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Lessons from COVID 19: Are we finally ready to make opioid treatment accessible?

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COVID-19 has devastated Americans across many communities, bringing unprecedented challenges to our economy, our healthcare system, and our way of life as we knew it. Like many historical moments and life-changing events, the COVID-19 pandemic has forced us to look inward and reflect deeply on our existing systems, shining a painful light on profound inequities and shortcomings of our healthcare and social support structures.

The addiction treatment system is no exception. While there is growing recognition among experts that opioid use as a leading public health problem, addiction treatment programs remain siloed from the healthcare system and burdened with protocols based on punitive ideologies rather than evidence-based practices. Despite overwhelming evidence for methadone and buprenorphine, two opioid agonists that substantially reduce overdose risk (Sordo et al., 2017), these medications remain highly controlled and inaccessible to most individuals in need of treatment for opioid use disorder. Strict regulations on the provision of such medications, often upheld as necessary to promote safety and avoid illicit diversion, are deeply embedded in a culture of stigma and criminalization that instead limit their use (Doernberg et al., 2019). This approach has generated treatment programs that prioritize adherence to rules, whether or not they are rational and effective, rather than promoting inclusion and retention. Like most patients failed by our current health system, those who suffer the most are the same vulnerable groups that will likely be hardest hit by COVID-19: Those who are victims of poverty, trauma, and discrimination and who frequently suffer from co-occurring conditions, such as depression, heart disease, HIV, and other illnesses.

Yet this restrictive approach has dramatically changed overnight, not because the paradigm has suddenly changed, but because the COVID-19 health crisis emerged. In just a matter of weeks, swift modifications in our opioid treatment regulations that the Substance Abuse and Mental Health Administration announced in March 2020 have revealed an alternative reality by which patients with opioid use disorder in the U.S. can now access treatment. Longer take-homes for methadone—which previously were only allowed after a patient completed years of daily visits to clinics—are now considered standard. Buprenorphine treatment initiation—previously requiring a lengthy evaluation process by a waivered physician followed by frequent monitoring—can now be done over a simple phone call. Mandates for supervised urine drug screens and in-person behavioral counseling sessions have been largely relinquished or adapted to be remote. At the same time, the drive to prevent the spread of COVID-19 in detention centers has led to the unprecedented dismissal of thousands of low-level drug charges, which would have otherwise led to the incarceration of many drug users with minimal or no access to effective treatment.

These changes are a reaction borne out of necessity to prevent a disastrous surge of COVID-19 cases and a simultaneous surge in relapse and overdose deaths (Becker & Fiellin, 2020). Social distancing policies and quarantine orders made requirements for numerous in-person visits and high vigilance of patients unrealistic and unsustainable. The truth, however, is that these requirements were never realistic or sustainable. Years of research have shown that requiring frequent visits, heavy monitoring, and mandatory participation in adjunct services to be eligible for life-saving medications created unnecessary barriers to accessing care (Krawczyk et al., 2019). Obstacles, such as long transportation times, difficulty managing appointments around work and childcare responsibilities, and the stigma associated with waiting in long lines to access treatment or provide urine drug tests under supervision, impede initiation and retention in treatment (Reisinger et al., 2009). These barriers have not only resulted in limited utilization of available treatment programs but have likely helped to sustain an illicit market of buprenorphine that allows opioid users to access treatment and reduce overdose risk more easily than enrolling in a formal treatment program (Carlson et al., 2020). Similarly, the health risks associated with crowded jails and cycling in and out of the criminal justice system did not begin with COVID-19: For decades, incarceration has created devastating outcomes for public health (Wildeman & Wang, 2017), increasing risk for overdose, trauma, homelessness, and reduced

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access to healthcare.

The current morass and devastation of COVID-19, therefore, offers an opportunity to adopt a much-needed revision to the status-quo and create a more sustainable, equitable, and harm reduction–oriented system. Existing models for services both in the U.S. and other countries exemplify the potential for offering opioid treatment through more accessible mechanisms (Calcaterra et al., 2019; Krawczyk et al., 2019), and simultaneously reducing both the over-regulation of scheduled agonist medications and the criminalization of drug use (Quintas & Arana, 2017). In addition, new protocols developed in response to COVID-19 will provide a natural experiment for clinicians, researchers, and advocates to study the impact of lower threshold treatment on patient health and overdose risk. These examples provide a path for the U.S. to follow when the COVID-19 crisis passes, and an opportunity to re-build an addiction treatment system focused on health rather than character reformation or punishment. In this way, this experience can contribute to much-needed improvements in addressing the overdose epidemic and a chance to reduce long-term inequities and suffering across our communities.

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