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Take-home Naloxone at Opioid Treatment Programs: A Lifesaver

Joanna G. Katzman, MD, MSPH, Snehal Bhatt, MD, and George D. Comerci Jr, MD, MACP

Opioid-related overdose deaths have increased almost 30% in the US since the COVID-19 pandemic began. Tragically, many of these deaths could be prevented with widespread availability of naloxone. One innocuous harm-reduction strategy would be the federal government mandating the provision of take-home naloxone and brief overdose education to patients at opioid treatment programs.

Take-home naloxone, for instance, may be used by a friend or a family member to save the life of the patient receiving treatment for opioid use disorder. Importantly, many studies demonstrate that patients receiving take-home naloxone at an opioid treatment program will use the naloxone to reverse an overdose of someone in their social network. Other successful indications for mandated take-home naloxone include: federal inmates leaving incarceration if they have an opioid substance use disorder diagnosis and federal police officers on active duty.

This editorial describes the various organizations, medical societies, and governmental agencies who may consider making robust actionable recommendations regarding naloxone for persons with opioid use disorder. The authors strongly recommend that professional organizations include take-home naloxone as a best practice for any patient who may be at an elevated risk for an opioid overdose.

Key Words: addiction, opioid overdose deaths, opioid treatment program, substance use disorder, take-home naloxone

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From the Department of Neurosurgery, University of New Mexico Health Sciences Center, (UNMHSC), Albuquerque, NM (JGK); UNMHSC, ECHO Institute (JGK, SB, GDC); Department of Psychiatry, UNMHSC, Albuquerque, NM (SB); and Department of Internal Medicine, UNMHSC, Albuquerque, NM (GDC).

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Send correspondence to Joanna G. Katzman, MD, MSPH, University of New Mexico, MSC 07 4245, Albuquerque, NM, 87131. E-mail: JKatzman@-salud.unm.edu.

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The COVID-19 pandemic has had a major impact on the health of Americans. It has disproportionately affected marginalized populations, and has especially impacted individuals with pre-existing mental health conditions and those with opioid and other substance use disorders.[1] Compared to the previous year, overall drug overdose deaths have increased almost 30% in 2020, exceeding 90,000. Alarmingly, the same time period saw an increase in opioid related overdose deaths by over 50%.[2] A multi-faceted approach to reduce drug overdose deaths needs to be instituted at a national level. One innocuous harm reduction strategy is to mandate take-home naloxone (THN) at all federally-qualified opioid treatment programs (OTPs) throughout the country.

THN is defined as the medication being given directly to the patient at the point of service.[3] Although co-prescription of naloxone with an opioid analgesic is one available harm reduction approach when prescribing either opioids for pain management or medications for opioid use disorder, it does not provide medication directly to the patient. Patients with opioid use disorder are more likely to use naloxone if they have directly obtained the medication in the clinical setting.[4]

Governmental and nongovernmental agencies, clinicians, and communities have rallied around a diverse range of efforts to mitigate the risk of opioid and other drug overdose deaths, even before the opioid epidemic was deemed a United States public health emergency on October 26, 2017. These include: drug overdose prevention education programs, syringe exchange programs, Good Samaritan laws, state and federal guidelines, and policies for responsible pain management. Other effective strategies involve access to medications for opioid use disorders, such as low threshold buprenorphine programs and emergency department initiated buprenorphine treatment. Most recently, on April 28, 2021, policy changes at the federal level modified the Drug Addiction Treatment Act waiver requirement with the goal of improving access to care. This new federal strategy allows eligible clinicians, including physicians, nurse practitioners, physician assistants, nurse midwives, and certified registered nurse anesthetists, to apply for their buprenorphine waiver without completing the previously mandated training. The policy change allows these clinicians to treat no more than 30 patients at a time, and removes the necessitated training as a barrier to caring for patients with opioid use disorder.

Employing a similar federal policy approach, but using a harm reduction strategy, opioid overdose deaths could be reduced by requiring OTPs to provide at least 2 doses of naloxone and brief overdose education for every patient

entered in their program. The most recent practice guidelines at the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry recommend the co-prescription of naloxone (not THN specifically) as a harm reduction medication at OTPs and outpatient based opioid programs.[5,6] Finally, although the Substance Abuse and Mental Health Administration opioid overdose toolkit (2018) suggests that co-prescription of naloxone may benefit patients receiving medication assisted treatment and high-dose opioids, the tool-kit does not reference THN, except suggesting that THN should not be cost-prohibitive.[7]

Studies have shown that people who inject drugs will use naloxone in their social network to help reverse the opioid overdose of a friend, family member, or even a stranger.[8,9] By directly providing 2 initial doses of naloxone and additional doses as needed, patients enrolled at an OTP can educate their social network about the harm reduction benefits of naloxone. These studies have demonstrated that the patient's family members and friends will readily use the naloxone on the patient or a community member.[8,9] McDonald et al, performed a systematic review of 22 well-designed THN programs and concluded that, not only were the evaluated programs safe, but they reduced overdose deaths in both the participants and the surrounding community.[8]

There are many possible barriers facing OTPs in providing naloxone at the point of service. These include: the cost of medication, the time required to educate patients, and the associated administrative barriers.[10] These limitations are likely not insurmountable especially if the goal is to decrease opioid overdose deaths. If the federal government can remove the buprenorphine/naloxone Drug Addiction Treatment Act waiver, then mandated THN for patients might also be considered. Although not a perfect solution, it has the potential to reduce thousands of opioid-related overdose deaths each year.

It is important to be cognizant of the risks and limitations of mandated THN at OTPs throughout the country: (1) Most OTPs are located in urban and suburban settings, whereas overdose fatalities in rural areas now exceed more densely populated areas.[11] (2) There is a risk that providing naloxone directly to patients is cost-prohibitive, and the OTP business model may not be viable by incorporating THN unless structured wisely.[10] (3) Clinicians cannot substitute THN for a written naloxone prescription, as significant jurisdictional variations exist between a patient's ability to obtain naloxone from a pharmacy and opioid overdose.[12] There also remains significant stigma with patient encounters at their local pharmacy.[13] This harm reduction strategy will only work if naloxone is distributed to the patient directly.

In our opinion, federally-funded OTPs should be required to give 2 doses of THN and brief overdose education to every patient, when he/she begins substance use treatment at an OTP. Additional doses of naloxone also need to be given to the patient when requested, and without question. From a public health standpoint, this strategy may also encourage people who misuse opioids, and/or have been reversed by naloxone to pursue SUD treatment. If our nation's leading addiction medicine organizations consider changing language to the existing practice guidelines to require THN to all patients at OTPs, this could certainly decrease opioid overdose deaths and help the progression towards federal mandates.

Although previous naloxone legislation, such as Good Samaritan laws, have been a states' responsibility, a federal policy to mandate THN at federally-qualified OTPs could be extremely helpful. Perhaps key stakeholders from multiple federal agencies can work collaboratively to make this happen. The Centers for Medicare and Medicaid might even work out an economic solution to the prohibitive cost of THN combined with overdose education during substance use treatment.

There may be other strategies that could be mandated at the federal level that could potentially lower the drug overdose death rate. Should mandating THN at OTPs be successful, then the next logical place to consider this practice would be for persons leaving a federal correctional facility with a diagnosis of opioid use disorder. Overdose is the leading cause of death for inmates leaving jail with a diagnosis of opioid SUD, with risk of overdose many times higher than before incarceration.[14] Federal police officers on active duty could also be trained to carry naloxone with them. Police officers throughout the US are increasingly using naloxone successfully while on active duty if called to the scene of an opioid overdose.[15] The Bureau of Indian Affairs is one federal agency whose active-duty officers have carried naloxone successfully since 2015.

The US needs local, state, and federal solutions to combat the opioid epidemic. The leading addiction orgnizations may want to consider changing their practice guidelines to recommend THN (instead of co-prescribing) for all patients at high risk of an opioid overdose. State medical boards and/or state opioid treatment authorities can also recommend or mandate THN. Mandating THN at federally-qualified OTPs may be an effective first step in the battle to prevent one more life lost to the opioid crisis.

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