Editorial: Stop allowing beliefs to get in the way of treating opioid use disorder

18 December 2018

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There is a breadth of academic research demonstrating that there are three medications that successfully treat opioid use disorder (OUD): methadone, buprenorphine, and naltrexone. However, patients face unnecessary barriers to evidence-based treatment from government regulations as well as providers' own beliefs that are not grounded in science, researchers from the Grayken Center for Addiction at Boston Medical Center (BMC) said in an *Annals of Internal Medicine* editorial.

The authors assert that providers should evaluate treatment for OUD like any other chronic illness, which means assessing the efficacy, cost, and risks and benefits analysis when determining treatment plans with their patients.

Unlike many chronic conditions, two of the three medications for OUD are limited by regulations. Methadone is only available in federally certified treatment programs and buprenorphine can only be prescribed by physicians, physician assistants and nurse practitioners who have completed training and have been waivered by the Drug Enforcement Administration. Most physicians do not have this waiver, and many who do are not prescribing buprenorphine at all.

Both methadone and buprenorphine are opioid agonists that reduce cravings for illicit substances like heroin. Despite much evidence to the contrary, some critics have called use of these medications "substituting one drug for another."

"With the growing number of individuals with opioid use disorder, we cannot allow beliefs about medications to blur the evidence showing methadone and buprenorphine to be safe and effective treatment," says Josh Barocas, MD, the editorial's corresponding author and infectious disease physician at BMC and assistant professor of medicine at BU School of Medicine (BUSM).

The third medication used to treat OUD, naltrexone, is not subject to such regulations and is favored among some institutions because it is not an opioid. However, the medication is an opioid antagonist, preventing opiate effects in the brain, and requires opioid-free detoxification for approximately one week, which can be difficult for some patients with OUD. The authors cite research that shows treatment with naltrexone is more expensive than buprenorphine, and that there are safety concerns with increased overdose risk if a relapse occurs.

"Patients should be given every option in their treatment for opioid use disorder and work with their clinicians to determine the best treatment plan for them," says Richard Saitz, MD, MPH, a general internal medicine physician and addiction expert at BMC, chair and professor of community health sciences at BU School of Public Health and professor of medicine at BUSM. "If clinicians and programs are limiting treatment to only offer naltrexone because of their beliefs or institutional beliefs, they are providing inferior care."

Stemming the rising number of overdose deaths is a key public health priority across the country. To

do so, the authors recommend removing bias and unnecessary regulation from decisions about treatment.

More information: Joshua A. Barocas et al, Being Explicit About Decisions: Prescribe Medications for Opioid Use Disorder on the Basis of Proven Effectiveness, Not Beliefs, *Annals of Internal Medicine* (2018). DOI: 10.7326/M18-3293

Provided by Boston Medical Center
APA citation: Editorial: Stop allowing beliefs to get in the way of treating opioid use disorder (2018, December 18) retrieved 1 May 2021 from https://medicalxpress.com/news/2018-12-editorial-beliefs-opioid-disorder.html

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