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Changing approaches to treating opioid withdrawal in the USA

Published Online May 8, 2023 https://doi.org/10.1016/S2215-0366(23)00145-1

In 2020, an estimated 91 799 people in the USA died of substance-related overdose—75% were related to opioids, and 85% of these opioid deaths were related to fentanyl. In 2021, overdose deaths increased to over 108 000 and provisional data from 2022 show a further increase.[1] The presentation of opioid withdrawal in hospitals is sometimes overlooked or even ignored, both of which are unacceptable. Possible reasons for overlooking or ignoring opioid withdrawal in hospitals include: implicit bias, poor knowledge regarding approaches to the management of opioid-related presentations, or a misunderstanding of the implications of unmanaged opioid use disorder (OUD). If we, as a society, do not change our pedagogical and practical approaches to opioid withdrawal in the USA, we fear that we will continue to see a rise in these preventable deaths.

In the USA, societal attitudes towards the use of drugs and towards people who use drugs must be adjusted before meaningful change can be made. A shift to viewing the problematic use of drugs as a public health issue rather than a moral issue is necessary to improve outcomes. Stigma associated with recreational drug use, on both individual and policy levels, is a tremendous burden and discourages help-seeking behaviour in this vulnerable population. Restructuring drug-scheduling laws and eliminating jail time as a consequence of possession of small quantities of illegal drugs might be the most direct way to address this bias. Implementation of government-funded initiatives to reduce use-associated harms would provide much benefit to people who use drugs; ideally, in conjunction with decriminalisation. Drug-checking services (which test the safety and chemical content of the drugs), syringe service programmes, naloxone distribution and training on its administration, and increased access to public health and social services are common harm reduction measures that are underutilised in the USA. The only two sanctioned overdose prevention centres, or safe consumption sites, in the USA, both in New York City, have been operating since November, 2021, and have been used by thousands of people with no deaths on site, and hundreds of reversed opioid overdoses.[2] Increased use of these approaches might be the best option to decrease deaths and provide crucial points of intervention to engage people who use drugs in discussions about medications for OUD, physical health, and mental health.

Marginalised racial groups are facing the brunt of this crisis, as illustrated by the disproportionate increase in overdose death rates for Black and Hispanic people in the USA during the COVID-19 pandemic.[3] This increase is indicative of the existence of various social and health inequities which must be addressed. Elimination of disparities is essential, if we aim to reduce harms, such as incarceration and death, in these populations.

Legal implications of mismanagement of OUD, including possible violations of the Emergency Medical Treatment and Labor Act, the Americans with Disabilities Act, the Rehabilitation Act, or Title VI of the Civil Rights Act, were outlined in a 2021 report from the Legal Action Center.[4] Unfortunately, not much has changed since the release of this report, and violations of these acts are difficult to track and seldom disclosed. Knowledge of

inappropriate management of OUD in clinical settings might demoralise people who use drugs, decreasing the probability of their engagement with either screening or treatment of drug-related infectious diseases (eg, HIV, hepatitis, and endocarditis). Appropriate management of OUD puts the human rights and dignity of people who use drugs at the centre and assists in establishing compassionate, therapeutic relationships with providers, which will improve outcomes for patients.

In a cohort of 17 568 patients in Massachusetts, USA, who presented to a hospital after a non-fatal opioid overdose between Jan 1, 2012 and Dec 31, 2014, 12 295 (70%) patients did not receive medications for OUD.[5] In a separate cohort of 11 557 patients who presented to an emergency room for opioid overdose in Massachusetts between July, 2011, and October, 2015, 635 (5·5%) died within 1 year post-discharge. Of those who died, 130 (20·5%) died in the first month post-discharge, and 29 (22·3%) of those patients died within the first 2 days.[6] These data are tragic, given that methadone and buprenorphine are well established to decrease opioid-related mortality.[7] Failure to provide medications for OUD to people presenting after an overdose represents an unfortunate, pervasive pattern of reluctance or ignorance on the part of clinicians to recognise that the time to intervene is in the hours and days following an overdose. We believe that an opioid overdose should be understood as an imminently life-threatening event and that providing medications for OUD and harm reduction counselling are essential—not to do so is an abnegation of our duties to save lives.

In the fentanyl era, opioid withdrawal treatment is even more urgent, given fentanyl's high potency and increased use-associated risk for fatal overdose compared with other opioids. Regulatory changes, such as the Dec 29, 2022, removal of the X-waiver requirement to prescribe buprenorphine in the USA, are urgently needed to expand access to medications for OUD. A similar regulatory change in France in 1995 led to a 79% decline in the total number of overdose deaths over the following 4 years and increased the number of patients in treatment for OUD ten times.[8] Methadone is accessible at community pharmacies within Canada, Australia, and the UK,[9] removing barriers to access and stigma cultivated by restricting administration or dispensing of methadone to government-sanctioned opioid treatment programmes as seen in the USA.

Medications that target withdrawal symptoms do not reduce drug cravings, which puts the individual at continued risk of overdose or other use-associated harms. This is similar to short stays in so-called detoxification programmes, which have been shown to be more harmful than helpful.[7] The use of short-acting opioid agonists is a patient-centred approach that can be helpful, or necessary, to mitigate symptoms and provide a withdrawal bridge for patients who

***Panel:* Ways to reduce overdose deaths in the USA**

Legislators and policy makers

- Federal laws that are compassionate and humane towards people who use drugs, prioritising harm reduction and rehabilitation over incarceration and punishment
- Removal of barriers to access to medications for opioid use disorder (OUD), such as restrictions on prescribing and dispensing
- Broad scope policy changes involving Joint Commission accreditation and Centers for Medicare and Medicaid Services reporting
- Research funding for innovative approaches to managing OUD

Institutions and hospitals

- Collaborative plans to guide clinicians in initiating medications for opioid withdrawal, similar to clinical pathways currently in place for alcohol withdrawal
- Collaboration in the form of multi-disciplinary grand rounds
- Development of institution-specific management strategies for OUD

Educational systems

- High priority initiatives to increase exposure to the management of OUD in undergraduate and graduate medical education
- Educational frameworks that promote OUD treatment as a clinical imperative

Clinicians

- Address personal biases and stigma towards people who use drugs to best offer standard of care for patients
- Familiarise with widely available information regarding standard and innovative approaches to the management of OUD and opioid-related presentations
- Increase involvement in local, state, and federal advocacy initiatives to support people who use drugs and remove barriers to treatment of OUD

Society

- Humanise media depictions of people who use drugs and drug use
- Promote the use of constructive and inclusive language to refer to people who use drugs and drug use

For more on the **Joint Commission** see https://www.jointcommission.org/

For more on the **X-waiver requirement** see https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement

are in a hospital setting.[10] Treatment of acute pain in people who have OUD requires higher doses of opioid agonists than in people without OUD and suboptimal management increases risk for withdrawal and can perpetuate the cycle of addiction. Innovative treatment approaches for OUD might also be helpful, such as rapid initiation of buprenorphine, which can stabilise patients using opioid agonists without precipitating withdrawal.

Now, more than ever, the USA must have a compassionate and harm reduction approach rather than a punitive one. OUD is a chronic and complex biopsychosocial condition, and we have the tools to save lives (panel). We must urgently reconsider our approach, both individually and systematically, to the treatment of OUD, beginning with treating opioid withdrawal and other opioid-related presentations as the medical emergencies they are.

MH and AE participate in the REACH Fellowship Program and receive funding, through the Minority Fellowship Program (grant number 5H79TI081358-04, from the Substance Abuse and Mental Health Services Administration). KLS declares no competing interests.

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