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A delicate compromise: Striking a balance between public safety measures and the psychosocial needs of staff and clients in residential substance use disorder treatment amid COVID-19

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ABSTRACT

In response to COVID-19, residential SUD treatment providers have significantly changed operations and clinical care to mitigate risk of infection for both clients and staff. While treatment facilities must enforce public safety measures in residential SUD treatment to protect the health of clients and staff, these measures create additional barriers to treatment engagement as well as health anxiety. We consider strategies to adjust clinical programming, enhance treatment engagement, and promote employee well-being in light of public safety measures and the chronic stressor of COVID-19.

The effects of COVID-19 on residential substance use disorder (SUD) treatment for beneficiaries of California's Medicaid program, Medi-Cal, are visceral and immediate in Los Angeles County, with facilities across the country reeling from similar challenges. Clients scheduled for intake and assessment are no longer greeted with smiling faces and handshakes, but the half-obscured, masked faces of the intake and admissions unit. Before clients enter the facility, staff provide clients with masks and hand sanitizer and administer a temperature check. Before COVID-19, only positive breathalyzer test readings and uranalysis results for benzodiazepines or opioids, florid psychosis, or imminent risk of harm to self or others created a barrier to same-day admission to residential SUD treatment and referral to a higher level of care. Now, a temperature reading of 100.4 precludes clients from getting through the door at publicly funded residential substance use treatment facilities.

Even before this twenty-first-century global pandemic, entering a residential treatment setting elicited a host of intense and varied emotions among some clients—shame, grief, anger, frustration, sadness, and fear. Accordingly, treatment staff attempted to combat low levels of treatment engagement and foster a connection to prevent high attrition rates. In this new era of COVID-19, treatment engagement and retention have become significantly more complicated with the impersonal nature of personal protective equipment (PPE) and social distancing in clients' interactions with both staff and peers. Furthermore, the 14-day period in an observation room, which some SUD treatment agencies require, creates further barriers to establishing social support and connection during the initial period of adjustment to residential SUD treatment.

Before COVID-19, clients attended psychoeducational groups and self-help meetings in residential SUD treatment facilities for many hours. As treatment providers implement public safety measures, group rooms are vacant, onsite self-help meetings have ceased, weekend visitation and leisure passes have been suspended, outdoor group sports are banned, and most medical and mental health appointments are conducted via telehealth platforms. The bustle and high-intensity pace of residential SUD treatment has been reduced to a lull with staff trying to create alternative activities and programs to maintain clients' spirits and treatment engagement. In the absence of substance use, a heavily programmed schedule, the social support of family members and friends, and the fellowship and camaraderie typically fostered in residential settings, clients struggle to cope with pronounced negative affect states, such as boredom, restlessness, anxiety, and depressive symptoms, leading to increased treatment abandonment.

Program directors' focus has shifted from primarily operational and clinical needs to the consistent application of public health measures in an institutional setting rife for transmission. To promote 6 ft of social distancing and simultaneously maintain a high census, program directors and their staff have resorted to rearranging furniture—carefully measuring 6 ft of distance between bunk beds, chairs in community rooms, and seats in dining rooms. Facilities submit to virtual

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walkthroughs with county agencies to ensure compliance. Instead of the usual litany of reminders about signing out for appointments, reporting to the nurse's office on time for medication distribution, or limiting their interactions with peers of the opposite sex, clients are repeatedly reminded to wash their hands, put their masks back on, and maintain social distance. Even prior to COVID-19, maintenance and cleaning had been a daily facet of residential SUD treatment with the occasional weekend "double scrub;" however, the frequency of cleaning has intensified throughout the day with particular attention to high traffic areas and surfaces, such as doors, phones, and computers.

These measures simultaneously provide reassurance that the facility is mitigating the risk of infection and a relentless reminder of the looming threat of COVID-19 for these essential workers and their clients. Additionally, sociodemographic factors and underlying comorbid conditions amplify the mortality risk of staff and clients in residential SUD treatment settings. Given that members of the SUD workforce are predominantly 45 years of age and older (Ryan et al., 2012), 27% of national admissions to publicly funded substance use treatment facilities were for clients aged 45 and older (SAMHSA, 2017), and the elderly experience the most significant risk of dying if infected with COVID-19 (Novel Coronavirus Pneumonia Emergency Response Epidemiology Team, 2020), the health anxiety in treatment settings is palpable. A female SUD counselor in her mid-fifties, who also cares for her elderly mother at home, reached out to her supervisor, to express high levels of anxiety and concern about the possibility of spreading the infection to her mother and inadvertently causing her death. This counselor adheres to stringent decontamination procedures before entering her home and continues to report to work despite a lingering wariness.

Moreover, early data from the CDC (Garg et al., 2020) reveals that Blacks and Latinx suffered higher COVID-19 death rates than that of their non-Hispanic white or Asian counterparts. Approximately 30% of the SUD workforce (Ryan et al., 2012), 30% of admissions to SUD treatment nationally (SAMHSA, 2017) and 45% of entries in California (SAMHSA, 2015) identify as non-Hispanic Black and/or Latinx. Chronic substance use can result in sequelae of chronic health conditions across the life course, such as cardiovascular problems and heart disease, pulmonary problems, cancer, diabetes, and infectious disease (Schulte & Hser, 2014). Clients and members of the SUD workforce who are in recovery with underlying comorbid health conditions may experience increased susceptibility to severe illness and death (Garg et al., 2020).

To continue to protect the safety of both staff and clients, who are at a higher risk for severe illness and death, public health measures must continue, including the provision of PPE, regular and ongoing sanitation and cleaning, consistent handwashing, installation of hand sanitizing stations at regular intervals throughout a facility, use of temperature readings, social distancing practices, the use of partitions between staff and clients when possible, the provision of counseling services outdoors as weather and privacy permit, and regular trainings regarding these measures for clients and staff. At the corporate level, agencies must offer paid sick-leave for symptomatic staff for two weeks; accommodate work-from-home arrangements for staff with severe underlying conditions; provide access to counseling services and EAPs for staff due to their increased risk of symptoms of PTSD, depression, and anxiety and potential relapse; provide hazard pay; promote self-care practices; and allocate the resources necessary for adequate PPE, cleaning, and sanitation. COVID-19 has highlighted the need for long-term shifts in organizational culture in the SUD treatment field to promote employee health and self-care.

Additionally, COVID-19 has altered the landscape for behavioral health service provision and creates an impetus for increased use of telehealth platforms. Residential SUD treatment facilities should allocate a greater portion of their budget to high speed Internet services as well as the purchase, installation, and maintenance of television monitors, projectors, webcams, laptops, and tablets to maintain clinical care standards and protect the health and safety of both employees and clients. In conjunction, these facilities should also provide ongoing training to their staff and clients related to the use of telehealth platforms, allowing for staff to telecommute or socially distance from their offices to facilitate psychoeducational groups or individual counseling sessions. These expanded technological capabilities also would provide clients with the opportunity to virtually participate in self-help meetings and social events as well as individual and group counseling sessions during the 14-day observation period. These investments in technological capabilities also present opportunities for the future post-COVID-19, such as the possibility to enhance recruitment and retention of SUD counseling staff through telecommuting; connect clients to a wider social support network through virtual self-help groups; provide virtual aftercare groups for clients; and link clients virtually to their physicians, mental health providers, probation officers, and children's social workers, decreasing their need to leave the facility during early phases of their recovery in which they may be particularly vulnerable to relapse.

Finally, enhancing treatment engagement and connection during social distancing poses unique challenges. It requires program directors and staff to generate creative solutions, such as modifications to improve the sense of welcoming and warmth; videos running on a loop in the lobby welcoming clients and providing them with optimistic and hopeful messages about treatment; shorter and regularly scheduled small group sessions with clients; scheduled journaling and meditation practice throughout the day; promotion of outdoor and individual activities such as gardening or yoga; and access to their cellular devices to connect to family, friends, religious services, or a sponsor in the self-help community. These renewed efforts to assist clients in developing their skills, interests, and social connections as well as structuring and managing their time in recovery could stand to inform ongoing programming efforts and practices post-pandemic.

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