An Aimless System Against an Intricate Tragedy: Barriers to the Medication-Assisted Treatment of the Opioid Epidemic

Background

Of the combined burden caused by *all* disease in the U.S., measured in Disability-Adjusted Life-Years lost in 2019, *4.66%* was due to Opioid-Use Disorder. (WHO) Though opioids are no longer being prescribed as carelessly for pain relief, opioid addiction is still pervasive among Americans, and treating those affected is essential to preventing further suffering. The gold-standard for treating OUD is Medication-Assisted Treatment (which makes use of Buprenorphine, Methadone, or Naltrexone) - and programs which bypass it are comparatively futile. Despite this, MAT has been critically under-utilized; facing severe availability and access issues. At least 87% of Americans with OUD did not receive MAT in 2019. (Nye) The defining elements of this problem are interconnected in a way which inevitably points to deeper flaws in the U.S. medical system, and untangling them can help suggest a more precise and effective method of approaching such crises.

Outline of Issues

The following is a brief review of the factors inhibiting MAT implementation in the U.S., garnered from patient/doctor accounts, similar research, an interview conducted with Deanna L. Medley (NP/certified MAT provider of 4 years), and multiple articles on the topic.

Type of Issue	Systemic	Specific to Opioids
Availability of Care	• There is a lack of standardized procedure used by physicians for treating SUD, especially	• Lack of treatment personnel: There is a historical resistance by physicians to treat OUD patients due to perceptions of them as

	procedures which prioritize MAT. ● Treatment facilities can be sparse in rural areas despite their recent expansion, and insurance plans don't cover all of them. ● Many treatment programs are inpatient or have required abstinence-periods for entry, which are often non-negotiable barriers to access. (Medley) ● A large portion of potential patients are prisoners, with limited MAT access, and prison is often seen as a sort of "abstinence-based treatment" in itself - despite 75% of released individuals with OUD experiencing relapse in the first three months. (Berg)	difficult patients, and of treatment being ineffective. Many treatment programs report high workloads and/or capacity issues. (Molfenter Et Al. and Medley) ● "As of August 2020, 43.7% of substance use treatment facilities that treat opioid use disorder [did] not offer any medication to treat OUD" (PEW Fact Sheet) ● Many treatment facilities are wholly abstinence-based, with MAT either being excluded from presented treatment options, or actively discouraged; even disallowed. ● MAT drugs are highly regulated due to fears of diversion, so few providers are able/willing to prescribe them. Only SAMHSA-certified programs can prescribe methadone, and to prescribe Buprenorphine to over 30 patients, providers must complete training and apply for waivers. These are steps that many physicians, according to Deanna Medley, "just couldn't be bothered with." As an example of just how badly this fear affects MAT, "West Virginia, the state with the highest drug overdose death rate in the nation, has had a statewide moratorium on methadone clinics

		since 2007 over worries the medication was being diverted to street markets and killing people." (Vestal)
Social	• Addiction is widely stigmatized as a personal failing, and possession of drugs is criminalized. In our interview, Deanna Medley shared the story of a hard-working young man, beloved by family, who was absolutely terrified of his addiction being revealed to loved ones - going as far as to pay for treatment in cash to avoid suspicion. • Healthcare in general is often deemed a privilege by the U.S. medical system and political environment. • One's community and current environment are essential factors in recovery, yet are often overlooked. (Medley)	• MAT's are portrayed as just replacing one drug with another - "not *real* recovery." Mrs. Medley recalled the story of an abstinent patient whose husband would defend his rampant alcoholism by comparing it to her use of Suboxone, saying things like "I just drink, look at what *you do*". Mrs. Medley told me that "the more he said that, the less she wanted to continue treatment", and that "I probably had that same conversation (refuting stigma) 25 times with different patients." • This treatment stigma extends to healthcare professionals, perpetuating the shortage of MAT providers and deepening the damage to patient confidence in MAT.
Pragmatic Access	• 8.82% of Americans were uninsured as of 2019. (Kolmar) • Insurance coverage varies	• Pursuing treatment is made excruciatingly difficult by addiction symptoms. • Appointments must often be

	wildly due to differences in Medicaid implementation, e.g. Massachusetts being 2.71% uninsured versus Texas's gargantuan 17.18%. (Kolmar) ● Patients may have family/work commitments; FMLA is extremely limited and childcare is expensive. (Medley) ● Transportation/travel distance can be extremely limiting in a car-reliant America.	frequent; even daily for Methadone due to regulation and procedures. ● Researchers note a lack of public knowledge about MAT even being an option, perhaps owing to a lack of advertisement/government information campaigns. (Roman, Abraham, and Knudsen) ● Uninsured MAT can be >$100/week. ● Stopping use is a difficult prospect: about 40% of those 12 and older who didn't receive treatment (which they perceived a need for) cited unreadiness to cease use as the reason in 2019. (SAMHSA) ● There are disqualifying factors for MAT, such as alcoholism, benzodiazepine use, or continued opioid use/relapse.
<u>Complex</u>	● Mental health is inseparable from addiction medicine but the two are often separated in treatment, and mental health care faces its own access and availabillity issues. ● There is a massive; growing shortage of mental healthcare providers. Their amount	● "An estimated 10 percent of chronic pain patients misuse prescription opioids. Chronic pain and associated emotional distress are thought to dysregulate the brain's stress and reward circuitry, increasing the risk for opioid use disorder." (NIDA 21) ● OUD is a lifelong disease, and even MAT's can have relapse-rates above 40% by the sixth month of treatment. This varies by amount of continued provider-supervision

	is limited by the number of residency slots available for doctors, as well as candidates pursuing the profession; how much they tend to earn.	(Nunes) and behavioral therapy among other things.

Discussion & Conclusion

At face-value, it seems completely illogical that an effective treatment to such a problematic disease is so severely malimplemented. With further inspection, that same frustration may likely be felt, but it's realized that there exists a sea of moving parts which culminate into our failure to administer MAT. It's easy to just blame addiction stigma, and assert that educating about addiction as a disease would open the gates to treatment; resulting in more-available care with more-willing patients. However, as my interview with Mrs. Medley highlighted: this wouldn't change the fact that treatment is expensive and time-consuming whilst patients have lives/families, childcare is costly, labor laws barely protect medical leave, opioid use can be grounds for firing and arrest, transportation is reliant on car ownership, addiction symptoms are ever-present, and comorbid diseases like mental illness and chronic pain are treated separately.

Even with intense social changes - the current system is designed for failure - and without affordable care that patients can easily access and that treats their medical needs in tandem, it will remain that way. Therefore, a more thorough investigation should be conducted using the preceding outline to guide towards policy solutions which it would defend and plan for the enactment of. In this, there is further analysis necessary of the sociopolitical past and present in connection to these issues: especially in the cases of medical payment structure, the process of training medical personnel, and how labor practices, childcare costs, and transportation infrastructure inhibit access to medical care.

The findings of this paper - that the issues of OUD treatment are complex and interconnected - should not serve any admission of defeat in the midst of such difficulty, but

rather as proof that there are fundamental issues in our current system, ones which demand fundamental change. Any complete solution must inherently be sweeping, and the only options which can be described as “extreme” are ones which allow this atrocious illness to continue. The following solutions are similarly necessary, but are plausible in a shorter-term politically:

- A firm standard of treatment for OUD: to be established by HHS, such as proposed by H.R.8884 during the 117th Congress (though MAT should be directly mentioned in the text).
- A requirement for MAT provisions in all newly subsidized OUD treatment facilities, along with an increase in such funding.
- Amending the Affordable Care Act as to specify the kinds of SUD treatment which are required to be covered, including medication-assisted and outpatient treatments.
- A mass education campaign targeted at addiction stigma as well as treatment stigma.
- An injection of funding into healthcare training - especially mental healthcare.
- An end to drug criminalization.

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