

Reply to Letter to the Editor Regarding Article: “Considering the Potential Benefits of Over-The-Counter Naloxone” [Response To Letter]

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Dear editor

We concur with Dr. Fuehrlein that increasing naloxone access is only one component of a comprehensive strategy to reduce opioid-related overdose (ORO) mortality. We believe efforts to increase access to medications for opioid use disorder (MOUD), including permitting healthcare professionals such as pharmacists and paramedics to facilitate initial and ongoing MOUD treatment,^{1–3} are crucial.

However, we strongly disagree that efforts to remove barriers to this lifesaving medication are incompatible with connecting people with opioid use disorder (OUD) to MOUD. To our knowledge, there is no evidence that requiring a patient to interact with a healthcare professional before obtaining naloxone increases the likelihood that the patient will receive MOUD. Unfortunately, prescribers do not routinely discuss OUD risks or co-prescribe naloxone when prescribing opioids, and even patients who experience an ORO often do not begin treatment with MOUD.^{4–6} Furthermore, pharmacists rarely assess the need for, or counsel on the benefits of, OUD treatment when dispensing naloxone, and often report feeling unprepared to do so.^{7,8}

Despite continuing legal and regulatory barriers associated with naloxone's status as a prescription-only medication, many people currently obtain naloxone without ever meeting a medical provider. In fact, harm reduction organizations were for many years the dominant source of take-home naloxone. In 2018, a limited subset of syringe services programs distributed over 700,000 naloxone doses, compared to approximately 550,000 naloxone prescriptions dispensed from retail pharmacies.^{9,10} In 2019, a single harm reduction initiative distributed over one million doses of naloxone across the United States.¹¹ These and similar low-barrier sources of naloxone are critical for reaching the many people who use drugs who avoid traditional healthcare settings due to past negative, stigmatizing experiences with healthcare professionals, as well as those without the financial means to access traditional care.¹² Low-barrier harm reduction programs are also extremely effective at connecting people to evidence-based treatment.¹³

We further note that not all illegal drug use is disordered use, and even occasional use of illegal or illegally-obtained drugs can lead to a potentially fatal ORO. Thus, many people who are at risk for ORO do not have an indication for MOUD. The need to facilitate naloxone access for people who are at risk of

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overdose but do not have OUD is increasingly urgent due to the increase of potent synthetic opioid adulterants in both non-opioid drugs and counterfeit opioid tablets.

Ensuring widespread access to naloxone is not sufficient to ensure that people with OUD engage with treatment, but in many cases it is necessary. People with OUD will not commit to treatment until they are personally ready. Imposing unnecessary naloxone access barriers may tragically reduce the likelihood they survive to that point. We therefore support the removal of barriers – stigma, legal, financial, and otherwise – that keep people from accessing both naloxone and MOUD, including moving at least one naloxone product OTC.

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