

Converging Crises: Caring for Hospitalized Adults With Substance Use Disorder in the Time of COVID-19

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The spread of SARS-CoV-2, the pathogen behind the COVID-19 pandemic, has converged with an unrelenting addiction epidemic. These combined crises will have profound effects on people with substance use disorders (SUD) and people in recovery. Hospitals—which were already hit hard by the addiction epidemic—are the last line of defense in the COVID-19 pandemic. Hospitalists have an important role in balancing the effects of these intersecting, synergistic crises.

People with SUD are disproportionately affected by major medical illnesses, including infections such as hepatitis C, HIV, and cardiovascular, pulmonary, and liver diseases.¹ They also experience high rates of hospitalization due to drug-related infections, injury, and overdose.² People with SUD commonly have intersecting vulnerabilities that may affect their healthcare experience and health outcomes, including housing and food insecurity, mental illness, and experiences of racism, incarceration, and other trauma. They may also harbor mistrust of healthcare providers because of previous negative encounters and discrimination with health systems.³ These vulnerabilities increase risks for COVID-19 morbidity and mortality.^{4,5} The COVID-19 pandemic may drive increases in use and harms from SUD among patients who already have an SUD, with widespread job loss, insurance loss,⁶ anxiety, and social isolation on the rise. We may also see increases in return to use among people in recovery or new substance use among those without a history of SUD.

The intersecting crises of SUD and COVID-19 are important for people with SUD and for public health. In this perspective, we describe how the COVID-19 pandemic has affected people with SUD and share practical resources for hospital providers to improve care for people with SUD during the pandemic and beyond.

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CONTEXTUALIZING COVID-19 AND SUD RISK Mistrust of Hospitals and Healthcare Providers

Fear of stigmatization is an ongoing problem for people with SUD, who often experience discrimination in hospitals and, as a result, may avoid hospital care.⁷ Much of this stigma is based on the false but persistent belief—widespread even among healthcare providers—that addiction is the result of bad choices and limited willpower; however, the science is clear that addiction is a disorder with neurobiological, genetic, and environmental underpinnings.³ These attitudes are likely to be amplified during COVID-19, as patients and providers experience higher levels of stress.

Increased Risks of Substance Use

Typically, people who use drugs are counseled to use with others nearby so that they might administer naloxone or call 911 in the event of an overdose.⁸ With physical distancing, people may be more likely to use alone. COVID-19 also introduces uncertainty into the drug supply chain through changes in drug production and trafficking.⁹ Further, access to alcohol may be limited as liquor stores close and public transportation becomes less available. As has been shown in other complex emergencies (such as social, political, economic, and environmental disasters), these barriers to obtaining substances may increase risks for withdrawal, for needing to exchange sex for money or drugs, for sharing syringes or drug preparation equipment,¹⁰ or for consuming other available sources of substances, like rubbing alcohol or hand sanitizer. COVID-19 may also increase risk for depression, anxiety, social isolation, and suicidality, all of which increase risk for return to use and overdose.

Changes to the Treatment Milieu

Many of the resources and services that people who use substances rely on to keep safe may be disrupted by COVID-19. Social distancing—the cornerstone of mitigating COVID-19 spread—may be challenging among people with SUD. Though federal regulations around methadone dispensing and buprenorphine prescribing have loosened in response to the pandemic,¹¹ individuals in treatment may still be required to provide

urine drug screens or be physically present to receive methadone doses, sometimes daily and in crowded waiting rooms.

Recovery support groups such as Alcoholics Anonymous (AA) and Self-Management and Recovery Training (SMART) provide social connection and are the foundation of many people's recovery. While many in-person meetings have rapidly transformed to online and telephone support, they remain inaccessible to the most marginalized members of communities: people without smart phones, computers, or internet. This digital shift may also disproportionately affect older adults, people with limited English proficiency, and people with low technological literacy. Limits for other resources, such as syringe service programs, community centers, food pantries, housing shelters, and other places that people depend on for clean water, food, showers, soap, and safer spaces to use, may limit services or close altogether; those that remain open may see an unprecedented rise in need for services as millions of Americans file for unemployment. For many, anxiety about the pandemic, unemployment, financial strain, increased isolation, family stressors, illness, and community losses can lead to enormous personal distress and trigger return to use; loss of a recovery network may further exacerbate this.

Intersectionality of SUD and Other Structural Inequities

Many of the inequities that increase people's risk for under-treated SUD also increase risk for COVID-19 infection, including racism,¹² poverty, and homelessness.⁴ "Stay home and stay safe" is not an option for people who are unsheltered or whose homes are unsafe because of risks of physical, sexual, or emotional violence. Poverty commonly forces people to live in crowded communal apartments or shelters, rely on public transportation, wait in long lines at food pantries, and continue to work, even if unwell. Many shelters have had to reduce the number of people they serve to reduce crowding and support social distancing, which further compounds risks of unstable housing. Unfortunately, the same structural inequities that exacerbate SUD worsen the COVID-19 crisis.¹³

ROLE FOR HOSPITALISTS

The intersecting vulnerabilities of SUD and COVID-19 heighten an already urgent need to address SUD among hospitalized patients.¹⁴ While COVID-19 may increase harms of substance use, it may also increase people's readiness to engage in treatment given changes to the drug supply and patient's concerns about health risks. As such, it is even more critical to make treatment readily accessible and support harm reduction. Hospitalists can take important, actionable steps for patients with SUD—many of which are good general practices¹⁴ (Appendix Table).

Hospitalists should do the following:

1. Identify and treat acute withdrawal.¹⁵
2. Manage acute pain, including providing high-dose opioids if needed.¹⁶ Both practices (1 and 2) are evidence-based, can promote patient's trust in providers,¹⁷ and can help avoid

patients leaving against medical advice (AMA). Leaving AMA can lead to poor individual health and further threaten public health if patients leave with undiagnosed or unmanaged COVID-19 infection.

3. Encourage their hospitals to provide patients with tablets or other means to communicate with family, friends, and recovery supports via videolink, and refer patients to virtual peer support and recovery meetings during hospitalization.¹⁸ These practices may further support patients in tolerating hospitalization and prevent AMA discharge.

4. Initiate medication for addiction during admission and refer to addiction treatment after discharge. COVID-19–related regulatory changes such as expanded telehealth buprenorphine options and fewer daily dosing requirements for methadone may make this easier. Further, hospitalists should offer medication for alcohol and tobacco use disorders,¹⁵ especially given heightened possibility of unhealthy alcohol use and the respiratory complications associated with both tobacco and COVID-19.

5. Assess mental health and suicide risks¹⁹ given their association with social isolation, job loss, and financial insecurity.

6. Discuss relapse prevention among people in recovery.

7. Assess overdose risk and promote harm reduction.¹⁹ Specifically, this may include counseling patients to avoid sharing smoking supplies to avoid COVID-19 transmission, identifying places to access clean syringes, prescribing naloxone,²⁰ and providing supports so that, if patients need to use alone, they can do so more safely.²¹

8. Consider high-risk transitions that may be exacerbated by COVID-19. COVID-19 may make safe discharge plans among people experiencing homelessness very challenging. Some communities are rapidly repurposing existing spaces or building new ones to care for people without a safe place to recover after acute hospitalization, yet many communities have no such resources. Hospital teams should consider the possibility that community services and SUD treatment resources may change rapidly during the pandemic. Hospitals can maintain updated resource lists and consider partnering with state and local health departments to improve safe care for people experiencing homelessness or lacking basic services.

COVID-19 is putting enormous strain on many US hospitals. Hospital-based addiction care is under resourced in the best of times,¹⁴ and while some hospitals have addiction consult services, many do not. To what degree hospitalists and hospital teams can address anything beyond COVID-19 emergencies will vary based on settings and resources. Furthermore, we recognize that who performs various activities will depend on individual hospital's resources and practices. Addiction consult services, if available, can play a critical role, as can hospital social workers and care managers, nurses, residents, students, and other members of the healthcare team.

Finally, though COVID-19 adds tremendous stress to hospitals, permanent improvements in SUD treatment systems such as telephone visits for buprenorphine or eased methadone restrictions may emerge that could reduce barriers to hospital-based addiction care.¹¹ Leveraging these changes now

may help hospital providers to better support patients long-term.

CONCLUSION

Hospitalization can be a challenging time for patients with SUD and for the hospital teams who care for them. These tensions are exacerbated by the COVID-19 pandemic, yet hospitalists play a critical role in addressing the converging crises of SUD and COVID-19. Providing comprehensive, compassionate, evidence-based care for hospitalized patients with SUD is important for both individual and community health during COVID-19.

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