Opioid Policy Changes During the COVID-19 Pandemic - and Beyond

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The United States is currently in the midst of 2 public health emergencies: COVID-19 and the ongoing opioid crisis. In an attempt to reduce preventable harm to individuals with opioid use disorder (OUD), federal, state, and local governments have temporarily modified law and policy to increase access to OUD treatment and divert some individuals at high risk away from the correctional system. In this Commentary, we briefly describe how people with OUD are at increased risk for COVID-19, discuss existing policy barriers to evidence-based prevention and treatment for individuals with OUD, explain the temporary rollbacks of those barriers, and argue that these changes should be made permanent. We also suggest several additional steps that federal and state governments can urgently take to reduce barriers to care for individuals with OUD, both during the current crisis and beyond.

Key Words: buprenorphine, COVID-19, incarceration, medication for opioid use disorder, methadone, opioid policy, opioid use disorder, telehealth, treatment access

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We are in the midst of 2 deadly, concurrent public health emergencies: COVID-19 and the opioid crisis. Both are nationwide catastrophes that require immediate action to stem the tide of preventable death and disability. Even taking into account actions already taken, the novel coronavirus is forecast to take the lives of over 100,000 people in the United States,[1] approximately the number lost to opioid overdose over the past 2 years.[2]

Reducing the impact of both crises will require unprecedented efforts from medical professionals as well as changes at all levels of government to ensure that the necessary tools are available to effectively combat these dual epidemics. Vaccine and pharmaceutical trials are under way, but we do not yet have proven treatments for the novel coronavirus. There are, however, effective medications to treat opioid use disorder (OUD) and reverse acute opioid overdose, as well as proven interventions to reduce harms associated with opioid injection.[3]

Opioid agonist medications for OUD, methadone and buprenorphine, reduce all-cause mortality by as much as fifty percent and are associated with positive changes in a number of other outcomes including reductions in overdose, resumed use, and HIV infections.[4] Naloxone, a relatively inexpensive and extremely effective pharmaceutical antidote to opioid overdose, has been distributed in the community for decades, where it is associated with reductions in opioid overdose deaths.[5] Finally, the provision of sterile syringes dramatically reduces the risk of bloodborne disease transmission related to sharing syringes for intravenous opioid use, and syringe services programs effectively link individuals with OUD to evidence-based treatment.[6]

Unfortunately, these effective interventions are often not available when and where they are needed, largely due to unnecessary legal restrictions. With limited exceptions, only federally certified opioid treatment programs are permitted to dispense methadone for OUD treatment, and federal regulations require that many individuals travel to the clinic most days of the week to obtain their medication. Buprenorphine is also highly regulated. Only providers who have obtained a federal "waiver" may prescribe buprenorphine for OUD treatment, and regulations limit the number of concurrent patients prescribers may treat.[7] Meanwhile, state laws limit access to sterile syringes, and naloxone's status as a prescription-only medication dramatically limits naloxone access, particularly among uninsured individuals and those without a health care home.[8,9]

While these restrictions are burdensome in the best of times, the impacts of the opioid crisis and COVID-19 are additive, compounding the risk of illness and death for high-risk individuals. People with OUD are likely at higher risk for COVID-19 due to higher prevalence of pre-existing health conditions and tobacco use, and because many people with severe OUD reside in congregate living situations, including group recovery housing, shelters, and correctional facilities, where they are unable to maintain physical distance from others.[10] Unfortunately, some of the measures that have been taken to reduce harms associated with the novel coronavirus may inadvertently increase OUD-related harms.[10] The offices of many medical providers, treatment programs, and harm reduction organizations have had to close or significantly reduce their hours, and disruptions to normal routines and increased social isolation may increase risk of resumed use among people in recovery from OUD. The crush of COVID-19

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cases is increasing emergency medical services response times in some areas, and distancing efforts may reduce the probability than an individual who overdoses will be discovered and given naloxone in time to prevent lasting injury or death. Altogether, this places people with OUD at increased risk for overdose and overdose death.

In acknowledgement of these facts, federal, state, and local governments have begun to identify and address previously accepted policies as unnecessary barriers to the health and well-being of people with OUD. To lessen some impediments to methadone treatment, the Substance Abuse and Mental Health Services Administration issued guidance in late March that allows states to permit all patients who are on a stable methadone dose to receive 28 days of take-home medication, and for patients who are less stable to receive 14 days of take-home medication.[11] It is, however, up to states to request this ability, and individual programs to implement the change.

Similarly, the Drug Enforcement Administration has waived a requirement that patients who wish to begin buprenorphine treatment have an in-person consultation with the prescriber. This change permits individuals seeking buprenorphine treatment to be prescribed the medication after consulting with a waivered prescriber via telemedicine, without having to physically visit the provider's office. As with the modification to methadone access requirements, this innovation is in effect only for the duration of the COVID-19 public health emergency.[12]

In light of the increased risk of transmission in crowded and often unsanitary jails and prisons, some jurisdictions have taken steps to reduce the number of people entering those facilities, and, in some cases, to release some individuals currently being incarcerated.[13] The vast majority of these individuals are being held awaiting trial or after being convicted of minor, non-violent crimes. Likewise, some police departments have reduced or entirely stopped making custodial arrests for low-level crimes such as loitering and public intoxication.[13]

These changes, while relatively minor, will likely lessen the impact of the COVID-19 crisis on people with OUD and may help reduce some of the racial disparities exacerbated by both epidemics. However, once the pandemic is resolved and the coronavirus-related emergency declarations are rescinded, the older policies will resume. Such an outcome would be contrary to common sense and evidence-based practice and should not be permitted to occur.

All of the recent changes to increase access to treatment and reduce incarceration that have been enacted during the COVID-19 crisis should persist not just for the duration of that emergency but in perpetuity. There is no evidence that requiring individuals to visit a methadone clinic most mornings improves outcomes, and a great deal of evidence that it reduces access to that lifesaving treatment.[14] Likewise, there is little reason to require an in-person evaluation for buprenorphine initiation, particularly in light of the impact of the opioid crisis on rural America, where waivered providers are few and far between.[15] There is neither reason to jail most people awaiting trial nor to incarcerate people for low-level crimes, many of which are related to lack of access to substance use disorder treatment or other mental health services.

Additional barriers should be lifted as well. Patient limits and the requirement that providers obtain a waiver to prescribe buprenorphine are unnecessary, limit access to buprenorphine, and should be rescinded. The Food and Drug Administration should make naloxone available over the counter, which would increase access to this lifesaving medication at the state and local levels. States should remove paraphernalia laws which criminalize possession of equipment for drug consumption, including sterile syringes. Finally, crimes of poverty should be addressed with evidence-based services, not jail time.

While the COVID-19 pandemic is having a tragic global impact, it has provided insight into our societal needs and shone a light on the ways in which law and policy negatively impact individuals with OUD. We should take those lessons to heart, and permanently dismantle laws that increase, rather than reduce, harm to the most vulnerable among us.

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