

Overdose Deaths Now Top 100,000 a Year. Why Do So Few People Addicted to Opioids Get Treatment that Could Save Them?

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2300 words

This story was [originally reported and published](#) by MindSite News, a nonprofit news outlet reporting on mental health.

The opioid crisis that helped kill [a record 108,000](#) Americans last year – and more than one million since 1999 – is by now a well-known tragedy. Less understood is that many if not most of these deaths are preventable.

Medications like buprenorphine are proven lifesavers, cutting fatalities in people with opioid use disorder [roughly in half](#). But the problem is that only a small fraction of the people in the U.S. addicted to opioids – a number variously estimated at between [3 million](#) and [7.6 million](#) – have access to these medications.

Fewer still get the optimal combination of medication plus counseling and group therapy – even though most people struggling with addiction also suffer from a mental health disorder.

A host of factors contribute to this widening treatment gap – a drastic shortage of the most effective programs and addiction providers, inadequate reimbursement levels in the federal Medicaid program and bureaucratic regulations that have limited the ability of physicians to prescribe treatments like buprenorphine, which is part of the gold-standard approach known as medication-assisted treatment, or MAT.

The Biden administration wants to reverse these trends. It has incrementally boosted funding for treatment, including MAT. But barriers abound.

Adrianna LeBlanc, 37, is one of many substance abusers who have been denied MAT to overcome their opioid addiction. When she was 20, the young mother in North Carolina started using cocaine and opioids while in an abusive relationship with her addicted boyfriend. Before long, she lost custody of her kids and became homeless.

After about six years, when she could no longer endure the misery, LeBlanc sought out treatment. She had heard that Suboxone, the brand name for a medication that combines buprenorphine and naloxone, was a miracle drug that helps people get clean. So she asked a doctor at a treatment center in Alamance County, North Carolina, to prescribe it.

“The doctor said she felt I was there to get Suboxone because it was a legal way to get high,” LeBlanc says. “And I was like, ‘What? Are you kidding me?’ I was in tears when I left. She made me feel like there was no help for me. So I went back on the streets for the next three years.”

LeBlanc’s road to recovery was unusual – she got clean while in prison for car theft and stayed clean for several years until she started using prescription pain medications after suffering spinal complications from childbirth. Once again, she sought out Suboxone, and this time, a doctor at Freedom House Recovery Center in Chapel Hill wrote a script for her in 2019.

Since then, LeBlanc has taken 24mg of Suboxone daily, and except for a brief relapse with cocaine, it has helped turn her life around. She works full time at a meat smokehouse, regained custody of her three older children and feels safe from the temptations of illegal drug use. “It doesn’t make me high or sleepy or affect how I feel,” she says. “But if anything comes my way during the day, I know that I’m safe. Suboxone has been everything to me.”

LeBlanc’s years-long struggle to get Suboxone illustrates a glaring inequity: While 70% of adult diabetics in the U.S. routinely use oral medications that keep them alive, only about 11% of opioid users receive MAT, according to a [2020 report](#) by the Substance Abuse and Mental Health Services Administration (SAMHSA).

“The treatment system is not working. Only one in ten people with substance use disorder are getting evidence-based care including MAT,” says Shawn Ryan, the chief medical officer of BrightView, one of the largest providers of addiction treatment in the Midwest. “We had the highest number of overdose deaths on record in 2021 and it probably will get worse.”

The complicated story of why so few users of heroin, fentanyl and prescription opioids undergo treatment begins with the lingering stigma in much of the U.S. that equates drug addiction with moral depravity or personal weakness. The stigma makes it easy for communities to oppose treatment centers and hard for politicians to fund them.

Treatment specialists are trying to change this moralistic narrative with medical facts. The success of MAT suggests that addiction operates much like a chronic medical condition – manageable with medications but hard to cure.

Buprenorphine and methadone are like a bridge over a scary gorge to recovery. The long-acting opioids reduce the physically intense withdrawal effects from highly potent opioids like fentanyl that frighten users and stop some of them from trying to clean up.

But opioid disorder is different from illnesses like diabetes in one important way: many who have it resist treatment, preferring to keep getting high rather than undergo painful opioid detox.

San Francisco, one of the nation's overdose hotspots, experienced the difficulties of getting users into treatment at its Tenderloin Linkage Center earlier this year. The idea was to coax people off the street and into treatment. But the center morphed into a de facto safe consumption site – in apparent violation of state law – and attracted widespread controversy. Facing criticism, Mayor London Breed shut it down.

Many are ready to get clean. But today's underfunded MAT system can't accommodate them. Medicaid reimburses addiction treatment programs at only 50% to 70% of what private insurers pay, says Ryan of BrightView. A [study released in July](#) found that Medicaid rates for substance use treatment were about a third lower than rates paid by Medicare. Other services, like nursing and counseling, are also underfunded, keeping many specialists from wanting to work in the field.

Compounding the problem are some of the most burdensome regulations in all of medicine. To provide even a limited amount of buprenorphine, physicians must have special so-called [X-waivers](#) from the Drug Enforcement Administration. And many states have their own set of treatment rules dictating when doctors can see patients, dosage limits and when they can come off meds. This is not done in the rest of American medicine, says Ryan.

If primary care physicians could more easily prescribe MAT from their general practices, it might greatly expand the number of patients served. It would also remove some of the stigma associated with going to an addiction treatment center, often located in marginalized communities.

Patients are 50% more likely to start treatment and stick with it in a primary care setting rather than an addiction treatment center, according to a [2017 study by the Commonwealth Fund](#). In California, the Center for Care Innovations has helped more than 70 primary care health centers create or expand MAT programs, increasing the number of doctors prescribing MAT by 150 and the number of patients receiving it by 2,000.

Building more treatment capacity also depends on increasing the workforce of trained addiction specialists who can prescribe MAT, and who also could supervise or consult with prescribing primary care physicians – just as psychiatrists often consult with pediatricians or family doctors who prescribe medicines for attention deficit disorder or depression.

In 2020, an estimated 3,200 certified addiction medicine specialists worked in a field that needs about 44,000, according to a [SAMHSA workforce report](#). The workforce also needs three times more nurses and five times more psychologists. Ryan's BrightView, with treatment locations in six states, has 53 pages of [job openings](#) on its website.

The American Board of Medical Specialties waited until 2015, years after overdose deaths began surging, to address the shortage of trained specialists by recognizing addiction medicine as a subspecialty. Only about [half of U.S. medical schools](#) now have addiction medicine fellowships.

With some 16,000 alcohol and drug treatment centers spread across the U.S., and only [half of those offering MAT](#), opioid users who seek help often end up on waiting lists. Americans who can pay \$20,000 for opioid treatment at private residential centers typically get admitted within a day. But everyone else and those on Medicaid have to wait an average of 14 days at most nonprofit programs, according to an [audit of residential opioid centers](#) by the Harvard T.H. Chan School of Public Health.

The Harvard audit, conducted as a “secret shopper” study of more than 600 mostly non-MAT facilities, revealed a lack of professional standards and raised concerns about the quality of care. More than 40% of the profit-seeking centers offered admission over the phone without doing a clinical evaluation to see if their services matched clients’ needs. Most also offered recruitment perks like gourmet food and free transportation and on average charged twice as much – about \$750 a day – as nonprofit programs.

“I hate to say this, because I work in this field, but we have some lousy treatment programs,” says Keith Humphreys, professor of psychiatry and behavioral sciences at Stanford and an adviser to federal health officials on substance abuse treatment. “That’s another challenge. We have weaker quality standards than in other areas of medicine.”

Clinical psychologist Emily Guarnotta says inadequate licensing requirements and staff training are behind the poor performance at some facilities. She interned during graduate school for a year at Sovereign Health, a network of treatment centers based in Southern California, before it was [raided by FBI agents](#) looking for evidence of fraud a few years ago and closed several facilities. She says Sovereign hired unlicensed clinicians while advertising that clients would be treated by licensed professionals.

“I’ve met many drug and alcohol counselors who were really effective and wonderful,” says Guarnotta, who is now in private practice in New York. “Some of them were in recovery themselves and I observed counselors coming to work under the influence and having inappropriate relationships with clients. The licensing requirements aren’t stringent enough and this creates problems.”

In the early days of drug treatment in the 1960s, the field was dominated by therapeutic communities that preached abstinence from all drugs, including medications like methadone. These self-help programs were based on the idea that a lack of discipline rather than brain chemistry caused addiction. The path to recovery required personal transformation unassisted by medications.

The harshest of these communities took steps like making adults wear diapers and placing them in a chair in the middle of a room surrounded by other clients, says Linda Sacco, the chief clinical officer at Phoenix House, a residential treatment center with locations across the country. This was considered therapy.

To this day, some therapeutic communities still refuse to work with clients who use the FDA-approved meds like buprenorphine, arguing erroneously that they are another form of addiction.

The therapeutic community approach, used at Delancey Street in San Francisco, can be effective with certain people like those who'd spent time in prison, says David Smith, the doctor who founded the Haight Ashbury Free Clinic and was a transformative figure in the treatment field. But the severe withdrawal symptoms from fentanyl, which is up to 50 times more potent than heroin, make MAT much more effective in keeping clients in treatment and preventing relapses, Smith says.

"The old-school approach works for some people, so we need a diversity of options," Smith says. "But MAT is the mainstay of treatment for opioid use disorder."

Many substance users also suffer from a mental health disorder – about 57% of substance users in treatment, according to the [2020 SAMHSA report](#). People with untreated depression or anxiety are much more likely to have a substance abuse problem than the general population. They might turn to alcohol and other substances to push away the blues and eventually become addicted. But drug use will likely worsen the psychiatric condition, making the patients even harder to treat.

For MAT centers like Phoenix and Sunrise, the mental health programs – including one-on-one, group therapy, and 12-step counseling – are just as important as the buprenorphine.

The upside is that once a patient with a dual diagnosis stops using drugs, the depressive symptoms tend to lift. "If you can get them over the hard part and into recovery, then the jittery and sad person starts to smile more and they seem emotionally lighter and happier," says Humphreys of Stanford. "It's a common experience."

In 2020, a record [711 drug users died](#) in San Francisco from an overdose, mostly from fentanyl.

Since then, the number of fatalities in San Francisco has been creeping down, thanks partly to the availability of Narcan, a medication that restores breathing after an opioid overdose. It's a sign, however small, that the opioid crisis perhaps can be contained as MAT expands under the Biden administration.

The pandemic opened the federal spending spigot in 2021, giving the administration its best shot to fund opioid treatment. It provided more than \$3 billion in additional funding to SAMHSA for block grants to states for drug treatment and prevention.

But despite the White House's request for another big infusion in the 2022 budget, the Democratic Congress only approved a token increase of about \$100 million for the agency's substance abuse treatment pipeline of about \$3.9 billion. That's far short of the hundreds of billions needed over time to build out MAT services and get a handle on the epidemic, says BrightView's Ryan.

In the meantime, he has a legislative battle to win. The House recently passed measures to end the requirement that doctors get a DEA waiver to administer buprenorphine and to add a requirement that physicians get eight hours of training before administering medications to drug abusers. The American Society of Addiction Medicine is pushing for the Senate to pass the measures this year, part of a strategy to keep chipping away at barriers to treatment, says Ryan, the society's legislative advocacy chair, who is "cautiously optimistic" they will pass.

"With Covid, the country has clearly shown that we can respond to a crisis with a massive national effort," Ryan says. "But with the opioid crisis, we have no financial incentives in place and super complicated regulations, so many physicians don't want to do treatment. If we remove these barriers, the system will build itself."

Vince Bielski is a freelance journalist based in Brooklyn who writes about the environment, clean energy, education, immigration and more. He worked for 16 years as a senior editor at Bloomberg News.