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The Next Chapter of America's Opioid Response

As overdose deaths continue to fall, expanding access to evidence-based treatment can help turn this progress into sustained recovery.

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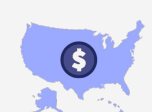


After years of devastating losses, the U.S. is seeing meaningful progress in the opioid crisis, including sharp declines in overdose deaths. Yet as many as 4 million Americans are still living with diagnosed opioid use disorder (OUD), and its consequences continue to ripple across families, health systems, workplaces and communities. The economic burden of OUD alone has been estimated at \$2.7 trillion annually in the U.S.

The next chapter of America's opioid response should be measured not only by lives saved, but by lives rebuilt — more people entering treatment, staying connected to care and sustaining recovery. The good news is that proven treatment options already exist. The challenge is making sure people can access them.

Pharmaceutical manufacturer Indivior understands the complexity — and the promise — of tackling this challenge. More than 25 years ago, the company helped pioneer the introduction of buprenorphine, a prescription medication to treat OUD, and has since remained singularly focused on delivering evidence-based treatment for people living with OUD.

The economic burden of OUD has been estimated at \$2.7 trillion annually — nearly 10% of the U.S. GDP.

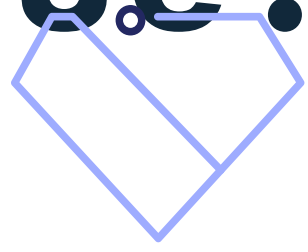


\$2.7 T

ANNUAL COST OF OUD IN THE U.S.

POLITICO Focus spoke with Indivior about the persistent treatment access gap, the evolution of long-acting injectable treatment and what policymakers can do to make sustained OUD recovery a reality for more Americans.

What Is The Issue?



OUD is a chronic, treatable brain disease, and patients and clinicians today have a range of evidence-based medications to choose from. One option that has not yet been widely adopted is long-acting injectable buprenorphine, which provides treatment over an extended period rather than requiring a daily dose. For some patients, that can make treatment easier to sustain, particularly when routines or care are disrupted.

But treatment access has not kept pace with treatment innovation. Of the millions of Americans living with OUD last year, fewer than 16 percent received an FDA-approved medication. This gap is particularly consequential in high-risk settings like jails and prisons, where nearly 1 in 5 people meet the criteria for OUD, and yet treatment remains limited and inconsistent.

That makes access to evidence-based treatment a policy imperative. People who choose medication should, under advisement from their provider, be able to access the full range of clinically appropriate, FDA-approved treatment options for OUD. Policy and payment systems should support, rather than narrow, that choice.

OUD treatment has evolved. Patients and providers now have multiple FDA-approved medications and formulations that can be tailored to individual needs. But awareness and access have not always kept up with science. That is why Indivior has partnered with communities, researchers, clinicians and policymakers to dismantle stigma and enable individual choice.

Recovery is not one-size-fits-all. A daily medication may work well for some. For others — including people who live far from treatment providers or face transportation barriers — a long-acting injectable may allow them the freedom to return to routines at work, at home and in their communities without having to worry about daily treatment or office visits. Some people may not choose medication at all. But choosing medication-assisted treatment, including a long-acting injectable, does not have to mean a lifelong commitment. Treatment needs can change throughout recovery.

The goal is for patients and clinicians to be able to choose from all clinically appropriate options without policy, coverage or logistical barriers effectively making the choice for them.

For many, sustained treatment is what makes it possible to hold a job, support a family and rebuild independence. It is the difference between cycling through crisis systems and contributing to their communities.

How Has Treatment Changed?



By The Numbers



46%

46% of Americans say the opioid crisis has worsened over the past five years.



<16%

Less than 16% of the 4 million Americans living with OUD last year received medication.



\$295,000/YR

The combination of behavioral therapy and long-acting injectable buprenorphine delivers \$295,000 in annual savings per patient.

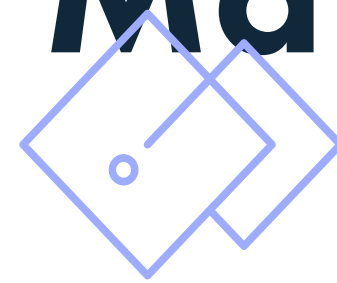
Recent drops in overdose deaths are significant. But that has not erased the treatment gaps that continue to put some populations at greater risk. OUD does not stay in one lane. When people cannot access or stay connected to treatment, the consequences show up across emergency rooms, hospitals, jails, families and taxpayer budgets.

Those gaps are especially visible in the criminal justice system. People with OUD are disproportionately represented in jails and prisons, making incarceration a critical opportunity to connect people with evidence-based care. Yet fewer than half of 1,028 jails surveyed nationally offered any medication for OUD and additional research found that nearly half of jails cite inadequate staffing as a primary barrier to offering medications for OUD. The problem becomes more acute after release when overdose risk can climb as high as 40-fold in the first two weeks after incarceration, just as people are navigating housing, transportation, insurance and community care.

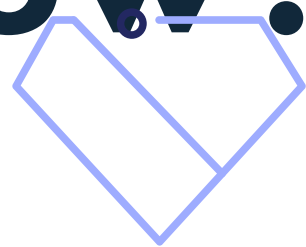
Long-acting injectables can help address all these challenges by supporting continuity through reentry while reducing the staffing demands of daily medication administration.

For American Indigenous communities, these challenges can intersect. Native communities experience disproportionately high rates of incarceration and the highest overdose death rates in the country — while facing significant barriers to accessing evidence-based treatment. For many in rural areas with limited or no treatment infrastructure, that makes the reentry transition from incarceration particularly consequential. Long-acting medications may offer one way to bridge that gap by making continuity of care more practical while reducing the need for daily treatment.

Why Does This Matter?



What Does The Evidence Show?



Evidence shows that keeping people connected to treatment can benefit both patients and the systems supporting them.

Medications for OUD, often referred to as MOUD, can help people stay engaged in care and reduce the cycle of return to opioid use, emergency treatment and incarceration. In correctional settings, providing medication during incarceration has been shown to mitigate the risks of post-release overdose, death and reincarceration.

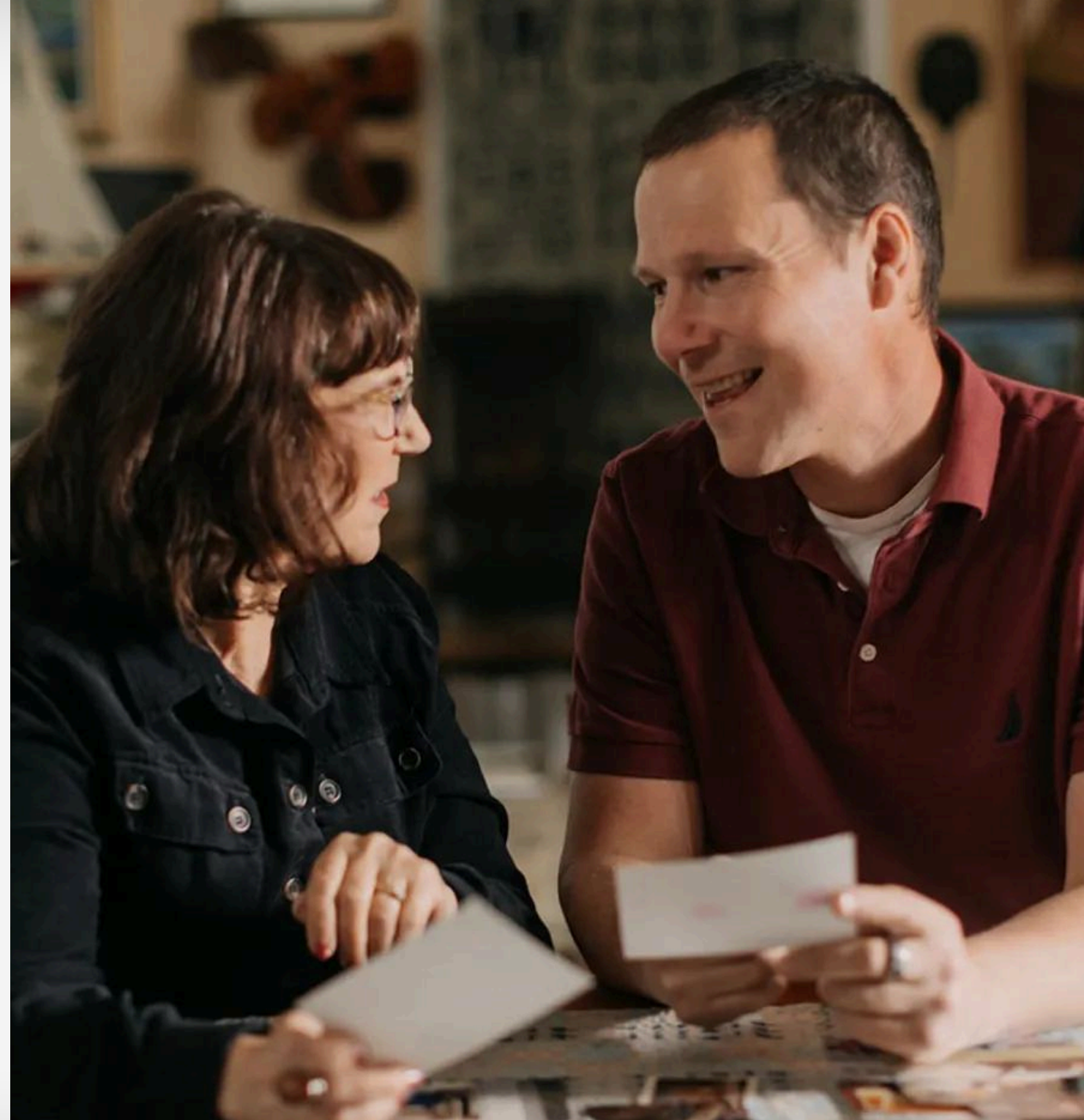
Long-acting injectable medications may add another layer of stability. In one real-world analysis, patients who remained adherent to monthly LAI buprenorphine had the lowest rates of emergency department visits, hospitalizations and detoxification visits. Their adjusted annual, non-MOUD medical costs were about \$15,000 lower than those of patients who remained adherent to other treatments.

Taken together, the evidence points to a larger opportunity: move OUD care from repeated crisis response toward sustained disease management. That requires both evidence-based medication and the supports that help people rebuild — behavioral healthcare, housing, employment, family and community connections and successful reintegration. This approach aligns with the Great American Recovery Initiative's emphasis on recovery, reintegration and stability.

Fewer Barriers. More Steps Forward.

When opioid use disorder treatment options are out of reach, recovery becomes harder. Expanding access to evidence-based treatments can help make recovery possible for more Americans.

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Recovery is individualized, and policy needs to make room for that.

People with OUD should be able to choose from the full range of clinically appropriate, FDA-approved medications with their clinicians — rather than have their options dictated by which treatment a system favors, covers or makes easiest to obtain.

That means examining federal program rules, grant requirements, reimbursement policies, prior authorization, fail-first policies and pharmacy restrictions to ensure they do not unintentionally disadvantage any treatment options. It also means aligning the funding pathways, including State Opioid Response grants and opioid settlement funds, so that access does not depend on where someone lives or which system they happen to touch. It also means strengthening continuity of care when people move between systems, particularly during incarceration, reentry and after hospitalization. Policies and programs designed to expand access to MOUD should preserve access to the full range of FDA-approved options, including long-acting injectables.

Medication should also never become a barrier to recovery itself. Housing, employment, reentry and recovery support programs should be available to people regardless of whether medication is part of their treatment.

The policy opportunity is clear: preserve patient and clinician choice, remove unnecessary barriers and close the gaps where people are most likely to fall out of care.

What Do We Need?



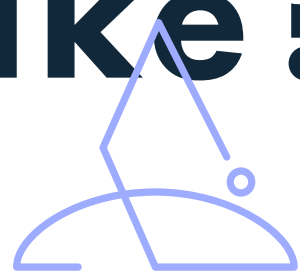
Where Public Health Meets Public Safety

Few investments do more for public safety than keeping people connected to treatment after release. It means fewer overdoses, fewer reincarcerations and safer communities. Individuals who were recently incarcerated face 40 times the risk of overdose in the first two weeks post-release. The cycle of re-arrest and re-incarceration has a vast human and financial toll. That's why a growing number of states are expanding MOUD access in correctional settings.

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What's at Stake?



National Recovery Month is a chance to recognize real progress — both for the millions of Americans taking steps forward and for the broader opioid response. Overdose deaths have fallen sharply. But fewer deaths do not automatically mean more people are in recovery.

Millions of Americans are still living with OUD, and when effective treatment is out of reach or interrupted, the consequences ripple outward: return to opioid use, emergency care, hospitalization, incarceration, disrupted families and lost opportunities to rebuild.

The next test is whether more people can move from surviving addiction to building stable lives in recovery. For policymakers, that means building a system that pays for continuity instead of crisis — and gives patients and clinicians access to the treatment options that can help them get there.



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