ASHP Statement on the Pharmacist's Role in Substance Use Disorder Prevention, Treatment, and Recovery

Position

The American Society of Health-System Pharmacists (ASHP) believes that pharmacists play vital roles in preventing and treating substance use disorders (SUD). Their responsibilities include delivering clinical care to patients, supporting those in recovery, engaging in research and education, and advocating for necessary resources to combat this public health crisis. Pharmacists are encouraged to promote workplace practices that reduce stigma around substance misuse and SUD. To effectively fulfill these responsibilities, pharmacists should continuously develop and maintain their competencies in providing comprehensive and collaborative SUD care.

Scope of Need

Unhealthy substance use and SUDs are major public health concerns in the United States. Based on SUD criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, approximately 48.5 million people aged 12 or older (17.1% of the population) had an SUD in the past year in 2023. Among those, only about one in four (23.6% or 12.8 million people) received substance use treatment. In both adolescents and adults with SUD, approximately 95% did not perceive a need for treatment.[1] Although drug-related overdose deaths are declining, over 98,000 American deaths occurred in 2024.[2] The vast majority of drug overdose deaths involve unregulated opioids and in 2022 roughly 6.1 million people had an opioid use disorder (OUD) in the prior year.[1] Costs related to the consequences of substance use the United States were nearly $1.5 trillion in 2020, up 37% from $1.07 trillion in 2017. [3-4] Unhealthy substance use and untreated SUD may increase the risk of significant comorbid chronic health conditions, death from overdose, or suicide. SUD may coexist with and complicate other mental health disorders. People who inject drugs have a higher prevalence of skin and soft tissue infections, hepatitis C, and human immunodeficiency virus.[5] Long-term excessive alcohol use can lead to heart disease, stroke, cancer, dementia, depression, anxiety, and cirrhosis. In addition to the impact on health, substance use has a profound impact on society, with reduced workplace productivity, financial hardships, environmental risks, vehicular accidents, difficulty with relationships, intimate partner violence, and high crime rates.[6] The COVID-19 pandemic led to increased alcohol consumption and misuse of other substances, particularly among people with mental health conditions, which increased the risk and number of fatal overdoses.[7-8] An increasing number of individuals are engaging in polysubstance use, exacerbating the risks. In 2019, nearly half of all drug overdose deaths involved multiple drugs.[9] In a sample of people with OUD from 2015 to 2017,

methamphetamine use tripled among people using heroin and doubled for people using opioids. Xylazine, a veterinary tranquilizer, is sometimes combined with opioids which results in a deep sedative effect and has been found in the US illicit drug supply, with increasing presence across the US from 2020 to 2021.[10] Xylazine use is linked to chronic, infected wounds on extremities that often occur away from injection sites sometimes requiring amputation.[10-11]

Access to SUD Care

Access to SUD care is inadequate and unevenly distributed. The delay between disease onset and initial treatment is estimated to be four to seven years partly due to a lack of providers and resources.[12-13] The U.S. Department of Health and Human Services estimates there will be a shortage of 23,650 primary care physicians by 2025.[14] Two thirds of primary care shortage areas are in rural communities,[15] exacerbated by 130 hospitals in rural areas closing in the last 10 years. In 2022, nearly 37% of rural counties lacked even one clinician with a DATA-waiver to prescribe buprenorphine for OUD,[16] which highlights the importance of barrier-free access to SUD care. Robust data supports medications for opioid use disorder (MOUD) as the gold standard of treatment for OUD. Elimination of the DATA-waiver in the Mainstreaming Addiction Treatment Act, as part of the Consolidated Appropriations Act of 2023, allows any provider registered with the Drug Enforcement Administration (DEA) to prescribe buprenorphine for OUD unless otherwise restricted by the clinician's state of licensure. While this increased the number of providers able to prescribe MOUD, support services, such as behavioral health and withdrawal management, are still not readily available in rural communities. The U.S. Department of Health and Human Services, through the Substance Abuse and Mental Health Services Administration (SAMHSA), released another important change in February 2024 to Part 8 of Title 42 in the Code of Federal Regulations.[17] This rule removes stigmatizing and outdated language, promotes a patient-centered approach, and reduces barriers to Opioid Treatment Program (OTP) care delivery. Important changes of less-stigmatizing terminology include replacing the terms *medication-assisted treatment (MAT)* with *MOUD* and replacing *detoxification* with *withdrawal management*. Some resulting OTP updates include allowing methadone take-home doses, allowing telephone or video telehealth (e.g., telemedicine) for MOUD treatment initiation without a prior in-person evaluation, and discouraging rigid reliance on toxicology testing results. Research demonstrates that telemedicine is as effective as office-based treatment and is associated with higher patient satisfaction and lower treatment discontinuation rates.[18-23] A stepped care model for MOUD has been described as a means of improving access to MOUD with a "no wrong door" approach to care,[24] providing care where patients prefer to be treated. Interprofessional collaborative care models have been fundamental to the success of such programs, using nurse care managers, pharmacist care managers,[25] and physician-pharmacist[26-27] collaborative models to improve access to care, reduce care fragmentation, improve patient satisfaction, and promote treatment retention.

Healthcare Workers and SUD

Healthcare workers are just as susceptible to SUD. Studies show that 10-15% of healthcare professionals will misuse substances at some point.[28-29] Healthcare practitioners with OUD may be required to enroll in a state-level program that mandates abstinence-based models of SUD treatment to maintain professional licensure. The effectiveness of such programs appears mixed and may not be suitable for all populations.[30] An unknown number of healthcare providers who could benefit from medications for SUD ultimately refuse such programs due to stigma, criminalization of substance use, and the requirement to adhere to a rigid abstinence-only approach. Instead of finishing a program, they often abandon their healthcare practice instead. When a healthcare worker needs SUD treatment, it is imperative that comprehensive, evidence-based, and stigma-free treatment and recovery services are available. [31-32]

Impact of Stigma

Stigma remains a significant driver of both SUD and overdose. People are stigmatized when they are labeled, set apart, and linked to undesirable characteristics that lead to status loss and discrimination, affecting their income, education, housing status, and well-being. Data suggests negative attitudes toward individuals with prescription-based OUD exceed those reported for other medical conditions, including mental illness.[33] Substance use is featured in media representations of impoverished populations,[32] and U.S. drug policies disproportionately target marginalized groups.[34-35] Stigma and discrimination experienced by LGBTQIA+ individuals have been associated with higher drug overdose rates.[35] Stigmatizing attitudes among health professionals are common and is a known barrier for access to MOUD.[36-40] Legislative changes like removal of the X-waiver, Maine's Stigma Reduction Legislation[41] and amendments to California's Mental Health Services Act[42] are important examples in advocacy and policy that support barrier- and stigma-free access to SUD treatment.

Impact of Social Determinants of Health

Social determinants of health (SDOH), also known as social drivers of health, include physical, sexual, or emotional traumas; sex; homelessness; economic instability; lower educational attainment; discrimination; racism; and social stigma.[43] These contribute to risk of developing SUD, SUD severity, and limit access to treatment. Historical trauma, stigma, and social exclusion from family and peer networks are associated with higher rates of overdose.[44] Adverse childhood experiences, traumas that occur in childhood, such as exposure to a parent's substance use or overdose, increase SUD risk in adulthood.[45] Communities with higher poverty rates or economic hardship face higher rates of opioid-related deaths, and overdose is more common among people who experience homelessness. Unhoused people are more likely to continue drug use after an overdose and are nine times more likely to die from an overdose.

Research shows higher overdose death rates for non-Hispanic Black Americans and more restricted access to MOUD and naloxone when compared to White Americans. Black Americans are less likely to seek out SUD treatment, partly due to higher rates of incarceration associated with SUD.[46-48] It is estimated that 85% of the prison population has an active SUD or were incarcerated for a crime involving drugs or drug use.[49] Despite evidence that SUD treatment while incarcerated reduces drug use and crime upon reentry to the community, rates of SUD treatment during incarceration are very low.[50]

Healthcare Professional Education and Training

Inadequate professional education is a key barrier to SUD care and harm reduction approaches as studies show that 45% of patients who present for medical care are affected by SUD, yet healthcare providers often fail to recognize the criteria for diagnosing it.[51] MOUD training during residency improves physicians' willingness and confidence to care for patients with OUD.[52] Incorporating SUD into pharmacy student curricula improves the attitudes of pharmacists caring for patients with SUD.[51-55] The need for strengthened training was recognized by a 2020 call for action from the National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic to improve clinician training on evidence-based care for patients with OUD.[56] In 2021, the American Council for Graduate Medical Education released recommendations and resources on preparing residents and fellows to manage pain and SUD, with considerations for both general and specialty-specific elements.[57] During the same year, a survey of U.S. pharmacy schools showed that respondent programs delivered a median of seven hours of OUD content in the required coursework and that 56.8% of faculty agreed or strongly agreed that students were adequately prepared to provide opioid interventions, with approximately 50% perceiving that screening, assessment, prescribing, referrals, and stigma were covered adequately.[58] ASHP policy supports the critical need for pharmacist education in SUD care: To encourage the inclusion of longitudinal SUD training in didactic pharmacy curricula, starting with an early initiation of education; use of evidence-based practices, including risk mitigation, harm reduction, and destigmatizing communication strategies; and increasing experiential education pertaining to SUD; and to support and foster standardized education and training on SUD, including dispelling common misconceptions to the pharmacy workforce and other healthcare professionals.[59]

Responsibilities

The role of pharmacists in SUD prevention and recovery is grounded in their contributions across a broad spectrum of practice settings, including community pharmacies, primary care, hospitals, emergency departments, mobile health units, managed care, public health, poison control, professional organizations, and academia.[60-63] Established models of pharmacist-provided SUD care demonstrate improved access, patient satisfaction and treatment retention.

[26, 64-69] With nine of ten Americans living within five miles of a pharmacy,[67] pharmacists are the most accessible healthcare professionals in the country. Pharmacies serve as access points for addiction services across the spectrum of care in health professional shortage areas and rural areas that are disproportionately affected by OUD.[70-72] Pharmacist-provided comprehensive medication management (CMM) services aim to achieve all five aspects of the quintuple aim[73] for healthcare improvement: providing high-quality care, reducing healthcare-related costs, improving the patient's care experience, improving healthcare professionals' work-life balance, and achieving health equity. Pharmacist-driven CMM services help ensure medications are used safely and effectively, while verifying patients can take the medication as intended and prescribed.[74] Emerging data also supports models of home delivery of buprenorphine from pharmacies to increase retention of care.[75] Pharmacists are equipped to lead efforts in SUD care and can assist in a variety of patient care, employee health, and community activities across any practice setting.

The scope of pharmacists' responsibilities in providing patient care will vary based on the mission and policies of their healthcare organization as well as patient population, state regulations, and local resources. The responsibilities listed below should be adapted to meet specific needs and circumstances. Because each responsibility may be applied to any given substance with the potential for misuse and harm, specific substances are not mentioned.

Prevention. Prevention of SUD includes a paradigm shift to promote multimodal and multidisciplinary approaches to screening and monitoring for unhealthy substance use. The following activities are involved in the pharmacists' roles in SUD prevention.

1. Providing early intervention to individuals who misuse substances but do not meet criteria for an SUD diagnosis. Early intervention includes screening and providing brief motivational interventions to educate individuals about the risks of unhealthy substance use and connect the patient's motivations and goals to limiting use of unhealthy substances.
2. Developing practices and policies in collaboration with other healthcare providers, communities, and local governments to prevent drug-related overdoses and deaths as part of state and federal overdose prevention action plans.
3. Increasing awareness of the risks associated with prescription opioid use and misuse, as well as educating patients who are prescribed opioids about the risks of medication sharing and encouraging appropriate disposal.
4. Providing resources and education to patients and clinicians on nonopioid pain management strategies, including addressing mental health and substance use treatment needs.

5. Participating in activities and providing education for healthcare providers, health systems, and communities to prevent unhealthy substance use among adolescents and young adults that include connecting those with an SUD to medication treatment.

Clinical care. Healthcare systems and their leadership have a responsibility to ensure that clinical pharmacy services are integrated into the SUD care provided by the interprofessional healthcare team. The opportunities listed below are for pharmacists to provide comprehensive SUD care to patients across the spectrum of treatment, harm reduction, and recovery.

1. Incorporating into practice screening for substance misuse, including alcohol (e.g., Alcohol Use Disorders Identification Test – Concise[76] [AUDIT-C]), opioids, or other illicit substances (e.g., Current Opioid Misuse Measure[77] [COMMS]), addressing results that may indicate unhealthy substance use or misuse, and providing treatment by including medications on formulary or creating a network of referrals for evaluation and treatment.
2. Adopting motivational interviewing or brief intervention to engage patients in treatment and methods of harm reduction.
3. Initiating, titrating, administering, and managing evidence-based pharmacotherapy for SUD including, timely follow-up, and monitoring for withdrawal symptoms and medication side effects.
4. Providing patient and caregiver education regarding unhealthy substance use, the dangers of medication sharing, harm reduction strategies, proper disposal of unused medications or illicit substances, and self-care (e.g., groups, resources).
5. Providing optional referrals to appropriate support groups for the needs of people whose lives are affected by their own or another person's SUD or unhealthy substance use.
6. Employing shared decision-making to promote collaborative, evidence-based, patient-centered care with realistic treatment goals.
7. Using non-stigmatizing language with patients, caregivers, and the healthcare team in verbal and written communications.[78]
8. Implementing harm reduction strategies, such as reviewing medications for high-risk combinations, providing overdose education, offering naloxone, screening for suicide risk, and providing nonprescription syringes and drug test strips as well as syringe disposal for patients who use illicit drugs.
9. Identifying lesions related to xylazine exposure, educate patients on possible causes, and advise on wound care options.
10. Referring patients for other care and social services that impact treatment, health equity, or recovery, and ensuring care coordination (e.g., therapy, housing assistance, acute care needs, mental health therapy).

11. Collaborating with interdisciplinary teams to implement evidence-based contingency management that reinforces positive behaviors such as medication adherence, point of care testing, and attendance at therapy sessions.
12. Collaborating with acute care, outpatient, and ambulatory care providers to ensure transitions of care and care coordination for patients after discharge for SUD treatment.
13. Engage patients in need of care and offer SUD treatment, overdose prevention, harm reduction, and other needed services (e.g., mental health and pain care) to patients lost to follow-up, high-risk and vulnerable populations (e.g., unhoused or justice-involved people, and those with a history of overdose or SUD), and underserved patients prone to health inequity.
14. Educating patients about the correct use, storage, handling, and disposal of prescription medications.

Recovery. Pharmacists should be involved in fostering SUD recovery by performing the following activities.

1. Ensuring patient confidentiality of participation in treatment and recovery activities, including colleagues or other health professionals by complying with HIPAA, 42 CFR Part 2, state laws, and professional ethics standards.
2. Participating in interprofessional efforts to support and care for the healthcare organization's employees and patients who are recovering from SUD.
3. Volunteering, consulting, or supporting peers through state-specific peer assistance programs, including: (a) ensuring program policies align with pharmacy practice standards, (b) interpreting clinical or professional issues to support license reactivation or reentry into practice; (c) conducting educational sessions or monitoring compliance with treatment and recovery plans (d) establishing behavioral standards and norms among all employees that discourage unhealthy substance use, and (e) offer guidance, encouragement, and accountability to pharmacists in recovery.
4. Providing ongoing pharmaceutical and supportive care for patients being treated for SUD.
5. Maintaining knowledge of professional support groups (e.g., state and national level pharmacist recovery networks) and other local, state, and national organizations' programs and resources available for preventing and treating SUD to share with patients.
6. Nurturing a stigma-free workplace culture and encouraging colleagues affected by SUD or unhealthy substance use to engage in employee assistance programs and other available recovery services to encourage treatment success, including leave policy flexibilities that allow for such participation.

Healthcare system and workforce support. Pharmacists should be involved in healthcare system and workforce support by performing the following activities.

1. Participating in or contributing to the development of unhealthy substance use prevention and medication-first assistance programs within healthcare organizations that consist of (a) a written substance use policy; (b) an employee education and awareness program; (c) a supervisor training program; (d) an employee assistance program; (e) peer support systems, such as pharmacist recovery networks; and (f) drug testing.[79]
2. Recognizing and then actively and immediately addressing any student or employee, including healthcare professionals, appearing under the influence of substances that impair their ability to safely perform their responsibilities, in alignment with the organization's policies and procedures, the principles of ethical and responsible pharmacy practice, and statutory requirements.
3. Promoting integration of pharmacy technicians to support clinical pharmacy practice in SUD through review of population health dashboards to identify patients in need of outreach; taking medication histories with an emphasis on opioid and MOUD use; administering validated substance use screening tools such as Opioid Risk Tool (ORT) or DAST; ensuring completion of urine drug screens, LFTs, and other safety labs, and referrals for other care needs; engaging patients using stigma-free communication, naloxone education, vaccine administration, and other activities within their scope of practice.[80]
4. Discouraging prescribing practices that lead to an excessive supply of controlled substances or inappropriate long-term opioid use (e.g., prescribing a larger quantity of pain medication than is clinically needed for treatment of short-term pain) as well as inappropriate involuntary tapering of opioid-based therapy.
5. Establishing a multidisciplinary controlled substance inventory system, in compliance with statutory and regulatory requirements, that discourages diversion and enhances accountability, such as purchase of controlled substances in tamper-evident containers, maintenance of a perpetual inventory, and utilization of an ongoing surveillance system.
6. Working with local, state, and federal authorities in controlling substance misuse, including participation in state prescription drug monitoring programs, encouraging participation in prescription disposal programs, complying with controlled substance reporting regulations, and cooperating in investigations that involve the misuse of controlled substances, especially diversion from a healthcare organization.
7. Promoting healthcare system participation in unhealthy substance use education and prevention programs (e.g., primary and secondary schools, colleges, churches, and civic organizations).

8. Maintaining personal professional competency in the consequences of unhealthy substance use and SUD prevention, treatment, recovery, harm reduction, and overdose prevention through formal and informal continuing education.

Education and research. Pharmacists' roles in SUD-related education and research include performing the following activities.

1. Participating in research and contributing to evidence that demonstrates important pharmacist roles and impacts on unhealthy substance use, overdose prevention, SUD treatment, and fostering recovery as part of collaborative care interprofessional practice.
2. Perform and support quality improvement initiatives to enhance clinical care/recovery/workforce support processes to be responsive to rapidly changing drug supply, new treatments, regulatory updates and notice of funding opportunities
3. Providing education on the appropriate use of psychoactive substances to healthcare providers and the public, including people recovering from SUD and their caregivers.[81]
4. Contributing to the development of college of pharmacy curricula, pharmacy technician education, residency program training experiences, and postgraduate continuing education on the topic of unhealthy substance use and SUD prevention, treatment, harm reduction, and fostering recovery.[82]
5. Providing SUD and unhealthy substance use education to the pharmacy workforce in addition to other professionals and employees of the healthcare organization.
6. Consulting with SUD counselors in SUD treatment programs about the pharmacology of unregulated substances and medications used for SUD treatment.
7. Promote low-barrier MOUD/buprenorphine access programs.
8. Surveillance systems – move and modify lab recommendations here?
9. Work alongside poison control centers and as part of surveillance research programs to identify and manage substance use and fatal and non-fatal overdoses by offering expert guidance on toxic exposures, contribute to surveillance of substance-related incidents, and promote education on prevention, harm reduction, and treatment resources

Advocacy. Participation in local, state, and national professional and community organizations are essential ways to access advocacy pathways. This includes state pharmacy associations, the AMA, NAMI, ASAM and local recovery networks to influence policies, improve treatment access, and address overdose and poisoning deaths through legislative efforts, public health campaigns, and community-based initiatives. Advocacy must include care processes that promote care delivery systems integration and removal of regulatory and legal barriers, particularly those related to public and private health insurance coverage restrictions on pharmacist scope of practice and reimbursement for providing clinical services. Advocates must

ensure sustainable care through payment policies that incentivize the provision of high-value care. To assist states when considering new legislation, the Legislative Analysis and Public Policy Association released the Model Pharmacist Collaboration for Medication for Opioid Use Disorder Act, with full support by the Office of National Drug Control Policy.[83] ASHP has created a model state law and model state protocol in support as well.[84-85] These documents outline state practice act language ready to be adopted. In July 2024, The American Society of Addiction Medicine released recommendations that calls on "states to develop programs to promote best practices in, and incentivize appropriately qualified, licensed physicians and pharmacists to engage in, patient-specific collaborative practice agreements for addiction medications, including reimbursement for pharmacists' services."[86] Notably, California[87-88], Nevada,[89] Oregon[90], and Colorado[91] have passed legislation that authorizes pharmacists to prescribe MOUD pursuant to statewide protocol. These states require health care plans and insurers to pay for or reimburse pharmacist provided services like that of a physician or other advanced practice provider. Reimbursement laws reside primarily at the state level and are required for pharmacists to be paid for their services. Enhanced access to comprehensive SUD care through direct patient care activities and defined pharmacy workforce roles will depend largely on successful advocacy for the following objectives.

1. Creation of payment models for pharmacist clinical services for patients with SUD across inpatient and outpatient settings that align with state and regulatory laws.
2. Integration of interprofessional education and clinical training for pharmacists in SUD prevention, treatment, harm reduction, and in fostering recovery as part of the required graduate curriculum and residency programs.
3. Pharmacist involvement in evaluation of changes in patient outcomes resulting from policies such as the Centers for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain–United States, 2022 and identification of necessary updates to improve patient outcomes.[92]
4. Pharmacists should be active followers and participants in their state opioid settlement or abatement funding priorities, programs, and evaluations.[93]
5. Review of prescription opioid restriction policies to identify, promote, and meaningfully support access to evidence-based pharmacotherapy for patients living with chronic pain, OUD, or both.
6. Reduction or removal of cost-sharing and administrative barriers for individuals to carry naloxone and promotion of good Samaritan laws that legally protect naloxone use.
7. Adoption of laws and policies that support barrier-free, legal access to unlimited sterile needle and syringe service programs to prevent the spread of bloodborne infectious diseases, as well as drug test strips to reduce overdoses among patients who use illicit substances.

8. Promotion of pharmacy workforce support for community-based harm reduction efforts in distributing naloxone, providing sterile syringe services and drug test strips to people who use illicit drugs, and providing connections to peer recovery specialists and overdose prevention centers.
9. Use of data monitoring and surveillance for entities receiving federal grants to execute overdose-related action plans, publicly report on the programs' progress, and partner with professional pharmacy, harm reduction, and other relevant organizations.
10. Implementation of evidence-based, comprehensive, medication-first, and harm reduction-informed approaches in all SUD specialty care, primary care, and inpatient settings for all people who seek treatment.
11. Passing, implementing, and evaluation legal, institutional, and corporate policies that ensure pharmacies stock treatments for SUD including buprenorphine.
12. Opposing the sale of alcohol and tobacco products by pharmacists and in pharmacies.

Conclusion

Substance use disorders (SUD) constitute a complex public health crisis, and medications for opioid use disorder (MOUD) are considered the gold standard for treatment. Pharmacists are uniquely positioned to support prevention, treatment, recovery, and harm reduction across all healthcare settings. With their accessibility, medication expertise, and trusted role in communities, pharmacists play a vital role in addressing gaps in care, reducing stigma, and improving patient outcomes. Telemedicine is a growing space for MOUD treatment initiation, as it has proven to increase access with high patient satisfaction, and lower discontinuation rates. Key takeaways include:

- Pharmacists must be integrated into interprofessional SUD care models.
- Ongoing education and training are essential to equip the pharmacy workforce.
- Stigma-free, patient-centered care should be standard practice.
- Advocacy for reimbursement, policy reform, and expanded scope is critical to sustain access to care.
- Pharmacist-led efforts in clinical care, public health, and research can drive meaningful change.

To address the urgent and evolving challenges of SUD, pharmacists must be empowered, supported, and recognized as essential contributors to a coordinated, evidence-based, and equitable response.

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Additional information

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