National Academy of Medicine
Action Collaborative on
Countering the U.S. Opioid Epidemic

KEY MESSAGES

The American Opioid Epidemic in Special Populations: Five Examples

The United States is in the midst of an unprecedented crisis of prescription and illicit opioid misuse, use disorder, and overdose. Although the crisis has affected large swaths of the U.S. population, it has impacted certain segments of the population with an extra level of intensity—justice-involved populations, rural populations, veterans, adolescents and young adults, and people who inject drugs. Research has clearly shown that solutions for the opioid overdose epidemic are not one size fits all, and special attention should be paid to these populations that may be suffering unduly.

The discussion paper "The American Opioid Epidemic in Special Populations: Five Examples" focuses on these five identified populations and, for each, reviews why the population warrants focused attention, current barriers encountered in accessing care, promising approaches in supporting this population, and high-impact research and action priorities.

Justice-Involved Populations

More than ten million people pass through the justice system each year and over two million people are confined in U.S. jails or prisons daily. Among those who encounter the justice system, rates of opioid use are significantly higher than in the general population. Justice-involved populations experience barriers to care due to both the short duration of jail stays (challenges screening and initiating treatment, as well as interrupting ongoing treatment) and the long duration of prison stays (challenges managing logistics of providing continuous care and stigma against medications for opioid use disorder [MOUD]). Continuity of care is critical as justice-involved populations move from jails and prisons back into their communities, and maintaining care has been historically difficult.

Research and action priorities for justice-involved populations could include:

1. Initiating and continuing MOUD while individuals are incarcerated, including through the use of telemedicine, and ensuring that MOUD is not interrupted upon return to the community.
2. Supporting the prescription of buprenorphine and methadone over naltrexone, absent trials that provide evidence of equivalent or better outcomes, and improving education to reduce MOUD stigma.
3. Pursuing regulatory adjustments that would allow for suspension, rather than termination, of Medicaid when an individual enters a jail or prison, and supporting pilot projects to facilitate treatment continuity.
4. Addressing logistical barriers to providing care by, for example, ensuring appropriate numbers of staff with buprenorphine waivers are available to care for the entire incarcerated population.
5. Expanding drug court models to require both provision of MOUD and additional social services, and focusing research on establishing standards for consistency and quality between drug courts.
6. Partnering with community organizations to provide employment opportunities for those who are on MOUD and transitioning out of incarceration.
7. Providing naloxone and education upon release to prevent against accidental death due to overdose.
8. Pursuing changes that would reduce total incarceration duration for people with OUD who have not been charged with violent or other serious offenses.
9. Ensuring that individuals who receive addiction treatment also receive high-quality behavioral health care.

Rural Populations

Drug overdose deaths grew 325% in nonmetropolitan areas, compared to 198% in metropolitan areas between 1999 and 2015, and patients in the most geographically isolated rural counties were 87% more likely than counterparts in large metropolitan counties to receive an opioid prescription between 2014 and 2017. Rural populations face numerous barriers to treatment, including a lack of appropriate providers and opioid treatment programs. Compared to their urban counterparts, rural residents often travel longer distances to receive health care and these transportation challenges can make adhering to treatment with MOUD difficult. In 2017, 56% of rural counties lacked a single physician with a DATA 2000 ("X") waiver, which allows them to prescribe MOUD, presenting significant challenges to being prescribed MOUD at all.

Research and action priorities for rural populations could include:

1. Continuing financial and technical assistance support for rural communities planning to and currently implementing evidence-based interventions to address the opioid epidemic.
2. Establishing entry points to treatment in rural service delivery settings which are less likely to invoke self and community stigma among these populations, such as churches, libraries, and other community-based settings.
3. Providing incentives for waivered physicians who work in rural communities to see as many patients in need of medication for opioid use disorder that their license allows.
4. Providing incentives for providers of non-pharmacologic, non-opioid pain management therapies to operate in rural communities, giving residents an alternative to opioid therapy for pain management.
5. Providing incentives for health care professionals to work in rural communities to address the challenges associated with a lack of providers.
6. Expanding reimbursement for the use of telemedicine to include waivered physicians and non-pharmacologic, non-opioid pain management therapies.

Adolescents and Young Adults

Adolescents and young adults (ages 12-24) have developing brains that make adolescents more vulnerable to the effects of substance use and increases the risk of developing substance use disorders more quickly than older adults. Adolescents and young adults are, generally, more likely to try opioids than older populations, and when they do initiate use, are more likely to develop an OUD. Adolescents experience significant barriers to accessing care, and are found to especially under-utilize treatment for OUD due primarily to financial barriers and a lack of confidence in the approachability and confidentiality of family members and health care providers.

Research and action priorities for adolescents and young adults could include:

1. Training pediatric providers to treat and prevent substance use.
2. Strengthening general behavioral health training and training in treating substance use disorders and pharmacotherapy prescription for providers.
3. Addressing the cost of treatment, including insurance coverage, for adolescents and young adults.
4. Developing adolescent and young adult treatment systems that recognize the unique developmental stage, strengths, and challenges of the population.
5. Promoting research on prevention strategies that incorporate peers, family members, and schools.

Veterans

The prevalence of OUD among VA-treated veterans is almost seven times that of the commercially insured, and veterans are more likely than the general population to have risk factors for OUD and overdose. Veterans returning from overseas deployments are at risk to misuse prescription opioids to treat service-related injuries and non-deployed active duty service members are also at heightened risk. Veterans experience many of the same barriers to OUD treatment as the general population, including self-stigma and system-level stigma and traveling long distances to receive treatment. Veterans do, however, benefit from the unique aspects of the VA's health system.

Research and action priorities for veterans could include:

1. Expanding access to and improving processes for the administration of MOUD for veterans in primary care settings.
2. Strengthening collaborations between the Department of Defense and the VA to improve opioid use disorder prevention and treatment for transitioning veterans, particularly those with service-related painful conditions.
3. Piloting telehealth programs that can reach veterans in rural areas.
4. Advancing interactive and effective provider education tools to improve evidence-based OUD care delivery.

People Who Inject Drugs

People who inject drugs (PWID) are at a higher risk for opioid injection drug use-related infectious diseases, including HIV and viral hepatitis. Beyond infectious disease-related harms, PWID are at increased risk for SUD, drug overdose, and engaging in high-risk sexual behaviors. PWID experience significant barriers to care, including stigma and social and structural challenges that limit seeking, accessing, and receiving substance use and infectious disease treatment, and harm reduction services.

Research and action priorities for people who inject drugs could include:

1. Increasing access to sterile injection equipment and education on safe injection practices, infection prevention strategies, and appropriate wound care through the expansion of syringe service programs.
2. Expanding access to MOUD among people who inject drugs, especially buprenorphine and methadone.
3. Increasing HIV and hepatitis testing, counseling, provision of PrEP, and improved linkage to antiretroviral treatment to prevent the transmission of HIV and hepatitis.
4. Scaling up viral hepatitis testing, linkage to direct-acting antiviral treatment, and vaccination for hepatitis A virus and hepatitis B virus.
5. Increasing access to overdose prevention education and naloxone distribution among PWID.
6. Expanding research to identify innovative service delivery models that can increase provision of MOUD and naloxone, access to infectious disease testing and treatment, and retention in treatment among people who inject drugs.

SOURCE: Blanco, C., M. M. Ali, A. Beswick, K. Drexler, C. Hoffman, C. M. Jones, T. R. A. Wiley, and A. Coukell. 2020. The American Opioid Epidemic in Special Populations: Five Examples. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202010b

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