Commentary on Jin et al. (2020): Expanding the impact of opioid agonist therapy for opioid use disorder - Are there lessons from the HIV/AIDS response?

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To The Editor Jin and colleagues reviewed opioid agonist therapy (OAT) for opioid use disorder (OUD) globally. Failure to access or adhere to OAT is a major concern.[1,2]

Accessing OAT and maintaining good adherence faces many barriers which can be geographical, financial, regulatory, situational, or logistic. In some settings, lack of services hinders access to treatment for people living with OUD. In other settings – even where health care and medications are provided free of charge – many people who have OUD do not seek OAT. In the United States, **recent "estimates suggest a gap between** treatment **need and capacity of 1.4 and 1.3 million in 2012, respectively"**.[3] The ongoing epidemic of OUD needs to develop strategies to recruit and keep patients on OAT.

Approaches described in the HIV/AIDS literature may be useful to improve rates of access and treatment retention. For instance, a 2017 meta-analysis showed that HIV testing uptake escalated after social media interventions and even more in the studies where social media interventions were "participatory".[4] Future research on OAT uptake could therefore assess the merit of using them to enhance OUD diagnosis in primary and specialty care settings (e.g., pain clinics).

We also often fail to identify OUD because of stigma. This is another important area where HIV/AIDS research documented a strong association with medication adherence.[5] Health care provider education could therefore employ strategies to reduce stigmatizing beliefs that may influence adherence.

The HIV literature documents the effectiveness of various types of interventions – professional interventions such as creation of multidisciplinary teams, educational interventions such as peer-led self-management, and electronic interventions, for example, text message reminders – in promoting adherence to therapy.[6] Although the current evidence on adherence-promoting interventions for OUD is not strong enough to encourage routine clinical use of behavioural approaches, the limited evidence available suggests that such strategies may be useful for determining the circumstances in which people with treatment-refractory OUD can reduce opioid use. Given premature dropout interrupts most treatment episodes, which hinders compliance to dosing guidelines and achievement of effective therapeutic doses,

we need new information technology practices – along with behavioural interventions proven effective in HIV/AIDS – to strengthen adherence and to support re-engagement in care after interruption.

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