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Want to Reduce Opioid Deaths? Get People the Medications They Need

Drugs like buprenorphine could sharply curb the nation's opioid overdose crisis. But federal laws make it difficult for people who need such medications to get them.

By The Editorial Board

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A federally funded report released last week came to a striking conclusion: More than 80 percent of the roughly two million people struggling with opioid addiction in the United States are not being treated with the medications most likely to nudge them into remission or prevent them from overdosing. This denial of care is so pervasive and egregious, the report's authors found, that it amounts to a serious ethical breach on the part of both health care providers and the criminal justice system.

The Food and Drug Administration has approved three medications to treat opioid use disorder — methadone, buprenorphine and naltrexone. All of them work by binding to the brain's opiate receptors in a way that reduces the cravings that people addicted to drugs like OxyContin and heroin experience, but without causing the same euphoric high as those drugs. Methadone and buprenorphine have proved especially effective. Patients who take one of those medications are half as likely to die from their addiction; they are also more likely to stay in treatment, and they tend to have better long-term health outcomes.

Neither drug is new or experimental — methadone was approved to treat opioid addiction in 1972 and buprenorphine in 2002. Some countries have shown that increasing access to them can significantly drive down the rate of overdose deaths. In France, for example, policies that enabled more doctors to prescribe buprenorphine helped lead to a tenfold increase in the number of people whose opioid use disorder was being treated and to a nearly 80 percent decline in overdose deaths in just four years.

Yet, many drug courts and most residential treatment programs in the United States prevent participants from using these medications; and the rehabilitation programs that do offer them rarely offer all three options. The treatments are not available in most emergency rooms, as The Times has reported, even though studies show that patients given buprenorphine in an E.R. are twice as likely to be in treatment a month later than those who are given an information pamphlet. They are also not available in most prisons, even though a significant portion of the federal inmate population suffers from opioid use disorder. Opioid overdose is a leading cause of death among those who've been recently released.

Part of the problem is stigma and a profound lack of awareness. Methadone and buprenorphine are opioids. They are weaker than drugs like OxyContin, fentanyl and heroin that have fueled the current crisis, but many law enforcement and medical professionals still see them as trading one addiction for another. Or they mistakenly believe that the medications should be used only temporarily, to help wean patients off stronger opioids. Or they see them as an optional complement to behavioral interventions instead of an essential component of opioid addiction management.

None of these perceptions is supported by the balance of scientific evidence.

There's also a logistical barrier to getting these drugs into the hands of people who need them. Doctors are allowed to give methadone only at specialized clinics where patients must report every day for their dose. Lines at such

clinics are often long, and according to the report, which came from the National Academies of Sciences, Engineering and Medicine, Medicaid does not cover the treatment in at least 14 states.

Buprenorphine is available by prescription, but health care professionals must obtain a special license to write those prescriptions, a process that requires them to complete hours of additional training, grant the Drug Enforcement Administration access to all of their patient records and agree to strict limits on the number of patients they can treat with the medication. In many states, would-be buprenorphine prescribers also must submit to stringent criteria for insurance reimbursement. These restrictions also are not justified by scientific evidence. They are not employed by other countries, and they are not used to manage the treatment of other chronic medical conditions in the United States.

Fewer than seven percent of the nation's doctors have gone through the trouble of clearing these hurdles. As a result, more than half of all counties have no licensed buprenorphine prescriber at all. That's too bad. According to the national academies report, just about anyone with opioid use disorder — teenagers, pregnant women, people with other serious medical conditions — can be treated safely and effectively with the medication.

President Trump declared a public health emergency to respond to the opioid crisis in 2017, but so far that declaration has led to very little meaningful action. Congress passed a suite of opioid bills in the fall, but that legislation contained almost no funding. And in most states, strategies that might truly mitigate the disaster — from evidence-based addiction treatments like methadone and buprenorphine to proven harm-reduction approaches like needle exchanges and safe injection sites — remain vastly underutilized or outright illegal.

Public health forecasts indicate that the opioid overdose epidemic might claim another 500,000 lives in the next decade. Many of those deaths could be avoided — if existing technologies would just be put to use.

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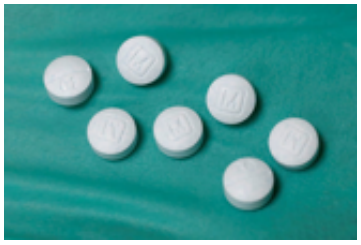

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***Correction:** March 27, 2019*

A previous version of this editorial referred imprecisely to the source of a report that found that over 80 percent of Americans addicted to opioids were not getting treatment with medications that could help. The report, from the National Academies of Sciences, Engineering and Medicine, was funded by the federal government. It was not a federal government report.

A version of this article appears in print on March 27, 2019, Section A, Page 22 of the New York edition with the headline: Strict Rules Hinder Addiction Treatment