about-us Reviewed section: Evidence to improve care	March 8, 2018	1
Newfoundland & Labrador Centre for Applied Health Research	http://www.nlcahr.mun.ca/CHRSP/EIC.php Scanned completed Evidence in Context Reports and Rapid Evidence Reports	March 8, 2018	0
BC Centre on Substance Use (BCCSU)	http://www.bccsu.ca/ Scanned Publications section: Reports and White Papers, Research Summaries and Clinical Care Guidance	March 9, 2018	
Canadian Institute for Substance Use Research (CISUR)	https://www.uvic.ca/research/centres/cisur/ Publications search: Hospital = 7; Harm reduction = 16; Emergency room = 9	March 8, 2018	3
Guidelines and Protocols Advisory Committee (GPAC), BC	https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/committees/guidelines-and-protocols-advisory-committee-gpac Browsed by topic area: Addictions and Substance Use = 3;	March 8, 2018	2
BC Guidelines	http://www.bcguidelines.ca BC Patient Safety & Quality Council	March 6, 2018	2
BC Patient Safety & Quality Council	https://bcpsqc.ca/ Knowledge Centre and Clinical Improvement sections	March 8, 2018	1
Canadian Institute for Health Information	https://www.cihi.ca/en/acute-care Section on Acute care – scanned Reports and analyses Section on Access Data and Reports section – filtered by ‘Mental health and addiction’ and ‘Emergency care’ results	March 8, 2018	0

Chart of websites scanned, concluded

Org name	URL for website	Date scanned	No. of relevant results
Non-Canadian			
Patient-Centered Outcomes Research Institute	https://www.pcori.org/ Scanned Research & Results section – Pain Care and Opioids	March 9, 2018	0
Physicians for Responsible Opioid Prescribing (PROP)	http://www.supportprop.org/ Scanned Resources section – Clinical Tools	March 9, 2018	1
Substance Abuse and Mental Health Services Administration (SAMHSA)	Treatment, Prevention & Recovery publications https://store.samhsa.gov/facet/Treatment-Prevention-Recovery Scanned Publications section: Treatment and Treatment Planning – Crisis Intervention, Emergency Department Treatment, Pain Management, Substance Abuse Screening	March 9, 2018	0

III. Google Search (first 5 pages of results scanned)

- (i) “acute care” comorbidities “substance use” site:.ca
- (ii) “acute care” withdrawal “substance use” site:.ca

IN BRIEF A Summary of the Evidence

Substance Use Disorder Interventions in Acute Care: A Review

Key Messages

Overall, the evidence on substance use disorder interventions in acute care varies in quality and in its findings. No relevant evidence-based guidelines were found.

Alcohol Use Disorder Interventions for Patients in Acute Care:

- Medications to prevent and treat alcohol withdrawal syndrome are clinically effective, and benzodiazepines are the mainstay for this purpose. Moderately dosed intravenous ethanol is effective in preventing withdrawal, and benzodiazepines, gamma-hydroxybutyric acid, and adjuvants such as clonidine and haloperidol are effective in treating alcohol withdrawal.
- Having a protocol or care guideline for preventing and treating alcohol withdrawal syndrome may improve outcomes such as length of stay and progression to delirium tremens.
- A symptom-triggered benzodiazepine protocol may be more effective than a fixed benzodiazepine protocol at reducing the duration of withdrawal and the length of stay in ICU and hospital.
- A brief intervention of motivational interviewing is at least as effective, and may be more effective, than other brief non-pharmacological interventions (e.g., brochures, contact lists or resources, phone follow-ups, or personal feedback) in reducing the amount and frequency of drinking.

Opioid Use Disorder Interventions for Patients in Acute Care:

- Buprenorphine initiated in the emergency department can increase engagement with addiction treatment, reduce self-reported illicit opioid use, and decrease use of inpatient addiction treatment services when compared with a brief intervention and referral.
- Buprenorphine initiated in the hospital for patients who are not seeking addiction treatment can effectively engage patients and reduce illicit opioid use after hospitalization compared with traditional detoxification programs.
- Buprenorphine initiated in the emergency department is more cost-effective than brief intervention and referral, and may still be cost-effective at a willingness-to-pay of zero.

Stimulant Use Disorder Interventions for Patients in Acute Care:

- Nicotine replacement therapy in ICU patients who are active smokers may increase harms including increased use of antipsychotic medications and physical restraints, and longer periods of intubation.
- A program involving cognitive behavioural therapy and group sessions seems to be effective in reducing smoking compared with groups with minimal intervention.

General Substance Use Disorder Interventions for Patients in Acute Care:

- Brief intervention for trauma patients who screen positive for substances may lower the risk of subsequent hospitalizations for trauma.
- A cost-benefit analysis found no economic benefit for screening, brief intervention, and referral to treatment (SBIRT) compared with minimal screening.

Context

Patients with a substance use disorder (SUD) may be admitted to acute care to treat their SUD, or can be admitted for other reasons – which may or may not be related to their SUD. For example, people who inject drugs could be admitted for a blood borne infection that resulted from their injection drug use, a person using alcohol could present as the result of an accidental fall, or a person with an SUD could happen to require surgery to remove their appendix (a completely unrelated medical condition). Many of the statistics available on patients with SUDs in hospital focus only on patients admitted specifically for their SUD and not those admitted due to other reasons associated with SUD or those treated in the emergency department or community settings. This makes it difficult to fully understand the impact that SUDs have on acute care, however SUDs are associated with high rates of hospitalizations, readmissions and long length of stay. For patients who are admitted to acute care for reasons unrelated to SUD, the initiation of SUD treatment during a hospital stay may relieve symptoms associated with withdrawal and reduce rates of discharge against medical advice.

Technology

A variety of therapies have been developed to treat SUDs, including medications and behavioural therapy. The therapy offered may differ based on the type of substance used and the severity of the addiction. For example, medication for opioid use disorder may include maintenance therapy with an opioid agonist, either methadone or buprenorphine, to ease withdrawal symptoms. Non-pharmacological treatment options such as behavioural therapies may be an option for multiple types of addiction.

Issue

Interventions delivered during hospital admission, including medication and behavioural therapy as well as timely access to post-discharge support, may improve care and outcomes for patients with SUD admitted to acute care settings. However, challenges exist in offering in-patient treatment, particularly behavioural interventions and post-discharge referrals, if resources are not available. An understanding of the clinical and cost-effectiveness of different interventions to treat patients with SUDs (specifically alcohol, opioids, or stimulant use disorders) in acute care, as well as related recommendations from guidelines will help to guide decisions about the treatment of SUD in acute care settings.

Methods

A limited literature search was conducted of key resources, and titles and abstracts of the retrieved publications were reviewed. Full-text publications were evaluated for final article selection according to predetermined selection criteria (population, intervention, comparator, outcomes, and study designs).

Results

The literature search identified 1,016 citations, of which 61 were identified as potentially relevant. An additional 2 potentially relevant articles were identified from other sources. Of these 63 articles, 17 met the criteria for inclusion in this report – 6 systematic reviews, 3 randomized controlled trials, 6 non-randomized studies, and 2 economic evaluations.

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