Closing the OUD Treatment Gap

By Jack B. Stein, PhD, National Institute on Drug Abuse

The great irony of the opioid crisis that is now claiming over 115 lives in America every day is that effective treatments exist for opioid use disorder (OUD), which could avert many of these deaths. OUD is the only drug use disorder for which there are medications proven effective at reducing illicit use and improving other outcomes; as of this past spring, there is now also a medication called lofexidine that can help control withdrawal symptoms. Yet effective treatments are not consistently being delivered to those who need them.

The "treatment gap" is revealed by national data from SAMHSA. In 2015, 7.5 million people had an illicit drug use disorder, of whom only about 31 percent (2.3 million) received any treatment. Only 1.5 million individuals received specialty treatment at a hospital, rehab facility, or mental health center.[1] The percentage of those receiving the standard of care for OUD, medication-assisted treatment or MAT, was far smaller. According to SAMHSA's Treatment Episode Data Set (TEDS), just under a third (31%) of patients in specialty treatment facilities for non-heroin OUDs and just over a third (37%) treated for heroin use disorder in 2015 had treatment plans that included medications.[2]

Over 80 percent of patients in treatment for OUD relapse in the absence of medications, whereas around 50 percent relapse with medications.[3] However, many of those who do receive maintenance medication (buprenorphine or methadone) get it for too short a period of time or for too low a dose to be effective. Nearly half of opioid-addicted patients treated in opioid treatment programs who initiate buprenorphine treatment receive 90 days or less of continuous treatment with that medication,[4] showing that many providers do not know how to administer it or are not following treatment guidelines. The already clear benefits of MAT over behavioral treatment alone (or worse, no treatment) might be even clearer if treatment protocols were more universally followed.

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The inadequacy of current OUD care is revealed in a recent retrospective cohort study of 17,568 people in Massachusetts who had survived an opioid overdose. Even though these individuals had already intersected with healthcare to reverse the worst potential consequence of their OUD and were clearly at high risk for a further overdose, only 30 percent received MAT in the 12 months after their overdose.[5] As would be expected from the already voluminous evidence base, there were significantly fewer overdoses among those who did receive methadone or buprenorphine than among those who did not. (Too few received naltrexone to draw strong conclusions about that drug's effectiveness.)

What can be done to deliver MAT to those who need it, and do so effectively? Research has supported several models of expanding adoption of MAT. Emergency Department (ED) Initiation of Office Based Opioid Treatment (OBOT) identifies patients with OUD after a non-fatal overdose, initiates them on buprenorphine, and connects them with a DATA-waivered provider who can continue their treatment after discharge. In a 2015 study, 78 percent of patients were engaged in buprenorphine treatment 30 days following discharge, compared with 37 percent of those referred to treatment but not initiated on buprenorphine in the ED.[6]

Increasing access to MAT in justice settings is also very important, since a high percentage of justice-involved individuals have OUD. Incorporating methadone or buprenorphine into criminal justice treatment programs has been shown to reduce post-release opioid use, hasten and increase duration of treatment engagement after release, and reduce both all-cause and overdose mortality rates after release.[7 8 9] Giving extended-release naltrexone to offenders upon release was also shown to reduce relapse to opioid use.[10]

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Researchers are actively seeking ways to improve compliance with MAT. The need for patients on maintenance medications to frequently visit their provider is one obstacle to retaining patients in treatment. New long-acting formulations of buprenorphine are being developed (including a 1-month depot formulation already approved last November), which will make this treatment more feasible for those who do not live near a DATA-waivered provider. Those in rural areas are particularly at a disadvantage, but a 2017 study showed that telemedicine was more successful at retaining patients in therapy than in-person group treatment, making this a particularly appealing method for potentially widening access to effective OUD treatment.[11]

Several policy-level changes such as increasing the number of DATA-waivered providers of buprenorphine and further increasing MAT capacity in primary care settings such as federally qualified health centers would help increase the number of patients treated effectively with

MAT. A collaborative care model that reimbursed nurse care managers to support buprenorphine-prescribing physicians in a Massachusetts practice achieved high success rates in a five-year study—51 percent treatment retention over 12 months and 93 percent of those patients remaining opioid- and cocaine-free.[12]

Last year, a Health Affairs blog by Arthur Robin Williams, Edward Nunes, and Mark Olfson recommended adopting lessons learned from HIV in confronting the opioid crisis.[13] They argue for applying a "cascade of care" model that identifies sequential stages of engagement in evidence-based treatment and targets interventions to increase retention at each stage, following established benchmarks to track performance of the interventions. The stages they identified in the cascade of care as it would be applied to the opioid crisis are:

- Diagnosis
- Linkage to care
- Initiation of MAT
- Retention on MAT for 6 months or more
- Continuous abstinence among patients retained in treatment

Such a model orients the treatment system to tracking outcomes at each of these stages. It would mean tracking patients who enter addiction treatment, tracking those who begin MAT, and tracking not only treatment but MAT retention. Although serious barriers exist at each of these stages and need to be addressed, the authors point out that those barriers were overcome in the case of HIV, leading to a halving of deaths from AIDS within two years of antiretrovirals becoming available.

Over the next several years, as part of the NIH Helping to End Addiction Long-term (HEAL) initiative, NIDA will be applying a comprehensive care delivery model in up to three hard-hit communities as a pilot project.[14] The HEALing Communities Study will find the best ways of delivering coordinated, evidence-based interventions across each stage of addiction diagnosis and treatment as well as prevention and recovery supports. Other communities will then be able to take what is learned from this study and apply that knowledge in their own locales.

Even as federal agencies and healthcare systems mobilize to remove the infrastructure-related impediments to delivering effective OUD treatment (e.g., lack of health insurance coverage for treatment, low reimbursement rates, patient limits for waivered providers, etc.), addiction treatment professionals on the ground can do much to close the treatment gap. Counselors can play an important role in supporting adherence to MAT regimens and in relapse prevention by addressing the multiple psychosocial issues often faced by individuals with OUD that may get in the way of keeping with their treatment plan.

Counselors and other treatment professionals can also work to counter the stigma that still exists against people with addiction and against medications used to treat it. Promoting non-stigmatizing language that recognizes addiction as a medical disorder rather than a moral failure remains important for changing the public mindset around substance use disorders. So is correcting the misconceptions that linger around MAT—such as the lingering misconception that medications replace one addiction with another or that people using medications to remain abstinent from illicit opioids are not "drug free."[15] As the Surgeon General's Report made clear in 2016, addressing addiction in America requires changing how we as a society talk about, and think about, drugs and drug use.[16]

The means to bring the opioid crisis under control and greatly reduce the numbers of people suffering and dying from their disorder already exist. Delivering them where they are needed requires organization and determination, as well as a willingness to overcome outmoded attitudes that continue to marginalize those suffering from addiction, as well as MAT approaches that are proven to work. Drug addiction counselors can help lead the way toward greater acceptance of these treatment modalities as well as support patients in adhering to their medication treatment.

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