ACMT Position Statement
Buprenorphine Administration in the Emergency Department

ACMT supports the administration of buprenorphine in the emergency department (ED) as a bridge to long-term addiction treatment.

Furthermore, ACMT supports the administration of buprenorphine to patients in the ED to treat opioid withdrawal and to reduce the risk of opioid overdose and death following discharge.

Background

In response to escalating opioid-related ED visits and fatalities across the nation, there is a pressing need for the expansion of treatment and recovery opportunities for patients suffering from the consequences of long-term opioid use, which include dependence, abuse, hyperalgesia, and addiction [1,2].

Within the healthcare community, it is widely agreed that opioid use disorder (OUD) is a chronic disease with medical and social components and that the best practice for management of OUD includes opioid agonist therapy (OAT) [3].OAT uses evidence-based approaches with either buprenorphine or methadone to allow patients to minimize the use of illicit opioids, prevent overdose, and improve overall health and functioning. For most patients, providing an initial dose of buprenorphine (also called initiation or induction) can be easily and safely performed in the ED or on an outpatient basis, with follow-up with a long-term treatment provider. OAT is generally supplemented with other long-term supportive measures such as group- and community-based or intensive outpatient programs. Although methadone and naltrexone are also used for addiction treatment, this statement focuses on buprenorphine due to its safety profile and ability to be both administered in and prescribed from the ED. Methadone may be administered to patients already managed in opioid treatment programs that use methadone but may not be prescribed.

Buprenorphine in the ED

Buprenorphine (in combination with naloxone in outpatient setting) has been utilized for nearly 20 years in an office- or clinic-based setting that allows for either observed or home initiation of therapy [4]. Providing an initial dose of buprenorphine during an ED visit for overdose, withdrawal, or OUD improves success in engagement of patients into medication assisted therapy (MAT, also called medication for addiction treatment) [5,6]. Furthermore, in the United States, any licensed prescriber of controlled substances can administer a dose of buprenorphine daily for up to three days, if desired [7]. (Outpatient prescription requires a Drug Addiction Treatment Act of 2000 ”X-waiver” on their DEA controlled substance registration [8].)

Outpatient prescription may help patients avoid return ED visits during the bridge period to a long term treatment program.

Although not all EDs currently have resources to assure ongoing treatment with buprenorphine, the ED is an important and ideal setting to administer or initiate buprenorphine for several reasons:

· ED sees a large number of patients presenting with opioid overdose, opioid withdrawal, or OUD;
· for many patients at high-risk for overdose, the ED is their primary access point to health care and treatment;
· evaluation in the ED represents an opportunity to engage patients in a discussion of OAT and harm reduction strategies to mitigate risk from the continued use of illicit drugs after discharge;
· Following initiation of buprenorphine in the ED, a bridge clinic or "warm handoff" to a treatment provider (where available) will improve engagement into long-term treatment;
· screening for OUD in patients who present to the ED for other medical reasons provides an important opportunity to begin intervention immediately for those who screen positive.
· Buprenorphine is relatively safe even in high doses and has a substantially lower abuse potential than full agonist opioids.

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