Patients with Substance Use Disorders: Challenges During Non-Psychiatric Inpatient Care

Doentes com Perturbação Por Uso de Substâncias: Desafios em Contexto de Internamento Não Psiquiátrico

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Patients with substance use disorders (SUD) represent a vulnerable population in general hospital wards, where medical staff often face significant challenges in their care. These patients face a substantially higher risk of medical complications (infectious, hepatic, neurological, and oncological disorders) directly related to their substance use – notably, nearly one in five inpatients in general hospital wards has an SUD.[1]

Research indicates that individuals with SUD are up to three times more likely to leave against medical advice (AMA) compared with patients without SUD, particularly those with opioid use disorder, intravenous drug use, or recent psychiatric admissions.[1] Leaving AMA is strongly associated with higher rates of hospital readmission, 30-day mortality, and overdose risk.[2] One study reported a tenfold increase in overdose rates within the first month following an AMA discharge.[1]

Qualitative studies provide valuable insight into the factors driving early discharge and patient dissatisfaction.[1] Negative interactions with healthcare professionals, perceived stigma, and lack of trust are frequently reported. Patients often report feeling judged or labelled, with many describing dismissive attitudes toward their medical concerns. Inadequate pain management is another critical issue: fear of undertreatment and withdrawal symptoms often drives patients to self-discharge and resume substance use to alleviate discomfort. Withdrawal management and detoxification present further obstacles. Not all clinicians are familiar with evidence-based guidelines for opioid or polysubstance withdrawal, leading to inconsistent care and worsening of withdrawal symptoms. In some cases, the discontinuation of prescribed psychiatric or maintenance medications further compounds distress and contributes to premature hospital departure. Based on previous negative detoxification experiences, some patients even increase their substance use before admission, anticipating the discomfort and inadequate symptom management they may face in the hospital.[3]

Hospital policies regarding SUD remain highly variable. Punitive approaches – restricting visitation, or heightened surveillance – can worsen mistrust and provoke disengagement. Conversely, patient-centred policies that emphasize evidence-based addiction treatment, harm reduction, and neutral, non-stigmatizing language have been shown to improve outcomes. The establishment of dedicated inpatient addiction consultation teams significantly reduces AMA discharges, increases abstinence days, and lowers post-discharge emergency visits.[3,4]

To improve care for hospitalized patients with SUD, hospitals should adopt standardized protocols for withdrawal management, ensure adequate pain control, implement staff training to reduce stigma, and provide dedicated inpatient addiction consultation teams, which evidence suggests can play a pivotal role in ensuring comprehensive and equitable treatment.[5] Ongoing attention to these challenges is essential in general hospital care, reinforcing the need to consistently approach addiction as a medical condition.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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