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Commentary on “The more things change: Buprenorphine/naloxone diversion continues while treatment is inaccessible”

Shannon Gwin Mitchell, PhD^a, Jan Gryczynski, PhD^a, and Robert P. Schwartz, MD^a

^aFriends Research Institute, 1040 Park Avenue, Suite 103, Baltimore, Maryland 21201

Abstract

This commentary puts the recent findings by Carroll et al. into historical perspective, noting both the long-held problem of medication diversion when pharmacotherapy access is limited, and the ways in which medication diversion concerns and regulations help create those treatment access barriers. Recent efforts to bridge the treatment gap, including increases in Federal funding through the 21st Century Cures Act and expanding the buprenorphine patient cap and scope of eligible providers under the Comprehensive Addiction Recovery Act (CARA) will likely help, however important structural barriers remain. Health insurance barriers, including limited Medicaid coverage, combined with stigma against pharmacotherapy persist, which likely means that people in need of treatment will continue to self-treat their symptoms with diverted medications, such as the buprenorphine/naloxone use noted by Carroll and colleagues.

Throughout the US, there has been a persistent gap between the need for opioid addiction treatment and treatment capacity (Jones et al., 2015). The tragedy of this gap is more evident than ever in light of the rapidly shifting dynamics underlying the current opioid epidemic. Most notably, the emergence of fentanyl and its analogues in the illicit opioid supply is driving the alarming rise in overdose mortality during a time when overdose deaths are already at a historic high (Rudd et al., 2016). Unfortunately, the gap between treatment need and availability is nothing new. Waiting lists for opioid addiction treatment in the public sector have existed in the US throughout the history of methadone treatment (Des Jarlais and Friedman, 1993; IOM, 1993; Schwartz et al., 2009). As noted by Carroll and her team (Carroll et al., 2018) and others, (Sigmon et al., 2016) waiting lists now exist for buprenorphine treatment as well, despite local and national efforts to expand treatment availability.

The reasons for the current opioid addiction treatment gap are multi-faceted (Agar and Reisinger, 2001) and it is apparent that structural barriers play an important role. These include Federal regulations restricting (US Dept. of Justice, 2018) the prescribing of buprenorphine to treat opioid addiction, including the requirement to obtain special training and a federal waiver of the Controlled Substance Act, as well as limitations on the number of patients that can be treated per provider. These restrictions are meant to balance the need for

Corresponding author: Shannon Gwin Mitchell, smitchell@friendsresearch.org, 1040 Park Avenue, Suite 103, Baltimore, Maryland 21201, Phone 410-837-3977 x238.

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treatment in the community with the desire to reduce the likelihood of inappropriate prescribing, in the hopes of limiting medication diversion. However, the opioid epidemic is tipping the balance even more in favor of expanding treatment than before.

Recent increases in Federal funding through the 21st Century Cures Act, along with the Comprehensive Addiction Recovery Act (CARA) of 2016 that permits nurse practitioners and physician assistants to obtain a waiver to prescribe buprenorphine and that increases the cap on the number of patients that certain physicians can treat, should help to expand treatment access. Unfortunately, it is unlikely that these efforts will be sufficient to bridge the treatment gap.

There are numerous other barriers to access to effective pharmacotherapy with buprenorphine, methadone, and extended release naltrexone that also need to be addressed (Sharma et al., 2017). Chief among them are the lack of health insurance coverage (including Medicaid), managed care barriers for those with insurance, inadequate funding for out-of-pocket expenses for treatment for the uninsured and underinsured, stigma against pharmacotherapy among individuals with opioid addiction and health care providers, and lack of penetration of pharmacotherapy in community corrections, jails, and prisons (Lee and Rich, 2011; Burns et al., 2016; Saloner et al., 2016).

The Carroll et al. (Carroll et al., 2018) study from Rhode Island is consistent with other larger nation-wide studies (Cicero et al., 2014) showing that the most frequent reason given for the use of diverted buprenorphine is to manage opioid withdrawal and to self-treat opioid addiction. Such individuals may indeed be amenable to treatment through medical services. In fact, the Carroll et al. (Carroll et al., 2018) study and other researchers (Lofwall and Walsh, 2014) found that unsuccessfully seeking buprenorphine treatment was associated with the use of diverted buprenorphine. Thus, paradoxically, an unintended consequence of restricted access to buprenorphine treatment is creating a market for “self-treatment” outside of appropriate medical supervision. It follows that an important approach to both addressing the opioid epidemic while simultaneously reducing the demand for diverted buprenorphine is making treatment more easily accessible and attractive to individuals with opioid addiction.

Although diverted buprenorphine appears to be most frequently used by people with opioid addiction to manage withdrawal and treat their disease, it is an opioid partial agonist with reinforcing properties that can be self-administered to achieve euphoria. The balance between the extent to which diverted buprenorphine is used for “self-treatment” compared with “getting high” depends on the availability and cost of other illicit opioids (including heroin and other prescription opioids) that are more reinforcing than buprenorphine. International experience has shown that in countries when the supply of heroin was curtailed due to successful enforcement, the illicit use of buprenorphine increased (Lofwall and Walsh, 2014). At the present time, this is not the case in the U.S., where for many years, heroin, and more recently fentanyl, has been available at low prices and high potency. Should efforts that restrict the availability of heroin and fentanyl in the US become highly effective, making these opioids difficult to find and expensive to obtain, it is possible that non-therapeutic use of diverted medications may increase. Thus, continued vigilance of the

extent and reasons for use of diverted buprenorphine must go hand in glove with expanded access to treatment.

New formulations of buprenorphine, such as the 6-month implant, monthly injection, and other injectables in the FDA pipeline, are poised to play an important role over the next several years in increasing treatment access while minimizing diversion. A number of other approaches can also be used to reduce the likelihood of diversion, including the use of computerized medication dispensing devices designed to increase adherence (Sigmon et al., 2016) and creating collaborative care between prescribing physicians and Opioid Treatment Programs (Stoller, 2015) or pharmacists (DiPaula and Menachery, 2015). Physicians who prescribe buprenorphine should utilize their States Prescription Monitoring Drug Program to ensure their patients are not obtaining other opioid prescriptions and should adopt the effective clinical practices detailed in ASAM's National Practice Guidelines (ASAM) (ASAM, 2015).

In the face of an unprecedented tide of overdose deaths, we urgently need to expand treatment availability and access to the full spectrum of FDA-approved medications and their various formulations. Retention in methadone and buprenorphine treatment has been shown to reduce overall mortality and overdose death (Sordo et al., 2017). Extended release naltrexone is effective in reducing illicit opioid use (Lee and Rich, 2011). Within two years of bringing antiretroviral HIV medications to scale, the US's HIV mortality rate was cut in half (William et al., 2017). The challenge facing us is bringing treatment for opioid addiction to scale while simultaneously monitoring and limiting the diversion of buprenorphine/naloxone. If there was ever a time to achieve this important aim, the time is now.

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