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An overdose surge will compound the COVID-19 pandemic if urgent action is not taken

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Abstract

In the uSA and around the world, the COVID-19 pandemic arrived as the population was fighting a devastating opioid overdose epidemic. urgent and decisive action is needed to protect particularly vulnerable populations, such as those with opioid use disorder, to prevent a compounding effect on public health.

As the global spread of the coronavirus SARS-CoV-2 continues, the pandemic's impact on people who are already marginalized and vulnerable will be profound, and the 'knock-on' effect on public health will be severe. This is particularly true of people with opioid use disorder.

wCounterintuitively, the fact that social-distancing measures are leading to perturbations in the illegal drug market, making it harder to access, could have negative effects on public health down the line. Richard Cowan's 'iron law of prohibition' dictates that under stricter regulation, illegal providers will produce more-powerful product because it takes up less space and is more easily transportable. Recently, this has driven the shift from heroin to fentanyl in the USA's illegal market[3]. Moreover, it is important to note that opioid use leads to tolerance of opioids. After weeks of reduced access to opioids, tolerance decreases, and once those with opioid use disorder gain access to opioids again, they are more likely to overdose. To compensate for lack of access to opioids, people with opioid use disorder may also seek other substances, such as alcohol and benzodiazepines, both of which potentiate overdose risk. These supply-side pressures, which result in an unpredictable and riskier product, combined with reduced tolerance, make each episode of use more likely to result in overdose[4].

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Competing interests

The authors declare no competing interests.

This challenging predicament, however, could offer opportunity. Poor access to illegal opioids may drive those who were undecided about use of methadone or buprenorphine to seek treatment. These medications are the most effective treatment we have for opioid use disorder. They successfully reduce craving, withdrawal, drug use, overdose and acute-care utilization[5].

Despite their effectiveness, these medications are underutilized, and most treatment facilities and healthcare settings do not make them easily available. To not immediately pursue a scale-up of availability and outreach to encourage people with opioid use disorder to engage with buprenorphine and methadone treatment would be foolhardy.

Due to the COVID-19 emergency, the US federal government has temporarily waived the initial in-person assessment for initiation of buprenorphine and has increased flexibility for the dispensation of take-home methadone. These changes allow prescribers to initiate buprenorphine treatment remotely. These changes are welcome, and the federal government should do more along these lines. All providers with prescriptive authority should be allowed to prescribe buprenorphine, which could be achieved by removal of the requirement for a US Drug Enforcement Administration 'X' waiver. Emergency funding for buprenorphine and methadone should be released so that patients who are unable to afford these treatments, particularly in states without Medicaid expansion, can access treatment. Importantly, the structure of treatment settings themselves could increase infectious spread without thoughtful redesign. Limiting requirements for frequent in-person visits, facilitating remote healthcare delivery and providing these healthcare providers with appropriate protective equipment would be paramount to preventing the further spread of SARS-CoV-2.

Pharmacies should also be better used to provide a more normalized pathway to care and align with social-distancing goals. They should be allowed to dispense methadone, and reimbursable prescriber–pharmacist collaborations that allow prescribers to delegate buprenorphine prescribing to pharmacists should be encouraged. Post–acute-care facilities such as skilled-nursing facilities should also be made exempt from regulations related to methadone and buprenorphine so that, like an acute-care hospital, these facilities could administer medications for opioid use disorder. This last change is particularly important as hospitals face capacity surges related to COVID-19 and need to move patients to lower acuity settings. At the same time that we pursue these new avenues to increase access to methadone and buprenorphine, we must continue broad access to proven harm-reduction interventions such as naloxone distribution and syringe-service programs.

Crisis leads to opportunity. COVID-19 presents unique and urgent challenges. However, it also presents an opportunity to create a healthcare system that truly addresses the needs of vulnerable populations, such as those with opioid use disorder. We must first act quickly to stave off a substantial increase in overdoses, an impending crisis on top of a crisis.

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