

ASAM COVID-19 TASK FORCE RECOMMENDATIONS

# CARING FOR PATIENTS DURING THE COVID-19 PANDEMIC

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Treating Unhoused People with  
Addiction During COVID-19



# TREATING UNHOUSED PEOPLE WITH ADDICTION DURING COVID-19

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A guide for addiction treatment clinicians and programs working to treat patients with substance use disorders safely and effectively during the COVID-19 pandemic<sup>1</sup>.

For additional recommendations for the Ongoing Management of the Continuum of Addiction Care during COVID-19, [please click here](#).

## CONTENT DISCLAIMER

This Clinical Guidance ("Guidance") is provided for informational and educational purposes only. It is intended to provide practical clinical guidance to addiction medicine physicians and others caring for individuals with substance use disorders during the COVID-19 pandemic as it unfolds. Adherence to any recommendations included in this Guidance will not ensure successful treatment in every situation. Furthermore, the recommendations contained in this Guidance should not be interpreted as setting a standard of care or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results.

The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biological behavior of the medical condition.

This Guidance and its conclusions and recommendations reflect the best available information at the time the Guidance was prepared. The results of future studies may require revisions to the recommendations in this Guidance to reflect new data.

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## TREATING UNHOUSED PEOPLE WITH ADDICTION DURING COVID-19

### Purpose of the document

The ongoing COVID-19 pandemic is presenting significant challenges for continuing to provide quality addiction treatment while minimizing patient, staff, and community risk for COVID-19. These challenges are even greater for clinicians and programs and organizations that serve patients who are experiencing homelessness. This resource provides guidance for how safety net systems may need to adapt to support individuals struggling with unstable housing and substance use disorders during the COVID-19 crisis.

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<sup>1</sup> This resource was developed by a Task Force appointed by ASAM's Executive Council. To enable more rapid development and dissemination it was not developed through ASAM's normal process for clinical guidance development that is overseen by the ASAM Quality Improvement Council.

## TOPICS:

1. [Caring for Patients with Addiction who are Experiencing Homelessness \(pg.2\)](#)
  - Re-Engineering Medication Delivery
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2. [Considerations for Isolation and Quarantine \(pg.6\)](#)
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### 1. Caring for Patients with Addiction who are Experiencing Homelessness

People who have substance use disorders and are experiencing homelessness are at high risk for COVID-19 infection due to their inability to adequately implement preventive measures that are advocated for the general population. For instance, physical distancing is impossible in crowded shelters and on the street where people congregate for protection from violence and overdose. Hand hygiene measures are difficult to follow due to lack of adequate access to bathrooms, sinks, and soap. People who are impaired due to intoxication or withdrawal are less likely to adhere to the use of masks or covering their cough, even if they do have access to masks.<sup>2</sup>

Alcohol and drug use behaviors are also likely to independently increase the probability of contracting coronavirus through a number of mechanisms including sharing substances, inhalation of substances, direct and indirect immunosuppressing effects (particularly when used heavily and chronically) and increased engagement in risky behaviors. The lack of access to adequate hygiene supplies and consistent sanitation facilities, along with limited access to healthcare are factors that may increase the risk of transmission and spread of COVID-19 among unsheltered populations<sup>3</sup>.

In addition, homelessness and addiction are both likely to be independently associated with a more severe course of COVID-19. People with addiction and those experiencing homelessness have high rates of chronic health conditions (e.g. respiratory disorders, cardiac disorders, chronic infections [HIV, HCV, infective endocarditis]) that confer risk, and many individuals experiencing homelessness are over age 50.<sup>4</sup> A recent analysis suggested that individuals experiencing homelessness who are infected by COVID-19 would be twice as likely to be hospitalized, two to four times as likely to require critical care, and two to three times more likely to die than the general population.<sup>5</sup>

During this public health crisis, people without access to housing will have significant need for both general medical care and addiction treatment. Improving access to treatment during this time is both critical to providing adequate care to these individuals and for protecting public health.

The CDC has released guidance for [Homeless Service Clinicians and Programs to Plan and Respond to COVID-19](#) and for people experiencing [Unsheltered Homelessness](#). These guidance documents both highlight the need for

<sup>2</sup> <https://www.statnews.com/2020/03/31/a-radical-approach-to-preventing-covid-19-infection-in-the-homeless/>

<sup>3</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html>

<sup>4</sup> <https://nhhc.org/wp-content/uploads/2020/03/Issue-brief-COVID-19-HCH-Community.pdf>

<sup>5</sup> [https://endhomelessness.org/wp-content/uploads/2020/03/COVID-paper\\_clean-636pm.pdf](https://endhomelessness.org/wp-content/uploads/2020/03/COVID-paper_clean-636pm.pdf)

and continued linkages to “medical, mental health, syringe services, and substance use treatment, including provision of medication-assisted therapies (e.g., buprenorphine, methadone maintenance, etc.).”

Continuity of care is critical for patients during this time. The relationship with a supportive treatment clinician/program may be one of the most stable relationships in the life of a person experiencing homelessness, so disruption of this relationship can be especially difficult.

Increased regulatory flexibility during this public health emergency is supporting increased access to treatment for addiction, including medications, through telehealth and increased access to take-home doses of methadone. However, individuals experiencing homelessness may not have access to a reliable phone, minutes, data plan, internet, or other technologies that would be needed to access telehealth services. In addition, they may not be able to safely store and manage a substantially increased number of take-home doses of methadone.

## Recommendations

- Treatment Clinician and Program Partnerships to Support Patients During COVID-19
  - Treatment clinicians and programs should work with outreach workers, emergency departments, harm reduction service programs to identify people and engage them in care.
    - Be ready to engage as people may be experiencing withdrawal at higher frequency if their drug supply has been disrupted.
  - Treatment clinicians and programs should work with their state and community leaders to identify strategies for supporting access to addiction treatment services during COVID-19. For example:
    - Providing phones (with minutes) to support engagement in telehealth
    - Partnering with street outreach teams, harm reduction service programs, jails and prisons, and other homeless service clinicians and programs to connect patients with addiction who are experiencing homelessness to treatment, including methadone or low barrier initiation of buprenorphine for those with opioid use disorder<sup>6</sup>.
    - Ensuring ongoing access to harm reduction services such as syringe services and naloxone.
  - Treatment clinicians and programs should work closely with isolation and quarantine facilities to provide addiction treatment to patients with, and those suspected of having, COVID-19.
    - Isolation and quarantine can be very stressful for people with addiction. Treating clinicians and programs may consider short term interventions to help patients tolerate staying in isolation and quarantine facilities.
    - For patients dependent on benzodiazepines, either prescribed or through illicit use, consider offering medications by prescription in order to prevent withdrawal.
    - For patients with stimulant use disorders, clinicians may consider treating patients with prescribed stimulants. Even though such treatment has not been shown conclusive-ly to improve the course of stimulant use disorder, the goal during this public health crisis is different, namely to help patients to tolerate staying in isolation and quarantine facilities for the limited period of time necessary to protect the patient and the broader community.
  - Treatment clinicians and programs should work with local jails and prisons, many of which are expediting release for low-level offenses, to ensure that people with substance use disorders who are also experiencing homelessness are linked to addiction treatment and housing services.
- Treatment Clinician and Program Adjustments to Clinical Services During COVID-19
  - Treatment clinicians and programs should do everything they can to ensure patients have consistent access to their addiction treatment medications.
  - If a patient is in need of care but does not have access to the technology needed to engage in

<sup>6</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6501460/>

- telehealth the treating clinician/program should either provide in person care or facilitate on site telehealth. Patients can access a phone or computer at the clinic, or through a partnering organization, while connecting to a clinician in a different room or organization to minimize risks to both patient and staff.
- In areas of community spread, addiction treatment clinicians and programs should assume that all patients accessing the facility may have been exposed to COVID-19.
    - Symptom screening, while important, will be of limited utility in identifying asymptomatic individuals or pre-symptomatic patients due to the long incubation period of the virus. Identification of symptomatic individuals for the purpose of helping them access needed medical care, however, is still recommended.
    - If rapid testing is available it can be used to cohort residents living in congregate settings, keeping those who test COVID-19 positive away from those who test negative in order to reduce exposures.
  - For patients with confirmed or suspected COVID-19, residential or inpatient treatment programs should work with their local public health department to have patients tested and identify an isolation site where they can access the ongoing care that they need for both addiction and COVID-19 if the residential treatment program is unable to provide sufficient isolation/quarantine space.
    - When discharging patients who lack stable access to housing and are not suspected of having COVID-19, the treatment program should:
      - Work with treatment clinicians and programs in the community to ensure that the patient is effectively engaged in the appropriate level of outpatient care.
      - Work with the community housing services, as well as local recovery homes, to identify housing and other recovery support services available to the patient.
      - Make sure the patient has a mask.
      - Ensure patients who might be at risk for opioid overdose have naloxone.
  - Opioid treatment clinicians and programs should work with shelters and alternative care sites to explore options for take-home doses of methadone and telehealth-based appointments.
    - Opioid treatment clinicians and programs should coordinate with shelter managers and staff at alternative care sites to ensure medication continuity for patients treated for OUD.
    - Opioid treatment programs should be prepared to deliver doses of methadone to established patients in shelters and alternative care sites, utilizing alternative medication delivery systems if those are available (e.g. mobile dispensing units, OTP staff or law enforcement-based delivery systems).
  - DATA-waived clinicians able to prescribe buprenorphine for patients with untreated OUD should make themselves known and available to shelters and alternative care sites through locally developed systems of care.
  - Detachment from treatment and recovery support groups can be particularly difficult for people experiencing homelessness, as they may be less likely to have the ability to access online support groups. Treatment clinicians and programs should consider options for supporting access to support groups.
    - On site groups that maintain physical distancing.
    - Provide technology for virtual support groups.
  - Patient Guidance during COVID-19
    - Medical clinicians should counsel patients with addiction about strategies to minimize their risk of transmission including physical distancing; hand hygiene when possible; not sharing cups, bottles, utensils, etc.; not sharing cigarettes, e-cigarettes, joints, etc.; and not sharing other drug use equipment (e.g. syringes, cookers, cottons).
    - Patients should also be advised on where to seek care if they develop COVID-19 symptoms,

- as well as where to seek care if they experience withdrawal or other potentially serious health issues related to their substance use.
- In areas of significant community spread, advise patients that emergency services may be slower to respond.
    - Emphasize importance of access to naloxone and having someone who can check in on them when using alcohol and substances.
    - Ensure patients have access to overdose education and naloxone kits- either through your agency, through community naloxone distribution programs, or pharmacy dispensing.
  - Hospitals and emergency departments should continue to screen for substance use disorder and withdrawal risk and should assess housing status before discharging patients with or suspected of having COVID-19. When possible, hospitals and emergency departments providing care to patients with opioid use disorder should:
    - Offer initiation of buprenorphine (or methadone for inpatient services) prior to discharge and ensure linkage to community-based treatment provider.
    - Offer naloxone kits (or if not possible, naloxone prescription) to anyone who may be at risk for opioid overdose.

## Re-Engineering Medication Delivery

Treatment clinicians and programs should consider new strategies for getting medications to patients, including those in isolation or quarantine, while minimizing the risk to patients, staff, and public health . This will likely involve close coordination with community safety net clinicians and programs and isolation and quarantine sites. [Some communities](#) are currently exploring the use of mobile dispensing units to deliver buprenorphine, methadone, and other medications to patients that cannot or should not come to an in-patient visit.<sup>7</sup>

The [DEA released guidance](#) related to alternative medication delivery systems for methadone on March 16, 2020 during the COVID-19 pandemic. The guidance allows for “door-step” delivery of controlled medications, specifically methadone, from OTPs to patients in need of isolation or quarantine. This delivery method requires that either an OTP staff member, a law enforcement officer, or a member of the National Guard deliver a duly ordered and dispensed amount of methadone to a patient in a locked box or container while maintaining appropriate physical distancing. Practically, this guidance means that the person delivering the medication must witness the patient or an approved member of the household retrieve the locked box/container from the doorstep. Deliveries of medication to patients unable to present in-person to an OTP can also be done through [established chain-of-custody protocols](#) with a responsible adult.

## Infection Control and Mitigation when Telehealth is not an Option

The CDC recommends that, “For street medicine or other healthcare staff who are providing medical care to clients with suspected or confirmed COVID-19 and close contact (within 6 feet) cannot be avoided, staff should at a minimum, wear eye protection (goggles or face shield), an N95 or higher level respirator (or a facemask if respirators are not available or staff are not fit tested), disposable gown, and disposable gloves. **Cloth face coverings are not PPE and should not be used when a respirator or facemask is indicated.** Healthcare clinicians and programs should follow infection control [guidelines](#).

Also see [Infection Control and Mitigation Strategies in Outpatient Settings](#) Guidance.

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<sup>7</sup>[https:// iltermag.org/new-york-home-methadone-delivery/](https://iltermag.org/new-york-home-methadone-delivery/)

## 2. Considerations for Isolation and Quarantine

People experiencing homelessness are unable to quarantine or isolate at home. Communities are taking varying approaches to providing facilities for this purpose, including use of convention centers, dormitories, hotel rooms, etc. with varying levels of staffing and medical capacity. However, individuals with addiction are sometimes prevented from accessing these facilities or are discharged because of addiction-related behaviors. CDC guidance<sup>8</sup> recommends that these sites “Arrange for continuity of and surge support for mental health, substance use treatment services, and general medical care.”

Patients who are admitted to an isolation or quarantine facility may not be seeking treatment for SUDs. To protect both individual and public health, harm reduction approaches should be used to create an environment in which the person feels welcomed and able to stay during the required period of isolation. This may involve tolerating ongoing substance use and supporting the provision of safer injection and inhalation equipment and overdose-prevention interventions including naloxone availability. The [National Health Care for the Homeless Council notes](#) that “Failure to accommodate substance use disorders will likely mean increases in fatal overdoses/dangerous withdrawals, higher rates of vulnerable people leaving I&Q [isolation and quarantine] against medical advice and compromised individual and public health.”

### Recommendations

An estimated 50% of people who are homeless have a substance use disorder.<sup>9</sup> Isolation and quarantine facilities should be prepared to address the needs of individuals with addiction by:

- Screening for substance use disorders and assessing both overdose and withdrawal risk as individuals enter the facility.
- Training facility staff on signs and symptoms of withdrawal, protocols for response, and when symptoms are identified, linkage to medical clinicians and treatment programs as needed.
- Working with community addiction treatment clinicians to develop protocols to triage and address risks related to substance use and addiction.
  - Establish protocols to efficiently assess and address withdrawal from alcohol, opioids, and benzodiazepines.
  - Establish protocols for reducing harms and discomfort associated with withdrawal from nicotine.
  - Develop protocols to proactively offer substance use disorder treatment services.
- Supporting the provision of addiction treatment services to residents through telehealth.
  - Explore options for providing access to technologies for telehealth (e.g. phones and minutes, computers, private space for these visits).
- Ensuring patients have continued access to medications for the treatment of substance use disorders, especially medications for opioid use disorder since discontinuation can put patients at significant risk for relapse and overdose, in addition to increasing risk for patients leaving early.
  - Coordinate with local OTPs to ensure medication continuity for patients who are receiving methadone or buprenorphine through the OTP.
  - Coordinate with local buprenorphine waived clinicians to enable both initiation and continuation of buprenorphine treatment.
  - Offer nicotine replacement treatment for patients who use tobacco products.
  - Offer medications and withdrawal management for alcohol use disorder for patients who are interested.

<sup>8</sup><https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>

<sup>9</sup>[https://www.samhsa.gov/sites/default/files/programs\\_campaigns/homelessness\\_programs\\_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf)



- Offer ability to initiate counseling services via telehealth when possible.
- Support the delivery of harm reduction services.
  - Train staff on overdose recognition, response protocol, and naloxone administration.
  - Maintain a sufficient supply of naloxone for both residents and staff.
  - When possible, ensure that patients being discharged have access to naloxone (through direct distribution, a prescription, or linkage to community-based naloxone distribution).
  - Coordinate access to syringe services.
  - Ensure access to sharps containers for safety of all individuals living at the facility and staff.
- Do not deny services to individuals on the basis of their addiction and do not discharge people because of substance use.
- Acknowledge that some residents may obtain and use substances while in isolation and quarantine. Be ready to ensure the safety of these, and other patients, and staff.
  - This is less likely to occur when appropriate medical services to screen for and treat withdrawal symptoms in a timely fashion are provided.
- Train staff on how to support and monitor residents who are intoxicated.
  - Encourage use of non-judgmental, trauma informed approaches.
  - Consider engaging peer support specialists who have experience working with individuals with addiction.
  - Directly address the biases that may lead to de-prioritization of care for these patients (particularly COVID care).
- Consider options for supporting access to support groups.
  - Onsite groups that maintain physical distancing.
  - Provide technology for virtual support groups.

### ● 3. Importance of Community Coordination for Supporting Individuals with Addiction Experiencing Homelessness

The CDC recommends a “whole community” approach to planning and responding to COVID-19 among people experiencing homelessness<sup>10</sup>. They recommend that:

A community coalition focused on COVID-19 planning and response should include:

- Local and state health departments
- Outreach teams and street medicine clinicians and programs
- Homeless service clinicians and programs and Continuum of Care leadership
- Emergency management
- Law enforcement
- Healthcare clinicians and programs
- Housing authorities
- Local government leadership

<sup>10</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>



- Other support services like case management, emergency food programs, syringe service programs, and behavioral health support
- People with lived experiences of homelessness

Addiction treatment clinicians and programs are critical partners in this work as most isolation and quarantine facilities and alternative care sites will not have the necessary staff or expertise to address the complex needs of individuals with addiction.

There are many options for community partnerships that can help address the needs of individuals with addiction who lack housing. For example, alternative care sites can partner with treatment clinicians and programs to deliver telehealth services. In Chicago, local federally qualified health centers (FQHCs) are partnering with alternative care sites to offer telehealth services for addiction treatment, including medications for opioid use disorder<sup>11</sup>. In another example from Boston, a substance use disorder bridge clinic is partnering with a drop-in health clinic, a local syringe service and harm reduction program, and other clinicians and programs who serve people who are homeless, using street-based outreach workers from these programs to initiate conversations about addiction treatment and connect interested people to care using their phones<sup>12</sup>.

The regulatory flexibility for providing [telehealth services](#) during this public health crisis is allowing treatment clinicians and programs to bill for these services. This may promote expansion of creative ways of expanding access to quality care for addiction.

## Recommendations

- Communities should forge partnerships focused on engaging people with substance use disorders who are experiencing homelessness with treatment for SUD and withdrawal, as well as harm reduction services.
  - Identify opportunities for outreach teams and clinicians and programs who serve people who are experiencing homelessness to partner with outpatient addiction treatment clinicians and programs to provide treatment for SUD, including medications for opioid use disorder.
- Given the high risk of coronavirus transmission within all congregate living settings (shelters, residential facilities, recovery homes), communities should prioritize these sites for increased access to surveillance testing<sup>13</sup>.

## 4. Reducing Harms During COVID-19

The COVID-19 pandemic is increasing the risk for harms associated with substance use in a number of ways:

- Increased stress related to risks and uncertainty because of COVID-19, as well as increased isolation may cause people with substance use disorders in remission to resume use or people with active substance use disorder to have exacerbation of symptoms.
- Physical distancing measures and other restrictions have limited access to harm reduction services including naloxone distribution and syringe service programs, which can put people at risk for overdose as well as infectious diseases.
- People may be more likely to use alone during this time which can increase risk of overdose death.
- Changes in the drug supply lead people to new substances and new sources which increases risks.
  - Disrupted drug supply chains may mean people are buying drugs from different sources or switching drugs which can put them at risk for overdose. See the UN Office of Drug Control's Research Brief on COVID-19 and the drug supply chain: <http://www.unodc.org/documents/data-and-analy->

<sup>11</sup><https://attcnetwork.org/centers/great-lakes-attc/event/chicago-street-outreach-and-linkage-oud-care-during-pandemic>

<sup>12</sup><https://www.bmc.org/healthcity/population-health/relaxed-federal-policies-enable-street-outreach-substance-use>

<sup>13</sup><https://www.ncbi.nlm.nih.gov.ezproxy.bu.edu/pubmed/32338732>

[sis/covid/Covid-19-and-drug-supply-chain-Mai2020.pdf](#)

- New unemployment and economic recession may make it difficult for people to be able to purchase substances which can put them at risk for withdrawal.
  - These circumstances may increase the demand for treatment.
- Reduced access to addiction treatment and harm reduction services because of program limitations in being able to deliver services while maintaining physical distancing recommendations, as well as changes in service delivery (i.e. move toward telehealth only)

## Recommendations

- Treatment clinicians and programs, isolation and quarantine sites, and harm reduction service programs should work together to develop strategies to provide treatment and harm reduction services to individuals in need.
- Hospitals and emergency departments should continue to screen for substance use disorder and withdrawal risk and ensure that patients are engaged in appropriate care. Ideally this should include offering initiation of buprenorphine for people with opioid use disorder, naloxone kit or naloxone prescription, and linkage to appropriate community-based treatment and/or harm reduction services.
- Outreach workers should be prepared to connect individuals in need of addiction treatment or withdrawal management services to treatment clinicians and programs in their communities, and should have up-to-date information on which service clinicians and programs are accepting clients and via what mechanism (telehealth, in-person, etc).

## 5. General Resources

- Interagency Council on Homelessness webinar series on Seattle Isolation and Quarantine facility; LA County hotels for I/Q; Boston COVID Recuperation Unit <https://www.bostonglobe.com/2020/04/26/metro/when-covid-19-patients-need-recuperate-home-have-no-home/>
- Strengthening Coordination Across the Social Safety Net for Patients with Addiction Webinar (NAM-ASAM Collaboration) <https://elearning.asam.org/products/coordination-across-the-social-safety-net-to-avert-a-crisis-among-patients-with-addiction-nam-asam-collaboration>
- Healthcare for the homeless guidance
  - <https://nhchc.org/wp-content/uploads/2020/03/Issue-brief-COVID-19-HCH-Community.pdf>
  - <https://nhchc.org/wp-content/uploads/2020/04/Issue-brief-2-COVID-19-HCH-Community-Public-Health-Actions.pdf>
  - <https://nhchc.org/wp-content/uploads/2020/04/Reducing-Harm-During-COVID-19-for-People-Using-Drugs-at-ACS1.pdf>
- UCSF A Medically Indicated Plan to Prevent Spread of COVID-19 Among Unhoused People
  - [https://sfunitedincrisis.org/wp-content/uploads/2020/04/COVID19\\_Unhoused\\_Plan.pdf](https://sfunitedincrisis.org/wp-content/uploads/2020/04/COVID19_Unhoused_Plan.pdf)

- British Columbia Center on Substance Use. Risk Mitigation in the Context of Dual Public Health Emergencies: <https://www.bccsu.ca/wp-content/uploads/2020/05/Risk-Mitigation-in-the-Context-of-Dual-Public-Health-Emergencies-v1.6.pdf>
- California Recommended Strategic Approaches for COVID-19 Response for Individuals Experiencing Homelessness <https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/Protocols-Homeless-Pop.pdf>
- UN Office of Drug Control Analysis of COVID-19 and Drug Supply Chains. <http://www.unodc.org/documents/data-and-analysis/covid/Covid-19-and-drug-supply-chain-Mai2020.pdf>
- Building an effective cross-sector partnership to address COVID-19 among vulnerably housed populations of Chicago [https://www.chicagohomeless.org/wp-content/uploads/2020/06/CHHRGE-White-Paper-06.11.2020\\_1.pdf](https://www.chicagohomeless.org/wp-content/uploads/2020/06/CHHRGE-White-Paper-06.11.2020_1.pdf)
- CDC Interim Guidance for Homeless Service Clinicians and programs to Plan and Respond to Coronavirus Disease 2019: <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>
- CDC Interim Guidance on Unsheltered Homelessness and Coronavirus Disease 2019 (COVID-19) for Homeless Service Clinicians and programs and Local Officials: <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html>
- Shatterproof blog on protecting vulnerable populations including people experiencing homelessness: <https://www.shatterproof.org/blog/moving-addiction-treatment-online-right-thing-do-could-leave-most-vulnerable-without-care>
- DEA memo on alternative delivery models for OTPs during COVID: [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-015\)%20SAMHSA%20Exemption%20NTP%20Deliveries%20\(CoronaVirus\).pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-015)%20SAMHSA%20Exemption%20NTP%20Deliveries%20(CoronaVirus).pdf)

