Invited Commentary

Building capacity more important than adding to overburdened emergency departments

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Rapid access to comprehensive addiction services would surely provide benefit to many in need. However, given current fiscal conditions, and the burden of our hospital systems, it remains unclear if our public health care system will have the means to rapidly and effectively implement such services. Given these realistic constraints, we believe a more practical approach to providing outstanding addiction services in the emergency department (ED) should rely on emergency physicians initiating life-saving medical treatment for addiction issues, and consulting addiction medicine only for more complex needs. Initiation of medical treatment should be followed by outpatient referral with timely follow-up for medication titration and provision of wrap-around services, thereby maximizing the value of existing outpatient addiction treatment options.

As mentioned by Hann et al. "connecting patients from hospital to specialized addiction resources leads to a reduction in repeat ED visits".[1] Allocation of resources to the community addiction medicine clinics with rapid access is of great importance, but putting addiction clinics into every hospital setting could be cost prohibitive. Supporting community specialty clinics not only improves the disposition planning of patients being initially treated in the ED, it also supports the community as a whole, where referrals can be accepted from all sources. This does not discount the need for addiction medicine consultations in the hospital and ED settings for complex referrals, but rather improving allocation of resources following trends in medicine to move into the community. It is known that the transition from tertiary care to community care can lead to poor communication and loss of follow-up.[2] Focus on improving that connection and not adding to an overburdened hospital system may prove more beneficial.

In patients with opioid use disorder initiating buprenorphine/naloxone therapy during patients' ED visits leads to almost double the number of patients in treatment at 30 days compared with outpatient referral alone.[3] Some emergency medicine (EM) providers may believe that starting long-term addiction treatment falls outside their scope of practice. This needs to change. The emergency physician is responsible for finding and treating immediately life-threatening conditions pertaining to any and all aspects of a patients physical and mental health, including addictions. Given that 6.5% of patients treated with naloxone for opiate overdose die within the same day,[4] it safe to assume that opioid use disorder is an immediate threat to life, and it is incumbent upon the emergency physician to diagnose and treat this illness. Considering initiation of long-term therapy for alcohol use disorder, such as with naltrexone or Acamprosate, is also the responsibility of the emergency physician.

Increasing emergency physicians' comfort and expertise in treating addiction should follow a two-pronged approach. Standard protocols starting treatment should be implemented on a regional basis, and residency education should include mandatory competencies around the acute treatment of addiction within the ED. In the case of buprenorphine/naloxone for opioid use disorder, protocol implementation on a provincial level has been shown to be both feasible and effective.[5] Similar efforts should be perused in all provinces and countries suffering from addiction epidemics. The current EM residency training guide

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CJEM 2020;22(2):135–136 DOI 10.1017/cem.2020.6

includes no entrustable professional activities or milestones directly pertaining to initiating proven medical treatment for alcohol use disorder, opioid use disorder, or any other substance use disorders.[6] This is a gross oversight and should be rectified with subsequent iterations of core competency curriculums. The EM community needs to overcome the stigma surrounding addiction and embrace our role in treating these life-threatening diseases.

We agree with Hann et al. in "the role of the ED in identifying and intervening upon patients at risk of morbidity and mortality consequences related to substance use"[1] but the role also includes the initiation of treatment. We also agree that expansion of rapid access addiction medicine clinics is imperative to the disposition of patients presenting to EDs with concerns of addiction. We hope to see further research into closing the gap between tertiary care and community clinics, where resources can be appropriately redistributed and care can be available for all people in need.

Keywords: Emergency medicine, drugs and pharmacology, mental health

Competing interests: Dr. Tanguay reports previous personal fees from Indivior, outside the submitted work. Dr. Ross has no conflicts to declare.

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