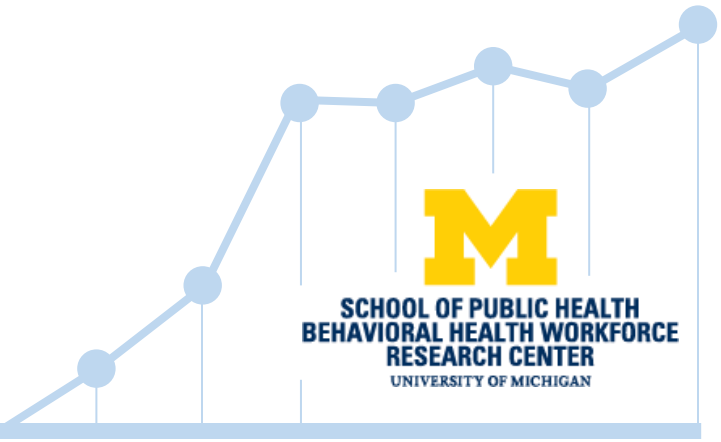
POLICY BRIEF

Factors that Influence Access to Medication-Assisted Treatment



Background

Each day, approximately 130 people in the U.S. die from opioid overdose.[1] The current opioid epidemic has contributed to a decrease in the average national life expectancy each year since 2015.[2] In 2017, an estimated 2.1 million people aged 12 years or older had an opioid use disorder (OUD).[3] Evidence-based practices to prevent, treat, and help people recover from OUD and other substance use disorders (SUDs) across a continuum of care and treatment settings exist; however, only approximately 20% of individuals with OUD receive treatment each year.[4]

The use of medications in conjunction with psychosocial and recovery support services to treat OUD, an intervention often referred to as medication-assisted treatment (MAT), is an effective option for treating individuals with SUDs, including OUD.[5,6] However, a range of barriers and challenges exist related to accessing MAT and other SUD treatment and services, including organizational culture and provider attitudes and patient insurance status. The research team at the Behavioral Health Workforce Research Center engaged in several activities to better understand factors that influence access to MAT. This brief explores the ways in which organizational culture and provider perceptions and attitudes affect access to MAT and other SUD treatment, how Medicaid and other insurance coverage impact access to MAT and other SUD treatment, and state-specific initiatives in place to address the opioid epidemic and other SUDs.

Methods

A mixed methods approach was used to investigate access to MAT and SUD in general, including:

1. A literature review and environmental scan.
2. An online survey distributed to State Opioid Treatment Authorities (SOTAs) and Single State Authorities (SSAs) within each state.
3. Key informant interviews with representatives from seven organizations offering SUD treatment services in Washington DC, Maryland, Virginia, Alabama, Nebraska, and Florida.

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Key Findings

The survey was completed by 59 unique organizations, representing 48 states and Puerto Rico. Slightly more than half of respondents identified as a SOTA (51%), with 44% identifying as an SSA. According to SOTAs and SSAs, states engage in several prevention efforts to address the opioid epidemic, including school- and community-based prevention programs (86%), coalitions (e.g., with local businesses, schools, law enforcement, hospitals, public health departments, local/state government; 83%); information sharing through social media (e.g., Twitter, Facebook) or conventional media (e.g., radio, television, or print ads; 81%), and engagement in evidence-based prevention practices (e.g., Project Towards No Drug Abuse, Strengthening Families Program; 81%).

States fund several treatment efforts including MAT (98%); intensive outpatient programs (90%); behavioral treatment, without medications (85%); employment of peer recovery support specialists in clinical settings (83%); and treatment efforts targeting special populations such as tribal populations, veterans, homeless individuals, pregnant women, and justice-involved clients (75%). The most common recovery support services funded by states include peer services (95%) and recovery housing (80%), while 56% fund medication-assisted recovery-specific recovery supports. The most common harm reduction efforts funded by states include the distribution of naloxone (Narcan) in communities impacted by the opioid crisis (97%) and community education activities or materials (80%). The SOTAs and SSAs rated several factors impacting patient engagement in MAT and other SUD treatments on a 3-point scale (3=large impact, 2=minimal impact, and 1=no impact).

Table 1. Factors Impacting Patient Engagement in Medication-Assisted Treatment and other Substance Use Disorder Treatments

Factor	**Mean Rating** (3=large impact, 2=minimal impact, 1=no impact)
Social stigma (characterized by prejudicial attitudes and discriminating behavior directed toward individuals treated for SUD as a result of the psychiatric label they have been given)	2.9
Individualized stigma (negative thoughts and feelings—such as shame, negative self-evaluative thoughts, and fear—that emerge from identification with a stigmatized group and their resulting behavioral impact—for example, avoidance of SUD treatment)	2.8
Transportation barriers/distance to services	2.7
Cultural norms (e.g., family involvement is an important focus in working with Hispanic and Native American communities; patient may not engage in treatment if a program does not have staff that included members of the same ethnic group)	2.4
Patient's inability to take time off work and/or secure adequate childcare	2.3
Patient's previous bad experiences with the treatment system	2.3
Patients do not think they need help	2.3
Too few opioid treatment programs in the state	2.3
Legislation (e.g., Ryan Haight Act)	2.2
Treatment cost (patients cannot afford treatment and/or do not have health insurance)	2.2
Wait lists for services	2.2
Patient's fear that treatment will not work	2.0
Other*	1.3

*Other factors impacting engagement include the Drug Enforcement Administration not permitting opioid treatment program satellite operations, too few rural providers, and the lack of alignment between payers and programs around issues such as preauthorization.

Interview Results

A range of systemic, social, and economic barriers to SUD treatment, including MAT, were identified by both survey respondents and key informants, including the number of treatment providers, Medicaid and other health insurance coverage, lack of stakeholder buy-in, and challenges working with clients in recovery homes and transitional housing (e.g., skepticism toward and/or prohibition of using medications for OUD in these settings). Another treatment barrier uncovered by the key informants was the behavioral workforce shortage, more generally. Sites are also facing challenges of effectively using peers owing to difficulties receiving reimbursement for their services. Key informants agreed that stigma is a major barrier to SUD treatment, including MAT, and noted various populations that are impacted by stigma. Consequently, organizations are implementing targeted outreach efforts to educate and engage these populations.

Conclusions

Barriers to the treatment of OUD and SUDs include lack of qualified treatment providers, disparities in treatment program access, regulatory barriers, financial barriers, and negative perceptions associated with treatment. Based on a review of data collected through this study and in order to improve access to SUD treatment, including MAT, the following policy and practice changes are recommended: 1) Strengthening the behavioral health workforce by identifying systems-level factors that influence behavioral health workforce capacity; 2) Broadening patient access to substance use disorder treatment by engaging in cross-agency collaborations, establishing partnerships with local hospitals, and increasing funding, training and assistance to support initiatives that engage unique populations; 3) Increasing and enhancing financing and reimbursement for treatment; and 4) Minimizing stigmatizing attitudes or behaviors that have the potential to lead to a deficiency in patient access to care.

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