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In-hospital Substance Use Policies: An Opportunity to Advance Equity, Reduce Stigma, and Offer Evidence-based Addiction Care

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In-hospital substance use is common among patients with addiction because of undertreated withdrawal, undertreated pain, negative feelings, and stigma. Health care system responses to in-hospital substance use often perpetuate stigma and criminalization of people with addiction, long etched into our culture by the racist War on Drugs. In this commentary, we describe how our hospital convened an interprofessional workgroup to revise our in-hospital substance use policy. Our updated policy recommends health care workers respond to substance use concerns by offering patients adequate pain control, evidence-based addiction treatment, and supportive services instead of punitive responses. We provide best-practice recommendations for in-hospital substance use policies.

Key Words: substance use disorder, opioid use disorder, hospital policy, acute care, addiction consult, equity

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CASE

A young pregnant woman with untreated cocaine and opioid use disorder presented to our hospital in labor. She started methadone for her opioid use disorder and planned to enter residential substance use treatment with her healthy baby after birth. While transferring to a postpartum room, hospital staff noticed foil and a lighter among her belongings and called campus security as our in-hospital substance use policy suggested. The sheriffs, who provide campus security, responded, discarded the substance use supplies, and checked for outstanding warrants per their protocol. The mother had a parole violation, so they arrested her on discharge. She left the postpartum unit in handcuffs instead of entering addiction treatment and parenting her child as she had planned.

IN-HOSPITAL SUBSTANCE USE

More than 40% of individuals with substance use disorders (SUDs) use substances during hospitalization to avoid withdrawal, undertreated pain, negative feelings (eg, loneliness, sadness, boredom, urge to use), and stigma.[1–4] In-hospital substance use is associated with increased rates of patient-directed discharges, readmissions, and death.[5] Although in-hospital substance use is common and associated with poor outcomes, little research exists to guide institutional policies.

Without policies, health care workers use personal beliefs about addiction when responding to in-hospital substance use.[2] These beliefs may be rooted in stigma and result in harmful responses including increased patient surveillance (eg, nursing visits, safety attendants, locating patients near nursing stations), punishing patients (eg, restrict visitors, reduce floor privileges, stop/decrease medications, threaten discharge), and calling security.[2] Cravings for substances and substance withdrawal, instead of being attributed to symptoms of an untreated disease, are equated to "drug-seeking" behaviors. Addiction is viewed as a personal choice and moral failing, and abstinence as the sole outcome for clinical success. These responses are unsurprising as health care workers have been historically undertrained to care for people with SUDs.

In-hospital substance use policies that center punitive measures are similarly harmful. They may result in riskier in-hospital substance use, overdose, patient-directed discharges, reduced trust, and increased stigma.[5] People with SUDs perceive hospitals as risky environments; they avoid or delay care and self-direct their discharge because of stigmatizing and traumatizing health care experiences, which increases morbidity and mortality.[5–8] In-hospital substance use policies that promote punitive measures also align with criminalization promoted by the War on Drugs compounding systemic racism, and missing opportunities to engage patients.

As illustrated by our case, our hospital's former policy led with a punitive approach that resulted in patient arrests. Punitive

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responses to in-hospital substance use are common. A Massachusetts hospital association's inpatient opioid misuse prevention policy stipulates that a 2-person search, which may include security, be performed for "a significant patient safety concern" to prevent patients from bringing opioids into the hospital.[9] We did not identify Centers for Medicare and Medicaid Services or Joint Commission on Accreditation of Healthcare Organizations standards on responding to in-hospital substance use. However, the Joint Commission references the International Association for Healthcare Security and Safety Guidelines, which defers to individual health care facilities to develop policies regarding security's role in patient care.[10]

In-hospital substance use policies could facilitate therapeutic responses instead of leaving health care workers to apply potentially stigmatizing beliefs about addiction.[6,11] To be effective, these policies must be patient centered, stigma free, evidence-based, nonpunitive, and coupled with addiction education for the health care workforce.

PATIENT CENTERED GUIDELINES CAN DISRUPT SYSTEMIC RACISM AND INEQUITY PERPETUATED BY HEALTH CARE SYSTEMS

Health care systems can perpetuate criminalization, racism, and inequities for people with SUDs, which are compounded for minoritized individuals. For example, although SUD prevalence is similar across race/ethnicity, Black and Latinx individuals comprise 75% of people in federal prisons for drug-related offenses despite only accounting for 32% of the US population.[12] Gaps in addiction treatment also exist: Black, Indigenous, and Latinx individuals have lower access to treatment than White individuals.[13,14] In the context of disproportionate criminalization and inadequate access to SUD treatment, minoritized patients may face increased risk of harm when in-hospital substance use occurs.

REVISING AND IMPLEMENTING OUR IN-HOSPITAL SUBSTANCE USE POLICY

After identifying how our hospital's policy caused harm by suggesting that security respond to in-hospital substance use concerns, we convened an interprofessional workgroup of administrators, nurses, and physicians to revise the policy. Our group included addiction specialists who examined the literature, elucidated why in-hospital substance use occurs, and agreed on best practices for responding without punitive measures.[2,4,5,8]

Our revised policy (Appendix, http://links.lww.com/JAM/A361) removes security as the first responder to in-hospital substance use concerns. The updated policy recommends a nonstigmatizing approach, starting with educating all patients, regardless of substance use history, about our in-hospital substance use policy. If substance use concerns arise, the policy guides health care workers to preserve patient dignity and respond with supportive interventions. It encourages obtaining patient permission to discuss substance use and then inquiring about in-hospital use with open-ended questions. This discussion is contextualized in concern for patient safety and desire to prevent addiction-related suffering.

If patients endorse substance use concerns, we offer (1) adequate pain control that accounts for high opioid tolerances; (2) evidence-based medications for cravings, withdrawal, and treatment; and (3) other supportive addiction consult team services (eg, daily visits, snacks, journals, radio, phone chargers) that help patients tolerate hospitalization. We then remind patients of our in-hospital substance use policy. The updated policy states that substances and substance use supplies either be discarded or stored in the patient's hospital room in a cabinet locked by hospital staff until discharge. In the absence of clear risk of imminent harm to patients and health care workers, we do not involve security, increase surveillance, or search patient belongings.

We coupled policy revisions with training for hospital staff, including information about addiction as a treatable disease, trauma-informed care, stigma, and person-first language.

OPPORTUNITIES FOR IMPROVEMENT

Although overall response to the revised policy has been positive, we have faced implementation challenges. Health care workers voiced concerns about personal and patient safety and legal repercussions.

We discuss safety threats versus fears founded in racism and stigma, as well as rare situations, such as violence toward health care workers, in which security might be called.[15] If health care workers are uncomfortable handling substances, which may occur in the context of personal experiences with addiction, we ensure that other team members can temporarily step in.

We approach patient safety concerns through education about addiction as a treatable disease. We review how adequately treating withdrawal and pain can decrease in-hospital substance use, thus reducing personal safety concerns, such as needlesticks, and other potential patient harms including infections, overdose, and encephalopathy. These discussions emphasize how our in-hospital substance use response can reduce patient-directed discharges, increase access to life-saving addiction treatment, maintain tolerance to reduce posthospitalization overdose mortality, and improve patient and health care worker experiences and safety.

Health care workers worry about legal repercussions, including losing their licenses because of handling unprescribed substances without security oversight. We mitigate these concerns by having legal, security, regulatory, leadership, and multiple hospital committees sponsor the policy.

RECOMMENDATIONS FOR IN-HOSPITAL SUBSTANCE USE POLICIES

Based on existing evidence and our experience updating our hospital's policy, we recommend the following best practices for nonpunitive, in-hospital substance use policies:

1. Convene an interprofessional group that includes patients to create or review the policy.
2. Ensure the policy is patient-centered and does not include punitive measures, including security as a first responder. If security is included, confirm they are a last resort.
3. Evaluate the policy with an equity lens to determine who will be disproportionately affected and how, based on policy implementation trends across race/ethnicity and substance use.
4. Obtain legal, security, regulatory, nursing, and leadership sponsorship of the policy to ensure consistent messaging and support.

5. Educate health care workers about the policy, evidence-based addiction care, harms of stigma, and SUD-related inequities, especially around race/ethnicity. Provide best-practice scripts of how to respond to in-hospital substance use concerns.
6. Involve health care workers in policy implementation and a continual improvement process.
7. Inform all patients, regardless of substance use history, of the policy on admission.
8. Offer patients adequate pain control, evidence-based addiction treatment, and supportive care that helps them tolerate hospitalization.

CONCLUSIONS

What does our revised policy look like in action? A patient with opioid use disorder was admitted, and his outpatient buprenorphine was inadvertently discontinued. He experienced pain, withdrawal, and cravings and used nonprescribed opioids. His team reviewed the updated policy and called our hospital's addiction consult team who reinitiated buprenorphine, recommended adequate pain control, and discussed the in-hospital substance use policy with him. He successfully completed treatment of his illness and was discharged.

With increasing rates of substance-related hospitalizations and persistent gaps in addiction treatment, in-hospital substance use will continue. Criminalization of substance use has fueled racial/ethnic inequities and not reduced addiction-related deaths. Health care systems can promote health and advance equity and antiracism by revising or developing policies to in-hospital substance use. These policies must dismantle stigma and punitive practices and facilitate compassionate, evidence-based addiction care. Further research should explore outcomes of in-hospital use policies and make best-practice recommendations for hospitals and regulatory agencies.

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