



Commentary on Hill et al.: Breaking down barriers-increasing access to lifesaving opioid use disorder medications to save lives

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Concise Statement:

Numerous barriers exist for patients attempting to access treatment for opioid-use disorder and/or naloxone, with geographical, racial, and age-related differences exacerbating these hardships.

Keywords

Opioid-use disorder; treatment; naloxone; buprenorphine

Commentary:

With drug-related deaths in the United States (US) increasing again after a brief reprieve in 2018, much work has focused on identifying real-world barriers to lifesaving medications for individuals with opioid-use disorder (OUD). In a recent issue of *Addiction*, Hill *et al.* examined the availability of buprenorphine/naloxone films and naloxone nasal spray (NNS) in commercial and independent pharmacies in Texas.(1) Using a 'secret shopper' approach, researchers phoned a random sample of pharmacies and asked about their availability of a 1-week supply of generic buprenorphine/naloxone (BUP/NX) films and of naloxone nasal spray (NNS). Only approximately one-third of pharmacies were able to fill both prescriptions; 40% could fill the BUP/NX alone, while NNS was available in 60% of pharmacies. Availability varied by pharmacy type (commercial v. independent), as did willingness to order the desired medications.

As this well executed study shows, real-world barriers to critical OUD medications are widespread. Buprenorphine is a standard-of-care treatment of OUD, and expanded access to naloxone is associated with reductions in opioid-related mortality.(2-5) But for these

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interventions to be effective, individuals with OUD need to be able to easily access them. Access varies by geography given the heterogeneity of the opioid-overdose epidemic as well as regional social (e.g., stigma and pervasive inaccurate beliefs about OUD and treatment), political (e.g., state and local laws facilitating or obstructing access), and healthcare-sector (e.g., density of OUD treatment providers) differences.

Findings similar to those of Hill *et al.* have been shown throughout the US. A recent study of naloxone availability in Pennsylvania found that only 45% of pharmacies stocked it.(6) After California passed legislation in 2016 allowing patients to obtain naloxone without a prescription, fewer than one-quarter of pharmacies reported distributing naloxone to patients without a prescription.(7) Naloxone distribution in the US remains heavily dependent on a patchwork of community and public health department distribution programs with diverse and variable funding streams. Naloxone distribution is more progressive in some settings outside the US, with federal governments funding take-home naloxone kits in Scotland, and countries like Italy and Australia allowing naloxone to be purchased over-the-counter.(8,9)

OUD medication access gaps in the US are exacerbated by longstanding racial inequities. Across settings and populations, studies consistently demonstrate poorer access to buprenorphine for Black and Latinx compared to non-Hispanic white individuals.(10-14) Historically, access to MOUD has been fragmented according to race with highly segregated predominantly Black and Latino communities having relatively greater access to methadone as compared to buprenorphine, while predominantly white communities have easier (though still inadequate) access to buprenorphine.(15) Ongoing and future interventions need to incorporate clear antiracist strategies to reduce disparities by race.

It is also important to highlight the barriers that adolescents and young adults face when accessing OUD medications, with less than one-quarter of US youth aged 13-22 receiving timely addiction treatment after an opioid overdose and far fewer receiving an evidence-based medication like buprenorphine.(16) Access to naloxone can be difficult for adolescents to obtain as pharmacies often incorrectly restrict dispensing to youth based on age.(17) Expanded youth access to naloxone needs to be a focus of future policy interventions, not only because youth may themselves have an OUD diagnosis, but also because they are often the family member of someone with OUD.(18)

Policymakers, clinicians, the pharmaceutical industry, and retail and independent pharmacies can implement several solutions to overcome the many access barriers to lifesaving medications for OUD. Given the safety margin of naloxone, the US Food & Drug Administration could make naloxone an over-the-counter purchase. Such a policy change would need to be bolstered by a fully funded national strategy (e.g., through partnerships between government and drug companies) to ensure an adequate, affordable supply of naloxone to retail and independent pharmacies; such a strategy, which should also be pursued for buprenorphine, should have the dual goals of maximizing naloxone availability and minimizing pharmacies' and patients' financial burden. The US Drug Enforcement Agency should eliminate the "X-waiver" (the federal requirement in the US that prescribers complete mandatory training and registration to provide buprenorphine for OUD treatment) to increase the number of buprenorphine prescribers and dismantle the inherent stigma

towards people with addiction that the X-waiver legislation was built upon.(19) In doing so, federal agencies should allow and incentivize pharmacists, who have enormous expertise in medication management, to offer OUD treatment, directly dispensing buprenorphine and naloxone. Until the barriers that prevent equitable access to OUD treatment and overdose interventions are undone, we will continue to see needless harm and death that is disproportionately experienced by marginalized communities.

References:

- Hill LG, Loera LJ, Evoy KE, Renfro ML, Torrez SB, Zagorski CM, et al. Availability of buprenorphine/naloxone films and naloxone nasal spray in community pharmacies in Texas, United States. *Addiction*. 2020;0–3.
- Abouk R, Pacula RL, Powell D. Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose. *JAMA Intern Med* [Internet]. 2019 5 6;07410:1–7. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/31058922>
- McClellan C, Lambdin BH, Ali MM, Mutter R, Davis CS, Wheeler E, et al. Opioid-overdose laws association with opioid use and overdose mortality. *Addict Behav* [Internet]. 2018;86(12 2017):90–5. Available from: 10.1016/j.addbeh.2018.03.014
- The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med* [Internet]. 2020;14(2S Suppl 1):1–91. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/32511106>
- Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *BMJ* [Internet]. 2013;346(7894):1–13. Available from: 10.1136/bmj.f174
- Graves RL, Andreyeva E, Perrone J, Shofer FS, Merchant RM, Meisel ZF. Naloxone Availability and Pharmacy Staff Knowledge of Standing Order for Naloxone in Pennsylvania Pharmacies. *J Addict Med*. 2019;13(4):272–8. [PubMed: 30585876]
- Puzantian T, Gasper JJ. Provision of Naloxone Without a Prescription by California Pharmacists 2 Years After Legislation Implementation. *JAMA* [Internet]. 2018;320(18):1933–4. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/30422185>
- McDonald R, Campbell ND, Strang J. Twenty years of take-home naloxone for the prevention of overdose deaths from heroin and other opioids—Conception and maturation. *Drug Alcohol Depend* [Internet]. 2017;178(3):176–87. Available from: 10.1016/j.drugalcdep.2017.05.001
- Bird SM, McAuley A, Perry S, Hunter C. Effectiveness of Scotland’s National Naloxone Programme for reducing opioid-related deaths: A before (2006–10) versus after (2011–13) comparison. *Addiction*. 2016;111(5):883–91. [PubMed: 26642424]
- Schiff DM, Nielsen T, Hoepfner BB, Terplan M, Hansen H, Bernson D, et al. Assessment of Racial and Ethnic Disparities in the Use of Medication to Treat Opioid Use Disorder Among Pregnant Women in Massachusetts. *JAMA Netw open*. 2020;3(5):e205734. [PubMed: 32453384]
- Hadland SE, Frank Wharam JW, Schuster MA, Zhang F, Samet JH, Larochelle MR. Trends in receipt of buprenorphine and naltrexone for opioid use disorder among adolescents and young adults, 2001–2014. Vol. 171, *JAMA Pediatrics*. 2017. p. 747–55. [PubMed: 28628701]
- Rhee TG, Rosenheck RA. Buprenorphine prescribing for opioid use disorder in medical practices: can office-based out-patient care address the opiate crisis in the United States? *Addiction*. 2019;114(11):1992–9. [PubMed: 31307111]
- Rhee TG, D’Onofrio G, Fiellin DA. Trends in the Use of Buprenorphine in US Emergency Departments, 2002–2017. *JAMA Netw open*. 2020;3(10):e2021209. [PubMed: 33079195]
- Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine Treatment Divide by Race/Ethnicity and Payment. *JAMA Psychiatry* [Internet]. 2019 9 1;76(9):979. Available from: <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2732871>

15. Goedel WC, Shapiro A, Cerdá M, Tsai JW, Hadland SE, Marshall BDL. Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States. *JAMA Netw open*. 2020;3(4):e203711. [PubMed: 32320038]
16. Alinsky RH, Zima BT, Rodean J, Matson PA, Larochelle MR, Adger H, et al. Receipt of Addiction Treatment after Opioid Overdose among Medicaid-Enrolled Adolescents and Young Adults. *JAMA Pediatr*. 2019;21287:1–10.
17. Jimenez DE, Singer MR, Adesman A. Availability of Naloxone in Pharmacies and Knowledge of Pharmacy Staff Regarding Dispensing Naloxone to Younger Adolescents. *J Adolesc Heal* [Internet]. 2019;65(5):698–701. Available from: 10.1016/j.jadohealth.2019.07.009
18. Chadi N, Hadland SE. Youth Access to Naloxone: The Next Frontier? *J Adolesc Heal* [Internet]. 2019;65(5):571–2. Available from: 10.1016/j.jadohealth.2019.08.005
19. Fiscella K, Beletsky L, Wakeman SE. Patients With Opioid Use Disorder Deserve Trained Providers. *Ann Intern Med* [Internet]. 2020;172(11):772–3. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/32479153>