# COVID-19 can change the way we respond to the opioid crisis – for the better

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COVID-19 arrives in the United States while the nation remains deeply challenged in responding to the opioid crisis. The public health response to COVID-19 has been unprecedented and, rightfully, takes immediate priority over other ongoing health emergencies. Yet physical distancing may exacerbate the risk of overdose death by increasing drug use in isolation and reducing access to harm reduction and treatment services. New policies and practices are being devised and implemented now to mitigate such unintended consequences. These efforts provide opportunities to test and implement more flexible and innovative approaches to opioid use disorder (OUD) treatment and overdose prevention. The approaches, many of which are not new but have never before been adopted on a wide scale in the U.S., have the potential to substantially improve our response to the opioid crisis if sustained when the threat of the COVID-19 pandemic recedes.

Harm reduction services such as distribution of sterile syringes, opioid-overdose reversing drugs (naloxone), and HIV/HCV testing have formed the backbone of the public health response to the overdose crisis. With syringe service programs shutting down or reducing face-to-face services due to COVID-19, community pharmacies have the opportunity to step in as providers of these essential services. Pharmacy distribution of naloxone and sterile syringes has been found highly effective in reducing overdose mortality (1). Most states now have legislation granting pharmacists authority to prescribe naloxone or to dispense without a prescription or have a standing order for pharmacy dispensing to patients meeting certain criteria, which is crucial during COVID-19 when outpatient services are substantially curtailed. In addition, 31 states grant pharmacists authorities to order and interpret laboratory tests. However, individuals who seek these services from community pharmacies often face stigma and many pharmacies do not

carry these supplies or provide these services even if permitted by law. Other opportunities include using mail order and mobile sites to distribute these life-saving supplies and relaxing "1-for-1" syringe exchange rules to allow fewer visits and facilitate secondary exchange. Adoption and availability of these approaches needs to be substantially ramped up to fully realize their promise.

Harm reduction has traditionally emphasized the importance of avoiding drug use in isolation in order to reduce the likelihood of death in the event of an overdose. How should these messages be adjusted for COVID-19, when physical distancing is being urged? Potential innovations such as using social media and telephone check-ins (for example, by a peer specialist) to maintain contact while using drugs could improve norms for all people who use drugs alone.

Due to COVID-19, patients are suddenly experiencing disrupted access to outpatient substance use disorder treatment, including evidence-based medication for OUD (MOUD), increasing risks of relapse and overdose. Of the three FDA-approved MOUDs - methadone, buprenorphine, and naltrexone – patients receiving methadone face the greatest peril as methadone maintenance treatment is only provided by federally certified Opioid Treatment Programs (OTPs), often requiring frequent attendance. In 2017, close to 383,000 patients received methadone maintenance treatment from an OTP (2), the vast majority of which was dispensed onsite daily. Prior to COVID-19, OTPs could submit online applications to the Substance Abuse and Mental Health Services Administration (SAMHSA) to request exceptions to daily in-clinic dosing for long-term, stable patients, enabling limited take-home supplies such as two-day take homes that

allow patients to attend the OTP every other day. Such patient-by-patient exceptions were quickly rendered inadequate by the current COVD-19 pandemic.

On March 16, SAMHSA issued guidance that allows states to request blanket exceptions for patients in OTPs to receive up to 14 or 28 days (depending on stability) of take-home doses of the patient's medication (methadone or buprenorphine). This dramatic shift will bring the U.S. closer in line with how methadone treatment has long been delivered elsewhere in the world (3). making treatment less onerous for patients and potentially opening up greater treatment capacity if the changes are sustained after COVID-19. A preliminary internet search as of April 7 indicates that 22 states had issued guidance to OTPs to implement the exception, suggesting variation in state adoption.

Even in states that adopt such exceptions, implementation will be at the discretion of a given OTP. OTPs whose revenues are closely tied to the volume of onsite dispensing and service delivery, based on contracts with state authorities or public or private insurance or cash payment, may be reluctant to implement these policies unless payments are changed. For example, New York State Medicaid has moved from fee-for-service payment for OTP services prior to COVID-19 to adopting the Medicare weekly bundled payment codes and rates for take-home medication alone or bundled with tele-counseling and medication management. Additionally, 91% of OTPs accept, and 10% rely exclusively on, cash payment. Clients may have difficulty with larger cash payment required for the extended take-home doses.

Telemedicine can now be used by medical providers to initiate and maintain opioid use disorder treatment. Effective March 31, the federal Drug Enforcement Administration, in partnership with SAMHSA, permits otherwise authorized providers to use telemedicine (including via telephone if necessary) to conduct medical evaluations to start patients on buprenorphine during the COVID-19 emergency (4), providing a much-needed exception to the in-person evaluation requirement implemented under the Ryan Haight Act of 2008. In-person visits are still required for the initiation of methadone however, in part because the first two weeks of methadone induction and dose changes have been associated with increased mortality while blood levels adjust. In New York City, a COVID-19 epicenter, the city-run hospital system has established a novel telemedicine buprenorphine induction clinic. The potential long-term benefits of sustaining this exception for stabilized patients may be especially meaningful for patients with OUD in rural areas who face substantial transportation barriers.

Early releases of jail inmates and prisoners have been advocated as a policy strategy to ease COVID-19 outbreaks and, if taken up on a large scale, could present an opportunity to expand access to OUD treatment in this population. The U.S. correctional systems house about 1.5 million prisoners and 700,000 jail inmates on any given day (5). Close to two-thirds of this population meet clinical diagnostic criteria for substance use disorders, of which, fewer than a quarter participate in a drug treatment program (6). MOUD initiation has been growing rapidly in correctional settings in recent years but is far from widespread. For example, New Jersey is in the process of introducing MOUD in every state prison and county jail. Further, inmates can enroll in the Intensive Recovery Treatment and Support Program to receive navigation services before and after release to connect to community MOUD providers (7). When devising policies

to expedite decarceration in the current pandemic, policymakers should consider initiating pharmacotherapy before release.

Regulatory changes and innovative clinical practices are happening in real time to continue to address the opioid crisis during the COVID-19 emergency. Many of these changes have the potential to expand OUD treatment, improve quality of care, and enhance the reach and effectiveness of overdose prevention, although, some changes present risks if scaled up without rigorous evidence. For example, less intensive in-person contacts with OTPs might increase the risk of dropping out of treatment. The natural experiments created by COVID-19 provide opportunities to evaluate adoption and outcomes in order to determine which of these changes are worth being sustained for the long run.

**References**

1. Abouk R, Pacula RL, Powell D: Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose. JAMA Intern Med 179:805-11, 2019

2. Substance Abuse and Mental Health Services Administration: National Survey of Substance Abuse Treatment Services (N-SSATS): 2017. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018

3. Bruneau J, Ahamad K, Goyer ME, et al.: Management of opioid use disorders: a national clinical practice guideline. CMAJ 190:E247-E57, 2018

4. U.S. Department of Justice Drug Enforcement Administration: DEA & SAMHSA Updated Guidance on Telemedicine. SAMHSA website, 2020. https://www.samhsa.gov/sites/default/files/dea-samhsa-buprenorphine-telemedicine.pdf. Accessed April 7, 2020.

5. Bureau of Justice Statistics: Key Statistics. Bureau of Justice Statistics website, 2018. https://www.bjs.gov/index.cfm?ty=kfa. Accessed April 7, 2020.

6. Bureau of Justice Statistics: Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009. Bureau of Justice Statistics website, 2017. https://www.bjs.gov/content/pub/pdf/dudaspji0709_sum.pdf. Accessed April 7, 2020.

7. Swarbrick M, Bohan M, Gitlitz R, et al.: Peer Health Navigators Support Individuals with an Opioid Use Disorder Transitioning from Prison. Drug Alcohol Depend 203:88-91, 2019