



# How Race Affects Access to Opioid Use Disorder Medications

By Malini Ghoshal, RPh, MS

**R**ates of substance misuse and overdose deaths affecting underrepresented groups have been increasing steadily in the past several years (SAMHSA, 2018), and when it comes to medication treatment options for opioid use disorder (OUD), there are stark divides in access based on racial, geographic, and economic barriers for many Black, Indigenous, and People of Color (BIPOC) populations (Smedley, Stith and Nelson, 2003; Abraham, Knudsen, Rieckmann & Roman, 2013; Goedel et al., 2020).

Buprenorphine, naltrexone, and methadone are currently approved by the Food and Drug Administration (FDA) for the treatment of OUD. Buprenorphine and methadone are widely considered effective treatment when coupled with professional counseling (Connery, 2015). Methadone (a full opioid agonist) and buprenorphine (a partial opioid agonist) are both effective for treatment of opioid-related acute care and opioid overdose prevention compared to non-medication-based treatment (Wakeman et al., 2020). Studies also show there are no major differences in long-term outcomes with either buprenorphine or methadone treatment (Hser et al., 2016).

However, there are differences between buprenorphine and methadone access related to regulation, prescribing, and distribution for OUD

treatment that have disproportionately led to bias and discrimination. Buprenorphine can be prescribed in office-based settings by medical providers, and the medication can be filled at pharmacies. In contrast, methadone for OUD can only be distributed through certified opioid treatment programs and for most patients, it requires an in-person visit and supervised dosing. This has led to stigma associated with methadone treatment (Nguemini Tiako, 2021; Harris, 2015).

In addition, several factors historically and in the present day regarding substance misuse continue to contribute to both unequal access to treatment medications and stigma specifically with methadone treatment for BIPOC individuals.

## Barriers to Treatment Access

Racially charged polarities in past and present policies and attitudes on substance misuse have led to discrimination and treatment disparities for BIPOC individuals with OUD, which include choice of access to treatment medications (Netherland & Hansen, 2016; Nguemini Tiako, 2020; SAMHSA, 2020; Hansen & Netherland, 2016). For many Black and Hispanic patients, medication-based treatment options and access are severely limited based on where they live and the cost of medications (SAMHSA, 2018; SAMHSA, 2020; SAMHSA, 2020; Blanco & Volkow, 2019).

Racial and ethnic makeup of communities may determine which medication (methadone or buprenorphine) will be available (Hansen, Siegel, Wanderling, & DiRocco, 2016). Research shows a majority of patients who receive buprenorphine treatment are White, have higher incomes and education levels, and have private insurance or self-pay compared to patients receiving methadone treatment (Hansen et al., 2013; Roberts et al., 2018). Most methadone treatment programs are located in Black and Hispanic neighborhoods and patients on methadone treatment face stigma, discrimination, and bias from their friends, employers, co-workers, and healthcare providers discouraging treatment outreach (Earnshaw et al., 2013; Harris & McElrath, 2012).

Further adding to the treatment-related disparities include the facts that fewer buprenorphine providers accept Medicaid and buprenorphine treatment programs more often rely on online advertising and other internet sources for patients, which may exclude low-income populations without internet access (Hansen, Siegel, Wanderling, & DiRocco, 2016).

In contrast, methadone clinics are frequently publicly funded, receive referrals from public health service agencies serving low-income populations and the criminal justice system, and are located in urban areas with higher underrepresented populations (Hansen, Siegel, Wanderling, & DiRocco, 2016; Clark, Samnaliev, Baxter & Leung, 2011; Parran et al., 2017; Nunn et al., 2009). These publicly-funded treatment programs often do not have physicians on staff and can provide only limited medication-based treatment options (Abraham, Knudsen, Rieckmann, & Roman, 2013).

Geographic challenges also increase access problems. A 2020 study showed that treatment facilities located in counties with higher populations of Black and Hispanic or Latino populations were more likely to provide methadone and facilities located in predominantly White counties were more likely to provide buprenorphine (Goedel et al., 2020). In fact, the study showed that in 2016, there were 18,868 facilities in the U.S. providing buprenorphine and only 1,698 facilities providing methadone. The fewer methadone treatment programs coupled with economic barriers to buprenorphine access for BIPOC patients sets up multiple levels of challenges for equitable treatment access.

Further, the study found in counties where White residents were unlikely to interact with Hispanic, Latino, and Black residents had higher buprenorphine treatment access. In contrast, methadone access was higher in counties where Black, Hispanic, and Latino residents were not likely to interact with White residents (Goedel et al., 2020).

These imbalances in program locations and number of treatment programs for each medication are a result of the historical racial, socio-political discourse of the “War on Drugs” and continue to contribute to negative stereotypes and discrimination linked to methadone treatment for BIPOC patients and lack of access to buprenorphine (Netherland & Hansen, 2016). Insufficient numbers of treatment providers, restrictive regulations for methadone prescribing and distribution, clinician implicit bias, and increased treatment costs have raised barriers and emphasized the urgent need to address racial disparities in addiction treatment (Fitzgerald & Hurst, 2017; Goedel et al., 2020).

The current COVID-19 pandemic has further magnified existing healthcare disparities for BIPOC communities, including for equal access to substance use disorder treatment and risks of poorer outcomes for both COVID-19 and SUD (Nguemini Tiako, 2020).

## What Can Be Done?

Strategies to improve equity in treatment requires comprehensive systemic shifts that focus on the causes of the disparities (ex. race, economic differences, geography). Further, removing restrictive methadone treatment regulations and increasing community physician and pharmacy involvement in treatment will increase availability of medications and reduce stereotypes and discrimination (Calcaterra et al., 2019).

Recently, the U.S. Department of Health and Human Services (HHS) has lifted waiver requirements for buprenorphine prescribing, which should enable broader prescribing for patients further reducing stigma associated with treatment (HHS, 2021). While removing waiver requirements is a crucial step in lowering access barriers for buprenorphine treatment for BIPOC patients, the existing economic, social, and political barriers also must be addressed. Due to years of prejudiced comparisons regarding the demographics of substance misuse (White versus BIPOC), there continues to be double standards regarding access to treatment.

To forge meaningful change toward equitable treatment access, some important areas for focus should include addressing regulatory and policy barriers to increase buprenorphine providers in underrepresented communities, increasing support for culturally sensitive training and education, and addressing clinician reimbursement and insurance requirement concerns (Hansen et al., 2013; Goedel et al., 2020). Today, there remains much work to be done to change policies and undo racial injustices that have led to stark differences in who can access treatment and the treatment that can be accessed. Equal access to treatment that is not predicated by race, gender, or socio-economic status of an individual is the goal.

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**Terminology Note:** The author used current guidance from the American Psychological Association regarding racial and ethnic nomenclature. The term “underrepresented groups” is used rather than “minority.” Use of some specific terminology (e.g., Hispanic/Latino) is based on reference sources cited.

*Racial and ethnic identity.* (2019). APA Style. <https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/racial-ethnic-minorities>

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