Recommendations for

Substance Use Prevention, Treatment & Recovery Operations during COVID-19

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Description of the Problem

In 2018, approximately 20.3 million American ages 12 and older battled a substance use disorder, also known as addiction[1]. Addiction is a chronic, relapsing, but treatable disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences[2]. Its development involves complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. The use of addictive substances alters and affects brain function and behavior, particularly during the vulnerable period of adolescence[3]. The National Institute on Drug Abuse describes 13 Principles of Drug Addiction Treatment that reflect a multi-dimensional approach to a complicated disorder and are informed by evidence[4]. Recovery from addiction is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential[5].

The opioid crisis began in the United States in the late 1990s, largely due to the trend towards using opioid medications for chronic pain management and resulted in a rise in overall opioid use throughout subsequent years. The result was an increase in opioid overdose deaths, which has occurred in three waves; the first wave in the 1990s involving prescription opioids, the second wave beginning in 2010 with a rise in overdose deaths involving heroin, and the third wave starting in 2013 with increases in deaths involving synthetic opioids such as fentanyl[6].

The opioid crisis remains a national public health emergency today. Despite the devastating challenges of the COVID-19 global pandemic, opioid and non-opioid overdoses continue to be a source of significant concern. More than 20 states have reported increases in opioid-related mortality since COVID-19 began to spread in the United States[7]. Table 1 represents the percent change in suspected overdoses and fatalities in a selection of individual communities or regions of the states represented in the W/B HIDTA region over a 10-week time period (March 1 – May 12) in 2020 compared to 2019.

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Overdoses continue, and the impact of COVID-19 on overdoses presents a very disturbing picture for some communities. Data for this table was collected directly from the areas themselves.

Table 1. Percent change in suspected overdoses March 1 through May 12 between 2019 and 2020 for communities in the W/B HIDTA region

W/B HIDTA Area (region, county, city, or town)	Total # ODs 2019/# Fatal ODs	Total # ODs 2020/# Fatal ODs	% change Total ODs	% change Fatal ODs
Maryland				
Anne Arundel County	163/34	143/28	↓ 12	↓ 18
Carroll County (March 1 – April 30)	59/10	49/6	↓ 17	↓ 40
Cecil County	164/16	122/23	↓ 25	↑ 44
Prince George's County	147/9	116/7	↓ 21	↓ 22
Virginia				
Arlington	9/1	13/4	↑ 44	↑ 300
Chesterfield County	85/9	119/12	↑ 40	↑ 33
Fairfax County **	33/NA***	43/NA	↑ 30	NA
Loudoun County	28/5	19/6	↓ 32	↑ 20
Northern Shenandoah Valley Region (Winchester City; Frederick, Shenandoah, Page, Warren, & Clarke counties; Towns of Front Royal and Strasburg)	34/8	52/14	↑ 53	↑ 75
Roanoke County****	8/0*	31/6	↑ 288	↑ 600
West Virginia				
Berkeley County	48/7*	166/16	↑ 245%	↑ 128%

*Data only available March 1 – April 30, 2019, **Represents opioid overdoses input into Emergency Departments only
***Not Available, ****Represents heroin overdoses only

Background

The High Intensity Drug Trafficking Areas (HIDTA) Program is a federal grant program administered by the White House Office of National Drug Control Policy (ONDCP). The HIDTA Program provides resources to federal, state, local, and tribal agencies to coordinate activities to address drug trafficking in specifically designated areas of the country where concentrations are highest. ONDCP designated the Washington/Baltimore HIDTA in 1994 to serve Maryland, Washington, DC, Virginia, and parts of West Virginia.

The Washington/Baltimore HIDTA COVID-19 Substance Use Task Force, comprised of thirteen members, included W/B HIDTA's Deputy Director for Treatment & Prevention, W/B HIDTA Public Health Analysts, treatment and health department representatives from W/B HIDTA counties, and Peer Recovery Specialists from across the W/B HIDTA region (Appendix A). The task force met three times during the week of May 11, 2020 to describe the challenges those with substance use disorders (SUDs) are reporting in the context of COVID-19 restrictions imposed by their states. The task force prepared a draft of this document and submitted it to an external committee of county, state and national substance use prevention, treatment and recovery representatives for review and feedback. This document encompasses recommendations from all above-mentioned parties.

During the initial meeting on May 11, 2020, the task force elucidated details on current challenges for those with SUDs, and the following four themes emerged: **Vulnerability, Connectivity, Accountability, and Access to Care**. The effects of increased vulnerability in the context of decreased connectivity, fewer opportunities for accountability, and decreased services have been demonstrated through an increase in overdoses for some communities, but not all. It is imperative to seize an opportunity to learn from the communities where the impact was less severe as well as characterize the challenges encountered in communities where the impact has been dire. As we consider national, state, community, and individual participation in the prevention and treatment of substance use during crises, it is also important to recognize and embrace these entities as an ecosystem comprised of a system of necessary interdependent relationships with the individual at the center. The purpose of this document is to offer systems-level recommendations for substance use prevention, treatment and recovery operations during national crises such as the COVID-19 pandemic.

1. **Vulnerability**

Task force members described the physical, mental, and behavioral vulnerabilities inherent in having a substance use disorder (SUD). Similar descriptions have been reported in several publications authored by representatives from federal and state agencies[8]. Under normal circumstances, those combatting SUD experience a host of factors (unemployment, housing, transportation, ongoing stigma for substance use disorders, and other concerns) that make them vulnerable to relapse and overdose. During the national COVID pandemic, these vulnerabilities, coupled, in some areas, with decreased availability of naloxone from harm reduction programs and decreased treatment services, are exacerbated and make those with SUD more likely to contract, experience complications from, and ultimately die from COVID.

2. **Connectivity**

A primary message emerging from task force discussions is that the frequency, dose, and quality of social connections among those in SUD treatment and recovery have been dramatically disrupted. Addiction is a complex disease affecting both brain function and behavior. Multiple needs must be addressed, including social needs, for treatment to be effective[4]. One peer recovery specialist on the task force stated, "A daily dose of quality connection is often needed to maintain recovery". While online delivery of many treatment and recovery strategies has been helpful and is essential to maintain some type of connection, many in recovery across the W/B HIDTA region report that it is difficult to maintain high quality connections using virtual platforms. They share that the hallmark of relationship development for many in recovery is being able to connect with peers through body language and presence as they share experiences of loneliness, isolation, and other emotions they are going through together. This dynamic is critical to feeling supported socially and helps to mitigate feelings of hopelessness. There continues to exist a digital divide that creates a barrier for access to treatment for some clients.

Conversely, there are a subset of individuals that are able to engage more fully in SUD disorder treatment via telehealth. Individuals that have adequate electronic devices to connect to telehealth, enough data and minutes to engage in services, and live in an area that they have connectivity via Wi-Fi, are able to engage in telehealth services, including intake and assessment, outpatient psychotherapy (individual and intensive outpatient therapy), and telepsychiatry, including Medication Assisted Treatment (MAT). In more rural areas, and for people with fewer resources (such as many of those

being discharged from jail or prison), their only option is to seek treatment through same day access services. Individuals without digital resources have occasionally had to take more perceived risks to physically enter a premise to engage in treatment, while others could easily connect at home.

3. Accountability

Randomized drug testing and recovery-oriented meetings such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) offer opportunities for monitoring progress as well as holding individuals accountable for their behaviors. Both of these strategies are grounded in evidence to support their effectiveness in treating substance use disorders[9,10,11], and continuous monitoring of drug use during treatment is recognized as one of the principles of drug addiction treatment[4]. In addition, several task force and external committee members emphasized that clients, particularly within court-mandated treatment programs, have overwhelmingly endorsed the continuation of routine and randomized testing as essential to maintaining abstinence. They describe it as an essential motivating factor and a source of feedback that imparts feelings of reinforcement and accomplishment. When states enacted shut down operations, the impact on these practices was immediate. Many probation and parole officers were repurposed to other responsibilities or asked to pause operations, and systems for randomized drug testing were disrupted. In addition, NA/AA meetings were either canceled or transitioned to online delivery methods. Many in the recovery community report that the accountability process and opportunities for connection do not just take place during the actual meeting, but very often occurs during the interactions and social engagement before and after the meetings. The opportunity for these less formal, yet critical, interactions was lost when the meetings transitioned to online delivery. Another aspect drawn out around accountability is that the regularity and frequency of the meetings also contributes to accountability and has been altered during COVID.

4. Access to Care

Immediate access to care is another principle of drug addiction treatment[4] that COVID-19 management strategies have affected. Many substance use treatment and recovery organizations have either reduced or eliminated intake options, and the processes to be assessed and referred to treatment have either lengthened or temporarily paused. Flexibility in MAT practices has been supported in some ways [12,13], but behavioral or psychosocial therapies, the most commonly used forms of substance use disorder treatment[4], were forced to transition to audio or virtual mechanisms for all individuals, even in communities with very low infection rates. Same Day Access to services, either in person or via telehealth, or for residential detox, did remain available in some communities throughout the pandemic.

Community re-entry programs for inmates released early from jail or prison have also been impacted for a multitude of reasons including the speed at which inmates are being released and staff being repurposed for COVID-19 management. Inmates are at a high risk of death from overdose when released due to lower tolerances and returning to environments that may trigger relapse [14,15]. During crises like COVID-19, gradual release into the community is not as possible, leaving coordinators unable to facilitate the same assessment and referral to community resource services available during normal operations. Many public community mental health providers were not given notice in advance when jails or prisons were planning to release inmates on early release and saw surges in people on early release in their lobbies during the pandemic without any warning.

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Basic Assumptions

1.   The individual must be at the center of system recommendations.

2.   No advancement in strategy is possible if it fails to consider any of the key stakeholders.

3.   Access to help and healing does not always mean reliance on face-to-face meetings but can include a technology-enhanced infrastructure.

4.   Relationships and interactions among stakeholders must be respectful and forward looking.

5.   Expertise and guidance is essential to chart a path forward to rebuild a more resilient system.

6.   A system should be built on the best available evidence that makes sense for the communities and populations of focus.

7.   Successful planning and implementation must take into account the baseline readiness and capacity of the organizations involved.

8.   Plans must incorporate a sober appreciation of the required resources to advance these systems. Resources include funding, technology, knowledge of programs and practices, systems knowledge and skills for planning and implementing new or changing existing programs and services (applied implementation science).

Recommendations

The recommendations outlined below are based on the W/B HIDTA region's experience to date with COVID-19 management strategies. These recommendations synthesize strategies to address the identified challenges of vulnerability, connectivity, accountability, and access to care.

1.   **Federal agencies specializing in substance use disorder prevention, treatment and recovery will collaborate with public health agencies to generate and initiate the following products**:

   a.   <u>Public Service Announcements to Promote Prevention Strategies and Awareness of Resources</u> – Direct the public's attention to media outlets during crises that offer:

      i.   Education on self-care and healthy coping strategies.

      ii.   Information on available resources for substance use support, assessment and treatment, at the local, state, and federal levels.

      iii.   Messages to reduce stigma related to substance use disorders and impact multiple levels of society, from the public to providers to policymakers.

   b.   <u>Specialty guidance for states</u>, which increases their awareness of vulnerabilities of those with substance use disorders and offers guidance on how to address substance use disorder stigma and state restrictions to support continued delivery of prevention, treatment and recovery services. Guidance would include language that:

      i.   Addresses the importance of adaptations to state level restrictions for substance use treatment and recovery services. Adaptations could include integration of a leveling system for restrictions in which counties with no or

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> minimal infected persons may continue to operate treatment and recovery services as usual but imposes more restrictions as the numbers rise.

   ii. Confirms treatment and recovery organizations are not liable if an individual contracts COVID-19 if all safety protocols are in place, properly implemented, and properly documented.

   iii. Ensures behavioral and psychosocial therapies and groups as well as MAT can still be delivered virtually and in-seat if counties are at minimal risk and appropriate protocols are in place.

   iv. Identifies and promotes successful models of telemedicine for support groups and behavioral therapies.

   c. <u>Development of an informational feedback loop</u> among federal agencies, states, and counties to disseminate guidance as well as receive feedback on the feasibility and ultimate effectiveness of its implementation.

   d. <u>Funding for technology resources</u> to ensure that people without access to virtual services can secure access.

   e. <u>Relaxation of telehealth regulatory barriers</u> at the federal and state levels to ensure that access to telehealth services remains an option for individuals helped by it.

2. **States will task a specific state agency responsible for identifying organizations in every county or region to serve as coordinating and advisory bodies for special operations for substance use services recommended by the state during crises like COVID-19. Identified organizations would be responsible for the following items and have a good understanding of their responsibilities in the event they are activated:**

   a. Ensuring state level guidance on safety protocols, SUD services, and available SUD resources are disseminated throughout the community.

   b. Supporting wellness and healthy coping strategy dissemination through prevention professionals in the community.

   c. Advising treatment and recovery organizations on implementation of the guidance and proper documentation demonstrating they are adhering to the guidance.

   d. Facilitating and coordinating in-seat support group meetings, which adhere to state level guidance, to include engaging community partners to offer larger spaces for support group meetings as one example.

   e. Supporting participant engagement to decrease social isolation through creative use of social media messaging and virtual service delivery mechanisms.

   f. Working with community partners to develop alternative protocols for administration of randomized drug testing for programs like Drug Treatment Courts while maintaining safety protocols.

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     g.   Accelerating access to safe and socially distanced harm reduction services (naloxone, syringe exchange, etc.) to save lives.

The identified organizations will be standing bodies that meet regularly to create protocols and assist with strengthening local systems in order to support SUD services during crises. The state agency will develop a mechanism for continuous communication with the county/region-level organizations and have a learning community mechanism in place for sharing ideas and resources.

3.   **All states will receive federal funding to develop or enhance a 24 hour/7 days per week, state-level substance use treatment hotline that can immediately connect people to substance use detox or treatment opportunities of all kinds (inpatient, outpatient, intensive outpatient, residential), including MAT, in their state. The hotline will:**

     a.   Have a real-time list of available state and private treatment and detox beds.

     b.   Assist patients with applying for Medicaid while searching for beds and apply Medicaid retroactively if the process is not complete by the time a bed is located.

     c.   Facilitate transportation to the treatment location.

     d.   Connect with other states to locate a bed if no beds are available in the patient's resident state.

     e.   Offer translator and deaf and hard of hearing services to facilitate communication.

4.   **Federal and state prisons, jails, probation districts, and local pre-trial offices will develop rapid re-entry protocols that will incorporate the needed assessments and support for inmates released earlier than expected due to crises such as COVID-19. Protocols will include:**

     a.   Equipping those with a known SUD or risk of SUD with Narcan/naloxone upon discharge.

     b.   Notice to community mental health providers of those being released early and referred to them along with a list any psychotropic or MAT medications they are taking.

     c.   Application for Medicaid benefits at release.

Conclusion

The recommendations described in this document reflect a system of emergency response activities that could be of significant benefit in safely minimizing the disruption of crises like COVID-19 on the treatment and recovery for those managing substance use disorders. It is important to note that approximately 50% of those with substance use disorders have co-occurring behavioral health conditions[16]. While these recommendations were developed by a task force specializing in the prevention, treatment and recovery of substance use disorders, they could easily be adapted for behavioral health disorders. The majority of these recommendations represent systems-level ideas that would be of benefit as standing operations and not only in public health crises.

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Appendix A

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