BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

Providing Care in Acute Care Settings

Substance Use: What You Should Know

How to engage with and provide care for people who use substances or have substance use disorders

Preamble

Acute care offers a critical opportunity to engage and provide evidence-based care to patients who use substances and to reduce morbidity and mortality

Lack of knowledge about substance use and substance use disorder care impacts the treatment that patients in acute care settings receive

Experiences of stigma, judgement, racism, and untreated withdrawal and pain can lead to self-initiated discharge or prevent patients from accessing acute care to receive life-saving treatment in the future

Prioritizing patient safety and comfort and collaboratively working with patients to meet their goals can improve the patient's experience in acute care

Sections:

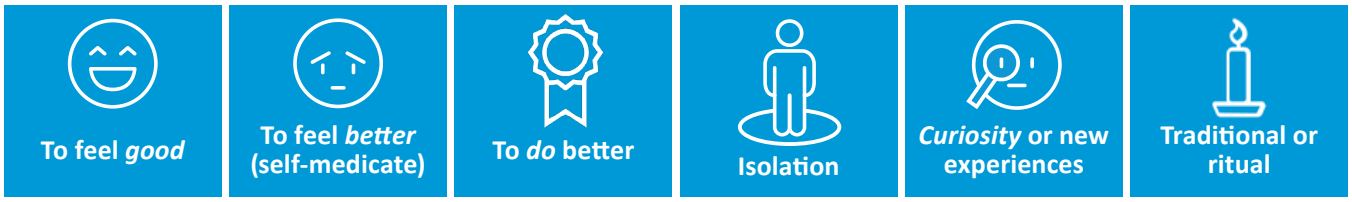
1. Substances and substance use

Common Substances

When providing care, you will encounter people who use one or more of the following regulated or unregulated psychoactive substances:

- Alcohol
- Sedatives and hypnotics
- Hallucinogens
- Opioids
- Stimulants
- Tobacco
- Cannabinoids
- Inhalants

Why People Use Substances



To feel good

Substances can help provide feelings of relaxation

To feel better

Substances can help self-manage or self-medicate withdrawal or pain, or reduce anxiety or stress in order to perform the activities of daily life

To do better

People can use substances to improve performance

Substances can be used for survival in unsafe environments

To address isolation

Substances can be used to alleviate feelings of social, cultural, or geographic isolation

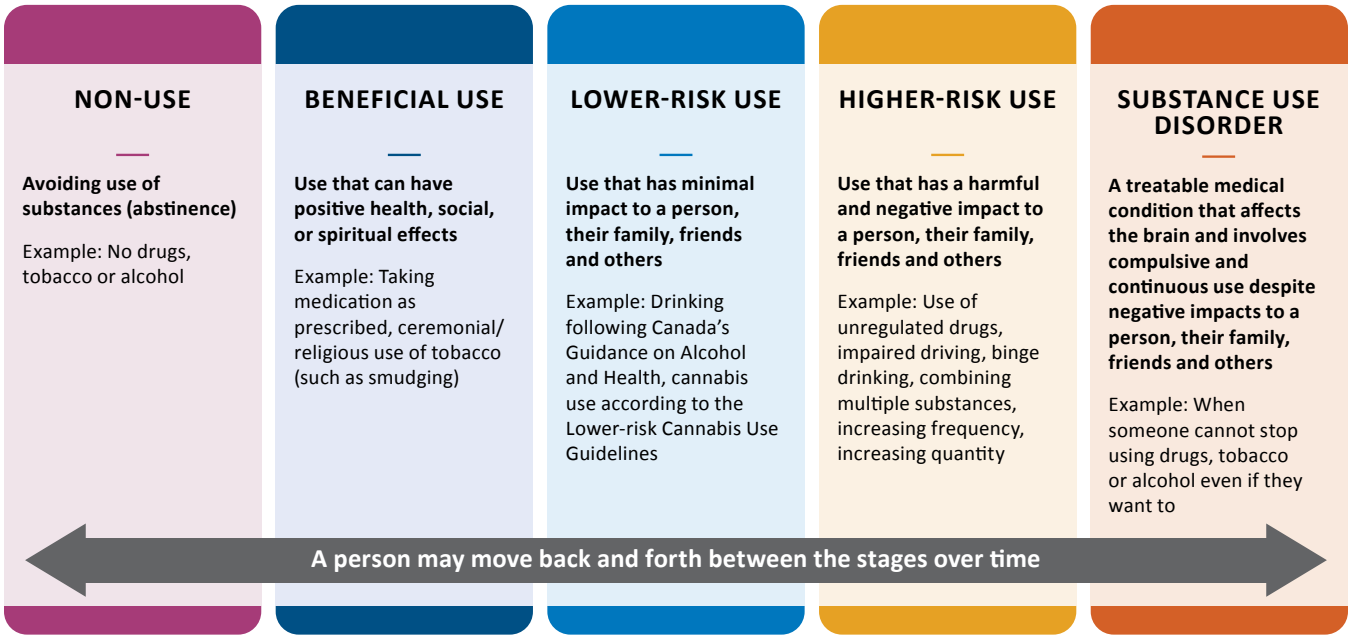
Curiosity or new experiences

Substances can be used discover new experiences, feelings, or insights

Traditional or ritual

Substances can be used as part of a person's cultural, religion, or ceremony

Substance Use Occurs on a Spectrum



All Paths Lead to Wellness

First Nations Health Authority created a strengths-based model of substance use supports that upholds Indigenous self-determination, emphasizes Indigenous harm reduction, and embeds Indigenous ways of knowing into a wholist approach to support Indigenous Peoples who use substances and Indigenous communities impacted by substance use.

What is a Substance Use Disorder?

A substance use disorder (SUD) is a complex condition that involves a pattern of substance use that negatively impacts a person's life and increases risks of substance-related harms. Substance use disorders can range from mild to severe and are treatable with evidence-based interventions. Not every person who uses substances has a substance use disorder.

Substance Use Disorders vs. Substance-induced Presentations

Substance-related disorders are divided into two groups:

1. Substance use disorders

- e.g., stimulant use disorder, opioid use disorder

2. Substance-induced presentations

- Intoxication
- Withdrawal
- Substance-induced mental disorders (e.g., methamphetamine-induced psychotic disorder)

Resources

Health Canada Spectrum of Substance Use

VCH's SURKit Addressing the Drug Toxicity Crisis in the Emergency Department

2. Principles of substance use care

Principles of Substance Use Care

Overarching principles to support dignity and safety, health equity, social justice, and engagement in care for people who use substances

Person-centred care

Collaboratively develop treatment plans using shared decision-making and set treatment goals that are meaningful to the patient.

Be open to and respectful of individual agency and choice.

Anti-racist practices

Challenge racist structures in health care, recognize one's role in oppressive systems, and provide anti-racist supports (e.g., interpretation, translation, accessible written materials, space for religious or cultural practices)

Harm reduction

Acknowledge and support steps taken by people to improve their health and well-being. Encourage the use of harm reduction services while the individual is in an acute care setting to minimize substance-related harms.

Comprehensive health management

Substance use disorders require comprehensive health care with regular medical, mental health, and psychosocial assessments.

Provide referrals when requested or appropriate

Trauma- and violence-informed practice

Create a safe and respectful environment that minimizes the potential for harm and re-traumatization (see p. 5 for more information).

Self-defined wellness and recovery

Validate individual goals, which may include abstinence, reducing use, safer use, or improved health and wellness.

Social determinants of health

Substance use occurs within a larger social context, which is shaped by inequities. Acknowledge disparities and, where possible, connect people to resources to meet their social and survival needs (e.g., housing, food/nutrition, financial assistance, employment).

Integrated continuum of care

Substance use disorders are understood to be chronic, relapsing, and remitting conditions.

Acute care should be part of a stepped and integrated approach including evidence-based pharmacotherapies, psychosocial supports and interventions, and wellness and recovery support services.

Indigenous cultural safety and humility

Make a meaningful commitment to providing culturally safe care and practicing cultural humility (see p. 7 for more information).

Family and social circle involvement in care

Encourage family and social circle to be involved in treatment planning, when appropriate and preferred by the patient.

Resources

- *Conversation Guide: Talking to People Who Use Substances*
- Island Health Caring Conversation Cards
- Toward the Heart BCCDC Harm Reduction Services
- *Indigenous Harm Reduction = Reducing the Harms of Colonialism* developed by the Canadian Aboriginal AIDS Network and the Interagency Coalition on AIDS and Development
- BC's First Nations Health Authority's (FNHA) fact sheet on Indigenous Harm Reduction Principles and Practices

Trauma- and Violence-informed Practice[1]

Trauma is an experience that overwhelms an individual's ability to cope. Many people who use substances have some history of trauma.

Trauma- and violence-informed care is intended to be sensitive to trauma, not treat it.

While a universal approach to trauma- and violence-informed practice is recommended, Indigenous peoples, women, and 2S/LGBTQQIA+ populations are more likely to have experienced trauma and violence as a result of racism, discrimination, and social inequity compared to other patient populations.

Many people who use substances do not experience hospitals as a safe space, due to fears or prior experiences of discrimination, stigma, and/or inadequate treatment of withdrawal, pain, and substance-related harms

Possible signs of a trauma response:

Physical	Psychiatric
Sweating	Flood of strong emotions
Muscle stiffness or difficulty relaxing	Inability to concentrate or respond to instructions
Shaking	Becoming disconnected from present conversation
Startle response, flinching	Gaps in memory around traumatic events
Inability to speak	
Change in breathing (breathing quickly or holding breath)	
Rapid heart rate	
No visible symptoms	

How to Practice Trauma-informed Care

Physical and Emotional Safety	Choice and Control
Acknowledge and attend to the person's immediate needs Use welcoming intake procedures. Explore and adapt the physical space. Consider emotions, water, food, transportation, child care, housing, and clothing. What does the person feel is important? You may not be able to address all their needs, but you can validate what they feel is important.	**Support self-determination, dignity, and personal choice through open communication** Equalize power imbalances by asking what name the person wants used and how they want to be spoken to. Let them choose what they want to share and reassure them if they cannot remember certain details. Create crisis plans.
Be as transparent, consistent, and predictable as possible Knowledge is power. Provide clear information about the care. Provide all the information you have on how long things will take. Follow through on promises in a timely manner. Before doing something, explain why.	**Explore and problem-solve barriers to participation and attendance together** Brainstorm together to remove or reduce barriers such as child care, transportation, or language. Do not assume that people automatically trust health care providers

[1] Adapted, with gratitude, from the Department of Addiction Medicine and Substance Use Services, Fraser Health's *Addiction Medicine: What Can You Do To Help?* resource

Physical and Emotional Safety	Choice and Control
Limit trauma-related information to a need-to-know basis Do not ask for details out of curiosity, only if needed for current care.	**Ask what the person's priorities and expectations for treatment are** Find out what is the most pressing for them and what their hopes are for treatment. Provide choices as to treatment preferences
Obtain informed consent and explain limits to confidentiality Explain how the information will be shared, and with whom.	**Use statements that make collaboration and choice explicit** "I'd like to understand your perspective" "Let's work through this together"
Allow the expression of feelings without fear of judgment Meet strong emotional responses with a calm voice and posture. Support the person to find a safe place and ways to ride waves of emotions.	**Recognize the ways people have adapted to cope and survive** "I understand that you're doing your best with what you've got to cope and survive"
Collaboratively develop grounding strategies Support people to identify their strengths and develop resilient coping skills. Use open-ended questions to discuss strategies. "What have you found helpful to calm down and get focused when you're feeling anxious?" Ask about and offer cultural supports	**Work in a feedback-informed way** Purposefully elicit feedback from patients and family. "Did you feel informed about what to expect?"

Resources

- The Centre of Excellence in Women's Health's *Gender-Informed Approaches to Substance Use Resource List*, the *New Terrain* toolkit, and *Integrating Sex and Gender Informed Evidence into your Practice* workbook
- Substance Abuse and Mental Health Services Administration (SAMHSA) *Trauma-Informed Care in Behavioral Health Services*
- EQUIP Health Care *Trauma- and Violence-Informed Care Tool* and webinars
- The VEGA (Violence, Evidence, Guidance, and Action) Project
- The Substance Abuse and Mental Health Services Administration's (SAMHSA) *Trauma-Informed Care in Behavioral Health Services*
- EQUIP Health Care's *Trauma- and Violence-Informed Care Tool*, Trauma- and Violence-Informed Care Workshop, and Trauma- and Violence-Informed Care Curriculum
- *Decolonizing Trauma Work: Indigenous Stories and Strategies* by Renee Linklater

Indigenous Cultural Safety and Humility

Health care providers should commit to the principles of culturally safe and anti-racist care and exercise cultural humility. Each health authority in BC has an Indigenous health team who can provide Indigenous-specific services, including Elders and patient navigators in some locations. First Nations Health Authority offers training and resources to support Indigenous cultural safety and humility in health care.

> **Historically, Indigenous people have always supported one another, relying on a deep sense of unity that is sacred to our culture … My situation started to improve significantly when my needs for cultural practices were accommodated. I began to see a glimmer of hope and experienced a remarkable shift in my commitment to overcoming substance use and rediscovering a sense of purpose in life.**
>
> –Person with Lived Experience

Cultural safety	Cultural humility*
• An outcome of respectful engagement • Recognizes and strives to address power imbalances embedded in the health system • Results in an environment free of racism and discrimination, where people feel safe when receiving health care	• A life-long process of self-reflection and self-critique, with a commitment to learning alongside others • Understanding personal and systemic biases • Developing and maintaining respectful processes and relationships based on mutual trust and reciprocity • Humbly acknowledging oneself as a learner
**Conceptualizations around cultural safety and humility may vary across First Nations, Métis, and Inuit People—we will know we have achieved cultural safety and humility when Indigenous Peoples tell us we have.*	

Some examples of Indigenous-specific racism, as detailed in "In Plain Sight", within health care include:

- Racist stereotyping (e.g., assuming that a patient is intoxicated, "drug-seeking," or "non-compliant" because they are Indigenous)
- Discrimination and oppression (e.g., denial of service, inappropriate pain management, distain for cultural healing)

Ongoing colonialism within the health care system negatively impacts health outcomes for Indigenous Peoples as a direct result of racism, discrimination, and segregation, including, but not limited to:

- Higher rates of:
  - Overdose deaths
  - Suicidal ideation
  - Chronic disease
  - Infant mortality rates
  - Stress
- Reduced life expectancy

> **Being constantly dictated by other cultural norms often triggers feelings of vulnerability and hampers self-advocacy among Indigenous individuals.**
>
> –Person with Lived Experience

Approaches to provide culturally safe and humble care to Indigenous Peoples:

- Understand the impacts of ongoing colonialism and the ways in which this occurs at all levels of the health care system
- Recognize and redress the power imbalances embedded in Western health systems[2]
- Understand health as wholistic, which comprises physical, mental, emotional, and spiritual wellness
- Recognize and respect:
  - Different communication styles
  - Culturally-specific norms and behaviours
- Approach patients with humility and openness
- Respect that not all Indigenous Peoples are connected to their culture as a result of ongoing colonialism
- Challenge personal assumptions, biases, and stereotypes
- Be flexible and willing to change how things are commonly done

Resources

Cultural Safety and Humility Standards

- First Nations Health Authority (FNHA) and Health Standards Organization Indigenous Cultural Safety, Cultural Humility, and Anti-Racism standard
- Professional Colleges' Indigenous cultural safety, cultural humility, and anti-racist standards
  - BC College of Nurses and Midwives
  - College of Physicians and Surgeons of BC
  - College of Pharmacists of BC
  - College of Psychologists BC

Training

- ICS Collaborative website and learning series
- FNHA and the BC Patient Safety & Quality Council's Cultural Safety and Cultural Humility webinar series, policies, and resources
- The San'yas Indigenous Cultural Safety Training Program offered by the Provincial Health Services Authority (PHSA) Aboriginal Health Program in BC
- Reconciliation Education online course
- New Respect Indigenous Cultural Safety course by Public Health Training for Equitable Systems Change (PHESC)

Reports, Legislation, and Declarations

These documents are recommended for deeper learning and understanding about Indigenous Peoples in BC and Canada.

- *Truth and Reconciliation Commission Reports* and *Calls to Action*
- *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*
- *United Nations Declaration on the. Rights of Indigenous Peoples* (UNDRIP)
- *Declaration on the Rights of Indigenous Peoples Act* (DRIPA)
- *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*
- *Taanishi kiiya? Miiyayow Métis saantii pi miyooayaan didaan BC* (Métis Public Health Surveillance Program–Baseline Report, 2021)
- *First Nations Population Health and Wellness Agenda*
- "Sacred and Strong – Upholding Our Matriarchal Roles: The Health and Wellness Journeys of First Nations Women and Girls Living in BC" report (FNHA)
- *Remembering Keegan: A BC First Nations Case Study Reflection*

[2] FNHA, 2016a

3. How to help in acute care

Acute Care Opportunities and Best Practices

Acute care offers a critical opportunity to **engage and provide evidence-based care** to patients who use substances and to reduce morbidity and mortality.
This includes:

- Optimal management of withdrawal symptoms and cravings
- Staying safe and comfortable during intoxication and withdrawal
- Stabilization on available treatment options
- Timely access to appropriate resources and care, including starting substance use treatment or offering a referral to community-based care
- Starting or continuing on the patient's path toward meeting their self-identified goals, which may include abstinence, reduced use, or safer use

> **The patient told me they had to leave in the middle of the night because of opiate withdrawal … This experience taught me the value of curiosity – in this case – what is the human need behind the action of leaving the hospital in the middle of the night?**
>
> **The answer to this informed best practice and led to a supportive outcome.**
>
> *–ED Clinician*

Best practices for providing care to patients who use substances in acute care

Treat the patient's primary medical condition, or reason for presenting in acute care, which may or may not be substance-use related

Screen and assess for substance use and substance use disorders

Provide the standard of care to all patients who use substances

- Care should not be limited or withheld in the event of ongoing unregulated substance use

Support the patient's substance use needs and goals and support self-defined recovery and wellness

- Goals may include abstinence, reduced use, safer use, or be less directly related to substance use like safe housing or reconnecting with family
- Patients may be reluctant to receive care, self-initiate discharge, or use unregulated substances if their substance use needs are not met while in acute care
- Ask patients what they need to help them stay to get their primary medical condition treated

Be familiar with the substance use and harm reduction services that are available in acute care and the local area

Facilitate referral to Indigenous patient navigators and peer navigators, where available

Provide harm reduction supplies and education

- See the BCCSU's acute care resource, *Acute Care and Opioid Use Disorder*
- Discuss increased risk of overdose due to lowered tolerance if substance use is stopped or reduced while in acute care

Provide referrals to community-based health care providers and other supports

Provide appropriate referrals in acute care (e.g., mental health) and create referral pathways by searching for and building relationships with other service providers

Improve transition of care (e.g., warm handoff, where possible) and ensure continuity of care

> **Success isn't just if a person wants to quit after you talk to them. It is also when they want to engage with you, feel safe to openly speak about their use, if they stay in hospital to complete treatment, and if they leave feeling seen, heard and cared for.**
>
> *–Conversation Guide: Talking to People Who Use Substances*

How to Help–Practical Strategies to Keep Yourself and Patients Safe

Create a Safe Environment

Signal safety to people who use substances by using person-centred and trauma-informed principles of care, which:

- Reduce stigma
- Increase access to care
- Prevent conflict

Distinguish between what is unsafe and what is uncomfortable for staff, and respond accordingly

- Consult Occupational Health and Safety (OHS) guidelines to understand and implement safety requirements (e.g., blood and body fluid exposure management)
- Learn about why people use substances and build trauma awareness to identify common behaviours that do not pose a safety risk but may cause discomfort for some staff (e.g., fidgeting, avoiding eye contact, speaking loudly)

Set clear expectations and boundaries with patients with kindness

- Empower patients with the information they need to receive support
- Share the limitations of what you can offer

Let patients know you care and you are doing your best to help them

Listen to what patients who use substances want

Identify and build on patient's strengths

Understand that an acute care setting may never feel safe for some patients due to past harms and experiences

Person-centred Language

Although care providers are encouraged to match people's preferred language, be careful to avoid outdated and potentially stigmatizing terms.

Rather than…	Use…
Addict, junkie, drug user	Person who uses drugs, person who injects drugs
Alcoholic, opioid addict	Person with alcohol use disorder, person with opioid use disorder
Denies/admits	Reports
"Clean"	Abstinent
"Clean" or "dirty" urine drug test	Urine drug test was positive for …, was negative for…
Non-compliant	Declined or chose not to
Demands	Repeatedly requests or asks for

> **People will forget what you said, people will forget what you did, but people will never forget how you made them feel.**
>
> – Maya Angelou

Actions

People who use substances may be uncomfortable, in withdrawal, or in pain while they are in acute care. Clinicians should be mindful of this each time they interact with a patient.

- Be gentle
- Be soothing
- Be kind
- Use low lights
- Use a quiet voice and sounds

Resources

Respectful Language and Stigma: Regarding People Who Use Substances

4. Asking about substance use

Ask about substance use

Upon intake or admission of inpatients, all patients should be screened for current substance use.

- Normalize asking about substance use in a non-judgmental, trauma-informed way, and culturally humble way, with the goal of providing culturally safe care (see Principles of Care, above)
  - Acknowledge the sensitivity of this topic for some people, especially pregnant patients and youth
- Create a safe space
- Disclose who will have access to the patient's response
- Disclose situations in which the clinician has a duty to report
- Approach from a place of non-judgement and curiosity
- Administer DSM-5-TR diagnostic interview for patients who screen positive for substance use
- Ask about the patient's goals around substance use and what support they need to achieve them
- Ask the patient if they are interested in working with a peer navigator, Indigenous patient navigator, or social worker, if available

> **We have this feeling when we're vulnerable, we know who has been there like us, we can see it in their eyes. They make us feel like we are wanted. Even if we don't ask for it, it can still help. When I was finally connected to an Indigenous Liaison, it gave me hope.**
>
> –Person with Lived Experience

For example:

"I ask everyone I treat about substances, so we can make a plan for pain, withdrawal management, or starting or continuing substance use treatment while you are in hospital."

"Can you share with me which substances you use? If you are comfortable, it would help to know how much of the substance and how often you use the substance, as well as how you use it."

"Have you ever experienced withdrawal symptoms? What type of withdrawal symptoms do you get?"

"With your permission, I'm going to record what we've discussed on your chart so the other hospital staff and I can follow through on the care plan."

"Anything you share may be recorded on your chart and will only be accessible to medical staff. It will remain confidential to everyone outside of medical staff unless there is a reason to believe you are at risk of hurting yourself or another person."

Connect to Substance Use Disorder Care

If the patient identifies substance use-related concerns, including withdrawal, follow the steps outlined in the BCCSU's acute care resources package or your site-specific protocols and decision support tools. Ask patients if they would like to be supported by peer navigators or Indigenous patient navigators, where available, and consult the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, or RACEapp as needed.

Consider a referral, with the patient's consent, to the inpatient consult team, RAAC or equivalent in your health authority for continuing substance use disorder care.

> **I approached the attending physician again to fill them in on the details I had just learned, and they refused to admit the patient or give them anything to keep them comfortable until detox.**
>
> **In this instance, I chose to ask the unit clerk to page the addiction medicine doctor on call. The addiction medicine doctor attended, admitted the patient, ordered something to prevent withdrawal and the patient went to detox the following morning.**
>
> –ED Clinician

Resources

The BCCSU's acute care resources:

- *Co-occurring Substance Use Principles of Care*
- *Acute Care and Opioid Use Disorder*
- *Managing Acute Opioid Withdrawal*
- *Opioid Agonist Treatment (OAT) Initiation*
- *Opioid Agonist Treatment (OAT) Maintenance*
- *Managing Stimulant Intoxication and Withdrawal*

5. Provincial substance use policy

Talk to Patients About Care for Their Substance Use While They are in Hospital

If a patient indicates they use unregulated substances, discuss treatment options with them with the goal of ensuring they are supported and can complete the course of care for the presenting problem which resulted in their admission.

Discuss with them the hospital policy which does not permit unregulated drug use in or around the facility. If the patient is interested, invite peer navigators to support the discussion.

Discuss with them the availability of local overdose prevention services and how to access them with the support of their medical team.

How to Help – Practical Strategies to Keep You and Your Patients Safe

What to do if someone is in possession of or uses unregulated substances in acute care facilities

It is important to create a space for discussion about substance use that aims to be culturally safe, free of stigma, and anti-racist so that patients feel safe enough that they do not leave before their care is completed

Signal safety to people who use substances by using person-centred and trauma-informed principles of care, which:

- Reduce stigma
- Increase access to care
- Reduce conflict

Follow health authority policies on prohibited items

Possession of unregulated substances

- Patients should not be asked if they are in possession of unregulated substances, but should be reminded that substance use is not permitted in hospital rooms or in/around the facility
- Clinicians should not search a patient's belongings, unless the possession of unregulated substances impacts the ability of the clinician to provide care

What to do if someone is in possession of or uses unregulated substances in acute care facilities (continued)

Use of unregulated substances

- **Clinicians are not responsible for ensuring patients do not use unregulated substances in hospital**; however, clinicians ensure that patients are offered appropriate management for withdrawal and pain, evidence-based pharmacotherapy and/or psychosocial treatment for substance use disorders, and careful monitoring for wellbeing
- **Clinicians are responsible for making decisions based on the patient's presentation and with the consent of the patient**

  Decisions to provide or administer medications should be based on whether the patient meets the clinical indication for that medication at the time of assessment
- Clinicians may be concerned If a patient discloses that they have unregulated substances in their possession for personal use, and are not using them in a public space, staff should:
  - Ask patients what would be helpful to support them in hospital
  - Provide care that aligns with the patient's goals (see best practices in Section 3)

Clinicians should not discharge patients solely for possession of or use of unregulated substances

Clinicians are not required to report patients to police for possession of use of unregulated substances

Consider consulting the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other local addiction medicine resources

Supporting patients who use unregulated substances in hospital

If a patient shares that they have used or intend to use unregulated substances in hospital, remind the patient that using unregulated substances in hospital is not allowed

Ask how the patient keeps themself safe when they use substances and discuss an overdose prevention plan

Develop a plan to reduce harm if the patient continues to use substances or returns to use

Encourage the use of harm reduction services in the local area, such as:

Drug checking services

- Drug Checking BC provides a list of local drug checking services
- Get Your Drugs Tested offers testing by mail and is available to all Canadians
- Substance Drug Checking offers testing by mail for people on Vancouver Island, by drop in in Victoria, and at a number of sites across Vancouver Island

Supervised consumption sites or overdose prevention services

- Patients may access support related to safer use strategies and linkages to addiction care
- Some existing overdose prevention services and supervised consumption sites do not allow substances to be smoked due to ventilation restrictions
- Discuss potential alternate routes of administration and safety with the patient

Supporting patients who use unregulated substances in hospital (continued)

Offer harm reduction supplies

Offer education on overdose prevention, recognition, and response

Discuss strategies to prevent overdose:

- Using with others when possible
- The Brave app or Lifeguard app
- National Overdose Response Service
- Starting with a small amount of substance, especially after a period of abstinence or decreased use (i.e., a "test dose")
- Share safety concerns and harms (e.g., sedation, overdose) related to co-occurring substance use

  Increased risk of overdose when using more than one CNS depressant (e.g., benzodiazepines, alcohol, opioids)

Review signs and symptoms of an overdose to ensure the patient can recognize an overdose

Discuss how to respond to an overdose

- Take-home Naloxone
  - Provide kits early in admission in case the patient self-initiates discharge
  - Review how to use naloxone with the patient, if the patient is interested
- Nasal Naloxone
  - First Nations patients may access nasal naloxone without a prescription through FNHA at pharmacies across the province

Seek medical assistance for overdoses and after naloxone administration

If a patient overdoses after using unregulated substances in hospital

- See Reversal of Overdose
- Follow site-specific protocols

If a patient continues high-risk unregulated substance use in hospital

- If all options listed above to support the patient in hospital have been exhausted, follow site-specific protocols and only consider discharging the patient as a final option
  - Consider the patient's presentation, primary medical concern, and the risk of overdose and death if discharged
  - Consider consulting the local inpatient consult team, 24/7 Addiction Medicine Clinician Support Line, RACEapp, or other local addiction medicine resources if considering discharging a patient for ongoing, high-risk unregulated substance use

Resources

Province of British Columbia Decriminalizing people who use drugs in B.C.

24/7 Addiction Medicine Clinician Support Line (778-945-7619)

Rapid Access to Consultative Expertise (RACE) for Addiction

6. Discharge and referrals

Initiation or Continuation of Evidence-based Substance Use Disorder Treatment

Continuation

If a patient is already receiving treatment for a substance use disorder when they arrive in acute care:

Check existing prescription:

- Ask the patient if they know what medication and dose they are currently prescribed
- Check PharmaNet
- Contact their regular prescriber or pharmacy

Continue current prescribed medications to minimize disruptions in care and harms from abrupt discontinuation of medication (i.e., withdrawal, accessing unregulated drug supply), where possible

- Dose adjustments for opioid agonist treatment (OAT) may be required if the individual has missed doses or lost tolerance
- See the BCCSU's acute care resources, *Acute Care and Opioid Use Disorder* and *Opioid Agonist Treatment (OAT) Maintenance*

Initiation

To initiate treatment, follow site-specific protocols, or see:

The BCCSU's acute care resources

- *Co-occurring Substance Use Principles of Care*
- *Acute Care and Opioid Use Disorder*
- *Opioid Agonist Treatment (OAT) Initiation*

The BCCSU's Help with Drinking website and Continuing Care Pathway for Adult Patients with AUD

Discharge

Discuss discharge plans as soon as possible and on an ongoing basis before anticipated discharge (e.g., determine the patient's pharmacy in case of abrupt discharge), including the continuation or discontinuation of any medications ordered in the hospital

Provide discharge prescriptions or medications

- **Buprenorphine** can be given or prescribed as take-home doses

  If initiating BUP-to-go in an ED, provide and review BUP-to-go home induction handouts with the patient
- **Methadone** and **slow-release oral morphine** prescriptions to be filled by a community pharmacy must be written by a prescriber who has completed POATSP and a preceptorship
  - Liaise with the local inpatient consult team, virtual addiction clinic, or community OAT clinic to ensure a discharge prescription is faxed to a community pharmacy
  - Follow organizational protocols on how to discharge a patient when a prescriber is not immediately available

Discharge (continued)

Continuity of care

Offer the patient resources to support continuity of care

Contact the community pharmacist and/or prescriber directly, when possible, before patient is discharged

- If patient does not have a community pharmacy, help locate an accessible pharmacy
  - Send relevant information to the community prescriber, including a discharge summary and pertinent investigations, procedures, consultations
  - If the patient requires a community-based OAT prescriber, refer to a local Rapid Access to Addiction Care Clinic (if available in your region) or community addiction clinic
    - OAT Clinics Accepting New Patients
    - **Note:** Some community OAT providers charge additional clinic fees. Contact clinics before referral to determine if clinic fees are required and discuss with the patient
    - In collaboration with the patient, book an appointment before discharge

> **While titrating down on my prescribed medication, my doctor continued to support 2 extra take home doses.**
>
> **This gave me the autonomy to manage my symptoms and ultimately led to my success in achieving the target dosage while remaining stable in my daily life.**
>
> –Person with Lived Experience

Consider referral to an outreach team, if available in the region

Provide information on community supports such as harm reduction services (e.g., overdose prevention sites), community-based health care clinics, psychosocial supports, Indigenous cultural supports and services, and educational materials (e.g., Opioids: A Survivor's Guide)

Discuss with the patient if any support people should be alerted of the treatment plan (e.g., family members, friends, staff at supportive housing, etc.)

- Offer to give a copy of important paperwork to a friend or family member, if helpful

Consultation

Consult with an addiction specialist, such as the local inpatient addiction medicine consult team (available at some acute care sites), for any questions or concerns.

24/7 Addiction Medicine Clinician Support Line

- Consult with an addictions medicine specialist 24 hours a day, 7 days a week
- Available to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment in BC
- 778-945-7619

Rapid Access to Consultative Expertise (RACE)

- Online application where primary care providers (physicians and nurse practitioners) can receive specialist advice

Resources

VCH's SURKit Transition to Care – Next Best Step

BCCSU: *A Guideline for the Clinical Management of Opioid Use Disorder (2023)*

BCCSU: The Provincial Opioid Addiction Treatment Support Program

Patient Resources

Rapid Access to Addiction Care (RAAC) Clinics

Providence Health Care, St. Paul's Hospital, Vancouver

Fraser Health Authority

- Fraser East RAAC
  - Abbotsford, Abbotsford ACT Building
  - Chilliwack, Chilliwack General Hospital
  - Mission, Mission MHSU Centre
- Fraser North RAAC
  - New Westminster, MHSU Centre, RCH
- Fraser South RAAC
  - Surrey, Creekside Withdrawal Management Centre

Island Health, Pembroke St, Victoria

Virtual Addictions Medicine Services

Vancouver Coastal Health Lighthouse Virtual Substance Use Care Clinic

- Free virtual clinic that uses telephone appointments to provide medical treatments and short-term stabilization for people who use substances
- Available 7 days per week including statutory holidays (604-806-8223 or toll-free 1-877-842-8884)

Interior Health Virtual Addiction Medicine (VAM)

- Provides urgent care and medical support for those with substance use disorder

Northern Health Virtual Substance Use Clinic

- Offers substance use support to residents of Northern Health 1-844-645-781

Opioid Treatment Access Line

- 1-833-804-8111
- People with opioid use disorder can access care from clinicians, including physicians and nurses
- Prescriptions for opioid agonist treatment medications
- Covered by PharmaCare

First Nations Virtual Doctor of the Day

- Virtual appointments available to all First Nations people and their families living in BC (1-855-344-3800)