Time to Change the Way We Approach Opioid Use Disorder: A Challenge to the Status Quo

Martin and colleagues' article (1) on the next stage of buprenorphine care for opioid use disorder (OUD) should disrupt clinical practice and enhance diffusion, dissemination, and implementation of evidence-based treatments of OUD. The opioid epidemic continues to escalate: In 2017, emergency department (ED) visits for nonfatal opioid overdose increased 30% and more than 49 000 persons died of opioid-related causes (2, 3). Research tell us that opioid agonist treatment (OAT) with buprenorphine and methadone saves lives by reducing fatal and nonfatal overdoses, cravings, transmission of HIV and hepatitis C, and crime (4). A recent study in Massachusetts (5) highlighted the benefits of OAT and risks for opioid overdose. In this study of 17 568 ED visits for nonfatal opioid overdose, 1-year mortality was 4.7 per 100 person-years, mortality decreased in patients treated with methadone or buprenorphine in the year after overdose, and no mortality benefit was seen in those treated with naltrexone (5). Thus, it is time to reevaluate how we think about and treat persons with OUD.

Martin and colleagues' findings and recommendations for the next stage of buprenorphine care suggest that we need to broaden our thinking about buprenorphine's effectiveness and the success of the Opioid Treatment Cascade of Care framework (6), which aims to increase the diagnosis, linkage to treatment, initiation of medication therapy, retention in treatment, and ongoing remission of persons with OUD. Unfortunately, the natural history of OUD indicates that many will go in and out of treatment—but we know that that they do better when in treatment. Although the optimal duration of OAT is unclear, data support an ongoing benefit from treatment and more deaths with cessation of treatment. The neurochemical changes in the brain reward system do not normalize over the short term; thus, cravings continue, and the pull to return to opioid use is substantial. Retaining patients in treatment is therefore essential. This article challenges many of the recommendations and overly conservative practices associated with early buprenorphine use, including limiting induction to a medical setting; requiring counseling; tapering medication dosages; and limiting access to patients without concomitant use of other drugs, such as prescribed or illicit benzodiazepines. Martin and colleagues' recommendations reflect a more progressive approach to OUD that minimizes barriers in the Opioid Treatment Cascade of Care, including linkage to and initiation of buprenorphine therapy.

Additional barriers to treatment include the likely well-intentioned, but ultimately harmful, mandate that counseling accompany medication. This requirement often prevents delivery of a life-saving medication. A systematic review of 35 independent studies found no benefit of adding psychosocial supports to standard physician management (7). Yet some states—such as West Virginia, which has one of the highest annual rates of opioid overdose, 43.4 per 100 000 persons (8)—mandate that counseling be provided alongside buprenorphine. This limits both the number of clinical settings that can prescribe buprenorphine and the number of patients whose work and home obligations make counseling sessions feasible. Persons with OUD often have multiple social problems, including unstable housing, co-occurring substance use, or mental health disorders, and some may benefit from counseling. However, initial treatment with buprenorphine will allow patients to think more clearly and eliminate the cycle of withdrawal and drug seeking so that they have the time and energy to address social issues.

Lessons learned from our study of ED-initiated buprenorphine treatment (9) are consistent with the issues raised by Martin and colleagues. In our randomized clinical trial, half of patients with OUD had no regular source of care or their regular source was the ED. Overall, they had a high rate of coexisting substance use: 55% reported use of cocaine, 47% use of benzodiazepines or sedatives, and 34% unhealthy alcohol use. The rate of co-occurring mental health issues was high, with 47% reporting treatment for a psychiatric condition in the past and 22% requiring a psychiatric evaluation at the time of the visit. Despite these challenges, 78% of patients in the ED-initiated buprenorphine group who were referred to an office-based primary care practice were found to be in formal addiction treatment at 30 days. This rate of engagement was 2 times that of patients who received only a referral or a brief intervention with a facilitated referral. Of those who started buprenorphine treatment, approximately 50% were not in sufficient withdrawal in the ED for induction, and they completed an unobserved induction without reported adverse events. Home induction has also been shown to be "safe and effective," with similar retention rates to office-based induction, and it enhances care by avoiding delays to treatment initiation, averting the need for multiple or prolonged clinic visits, and expanding intake beyond when patients are uncomfortable from withdrawal (10). As emergency physicians (who routinely provide care for patients with both fatal and nonfatal overdose), we are acutely aware of the life-threatening risks associated with ongoing use. Unlike other diseases of addiction, every single use of opioids carries risk for fatal overdose.

The magnitude of the opioid epidemic necessitates a reexamination of the conservative and restrictive approaches to buprenorphine use that have not effectively stemmed the epidemic. As highlighted in the 2017 advisory from the U.S. Food and Drug Adminis-

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tration, any restriction on access to buprenorphine should be weighed against the risks of untreated OUD. The influx of fentanyl and fentanyl analogues has changed the way we calculate the risk of withholding access to this life-saving medication because of concomitant use of benzodiazepines or other drugs or opioid-positive results on urine tests during treatment. A reduction in opioid use should be viewed as a step forward rather than treatment failure. Care with OAT should be escalated rather than stopped if ongoing drug use is identified. This treatment saves lives, and we must accelerate the success of the Opioid Treatment Cascade of Care. It is time to change the way we think about OUD and the way we treat patients who have it. The recommendations in Martin and colleagues' article are a great leap forward.

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