Recommendations for the Reduction of Barriers to Treatment for Opioid Use Disorder

Approved by: Dr. Michael Klemp-North
Date: 8/12/2019
Recommendations for the Reduction of Barriers to Treatment for Opioid Use Disorder

A Seminar Paper
Presented to the Graduate Facility
University of Wisconsin-Platteville

In Partial Fulfillment of the Requirements for the Degree
Masters of Science in Criminal Justice

Ashley M. Cooper
August 2019
Acknowledgements

Working towards my masters has not been without challenge. I give much credit to my parents Kris and Mike, my aunt Kaylen, my sister Alex, and my fiancé Jordan for supporting me throughout this journey. Thank you for helping me realize my potential and encouraging me to pursue my passion for criminal justice.
Abstract

Recommendations for the Reduction of Barriers to Treatment for Opioid Use Disorder

Ashley M. Cooper
Under Supervision of Dr. Michael Klemp-North

Statement of the Problem

Opioid use in the United States has been increasing for years and has recently been recognized as a nationwide crisis. A substantial number of Americans are overdosing and dying each day. However, options for treating this disorder remain low and unutilized due to barriers related to physical capital and availability of treatment.

Methods of Approach

Information gathered for this paper was from secondary sources. These sources include journal articles which identify barriers based on reports from clinicians and drug abusers themselves. Further information was obtained from the Substance Abuse and Mental Health Services Administration and the National Institute on Drug Abuse, to better understand Opioid Use Disorder.

Anticipated Outcomes

Understanding barriers to treatment for Opioid Use Disorder will lead to an increase in services which allow more people in need to enter treatment and achieve recovery. Case management and increases in clinical staff will allow for individuals receive the support they need.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROVAL PAGE</td>
<td>I</td>
</tr>
<tr>
<td>TITLE PAGE</td>
<td>II</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>III</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>IV</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>V</td>
</tr>
<tr>
<td><strong>SECTIONS:</strong></td>
<td></td>
</tr>
<tr>
<td>I.  INTRODUCTION: CALL FOR A REDUCTION OF BARRIERS TO TREATMENT</td>
<td></td>
</tr>
<tr>
<td>FOR OPIOID USE DISORDER</td>
<td>1</td>
</tr>
<tr>
<td>II. LITERATURE REVIEW: ASSESSING TREATMENT TYPES AND</td>
<td></td>
</tr>
<tr>
<td>IDENTIFYING BARRIERS TO THOSE TREATMENTS</td>
<td>4</td>
</tr>
<tr>
<td>A. Opioid Use Disorder (OUD)</td>
<td></td>
</tr>
<tr>
<td>B. Available Treatment Options for OUD</td>
<td></td>
</tr>
<tr>
<td>C. Clinician Identified Barriers to Treatment</td>
<td></td>
</tr>
<tr>
<td>D. Barriers Identified Directly by Opioid Addicts</td>
<td></td>
</tr>
<tr>
<td>III. THEORETICAL FRAMEWORK</td>
<td>16</td>
</tr>
<tr>
<td>A. Social Bond Theory</td>
<td></td>
</tr>
<tr>
<td>IV. RECOMMENDATIONS</td>
<td>19</td>
</tr>
<tr>
<td>V. SUMMARY AND CONCLUSIONS</td>
<td>23</td>
</tr>
<tr>
<td>VI. REFERENCES</td>
<td>27</td>
</tr>
</tbody>
</table>
I. INTRODUCTION: CALL FOR A REDUCTION OF BARRIERS TO TREATMENT FOR OPIOID USE DISORDER

Opioids are “potent medications science has developed that have great potential for relieving suffering, as well as great potential for abuse” (Executive Office of the President of the United States, 2011, p.1). It is no secret that America has been facing an opioid crisis; legislatures are even calling it an epidemic. However, opioid addiction isn’t a new phenomenon. American history has known addiction well. Millions of opiates were issued to our sick and wounded soldiers during the Civil War, oftentimes resulting in addiction. “Even if a disabled soldier survived the war without becoming addicted, there was a good chance he would later meet up with a hypodermic-wielding physician” (Trickey, 2018, para. 5). This trend continued into World War I and World War II, in which morphine was liberally used as a “wonder drug”. Doctors used it to relieve female menstrual cramps, headaches, and delirium, and on the battlefield, morphine was used to relieve the pain of men with traumatic injuries. David T. Courtwright, author of Dark Paradise: A History of Opiate Addiction in America, writes, “it’s almost as if someone had handed them a magic wand…though it could cure little, it could relieve anything” (Trickey, 2018, para. 5). This frequent use of morphine sent even more men and women home with an addiction.

Now, almost 100 years later, America faces an epidemic of opiate addiction, expanding beyond prescription opiates and battlefield morphine. Drugs such as heroin and fentanyl are claiming the lives of many Americans on a daily basis. While heroin is chemically similar to morphine, fentanyl is 100 times more potent and deadly than morphine and is becoming increasing available on the streets. Recent overdose deaths have been caused by users “unwittingly purchasing and using fentanyl when believing he or she is purchasing heroin or prescription pills” (Opioid Addiction and Prevention, n.d., para. 5).
Millions of people throughout the United States abuse prescription drugs and illicit street drugs. What makes opioids unique from other drugs, is their ability to alter the brain. When an opioid is introduced to the body, they attach to receptors in the brain, which are responsible for diminishing pain and creating feelings of pleasure. With continued introduction of these drugs to the nerve receptors in the brain, the brain becomes used to them, building up tolerance and leading to compulsive urges to use. With increased tolerance, people are led to use progressively more, likely leading to overdose. Overdoses in the United States have been steadily growing with the introduction of easily accessed opioids. One can overdose on prescription opiates like morphine and oxycodone or on illicit street drugs, such as heroin and fentanyl.

While the number of those suffering from opioid addiction in America is astonishing, and perhaps the most well-known adverse effect of opioid use, there are other associated risks as well. Increases in neonatal abstinence syndrome and the spread of infectious diseases, such as HIV and Hepatitis-C are associated with opioid use. This is a public health matter and should be addressed by federal, state, and local governments in order to reduce further unnecessary deaths. According to Gomes, Mamdani, Peterson, and Jurri link, recent increases in opioid deaths have “highlighted a need for targeted programs and policies that focus on improved addiction care and harm reduction measured in high-risk populations” (2019, p. 1).

Government officials are calling for reforms to decrease the ease of access to prescription opiates, but this is not enough. Due to the number of individuals actively using illicit and prescription opioids, access to treatment is necessary. It is important to understand that opioid addicts experience a host of barriers that keep them from finding or even seeking treatment. As more state and local governments look into options for treatment of Opioid Use Disorder, determining the barriers to treatment experienced by users is crucial. The overall objective of this
research is to determine the barriers to treatment for those suffering from Opioid Use Disorder and recommend changes that can be made to eliminate those barriers.
II. LITERATURE REVIEW: OPIOID USE DISORDER, AVAILABLE TREATMENT OPTIONS FOR OPIOID USE DISORDER, CLINICIAN IDENTIFIED BARRIERS TO TREATMENT, BARRIERS IDENTIFIED BY OPIOID ADDICTS

A. Opioid Use Disorder

Opioids are a class of drugs derived from, or chemically similar to, opium. The current opioid epidemic has been growing to its peak since the 1990’s. For years, opiates were used to treat issues ranging from diarrhea and toothaches to more chronic, serious pain. In the 1990’s, however, doctors began to increase the rate at which these drugs were prescribed due to the assurance by various pharmaceutical companies, that prescription opiates were not addictive. As a result, these prescriptions began to be diverted to the streets and misused by millions of Americans.

The once thought, long-term treatment benefits of opiates, are now limited by the knowledge that these drugs can lead to “analgesic tolerance, worsening of pain, and the development of an Opioid Use Disorder in those in whom the opiates were initially prescribed for chronic pain” (Robinson, 2016, p. 8). Some are under the impression that if physicians prescribe the medications, they must not be harmful. However, consider this - prescription opiates and illicit drugs, like heroin and fentanyl, overlap in significant ways. They bind to receptors in the brain that control perceptions of pain and rewards. Notably, “prescription opioid use is a risk factor for heroin use” and “heroin use is driven by its lower costs and higher availability” (Prescription opioids and heroin, 2018, p. 4). Now, in addition to the 2 million Americans addicted to prescription opiates, there are those becoming addicted to opioids of all kinds at similarly growing rates. They have become a danger not only to our health, but to our social and economic well-being as well.
For the first time, Americans are using opioids at astonishing rates. On the average day in America, “575 people will try heroin for the first time” (Opioid addiction and prevention, n.d., para. 9). According to the DSM-V, Opioid Use Disorder can be determined by the following experienced characteristics:

- “Taking larger amounts or taking drugs over a longer period than intended.
- “Persistent desire or unsuccessful efforts to cut down or control opioid use.
- “Spending a great deal of time obtaining or using the opioid or recovering from its effects.
- “Craving, or a strong desire or urge to use opioids.
- “Problems fulfilling obligations at work, school or home.
- “Continued opioid use despite having recurring social or interpersonal problems.
- “Giving up or reducing activities because of opioid use.
- “Using opioids in physically hazardous situations.
- “Continued opioid use despite ongoing physical or psychological problem likely to have been caused or worsened by opioids.
- “Tolerance (i.e., need for increased amounts or diminished effect with continued use of the same amount).
- “Experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms.

“Opioid Use Disorder is a chronic lifelong disorder, with serious potential consequences including disability, relapses, and death” (Saxon, 2018, para. 9).

The serious consequences of using lead others to question why one would use opioids in the first place. It is important to note, “nearly all addicted individuals believe at the
onset that they can stop using drugs on their own, and most try to stop without treatment. Although some people are successful, many attempts result in failure to achieve long-term abstinence” (National Institute on Drug Abuse, 2018, p. 9). Opioids make long-term abstinence difficult for a number of reasons; the primary being withdrawal.

Withdrawal occurs when a person cuts off the supply of opioids to the brain. The results can be debilitating, oftentimes leading dependents to returned use. Depending on the amount of drug a person would use on a daily basis, symptoms of withdrawal can range from minor symptoms, such as runny nose, sweating, and yawning, to more severe symptoms, such as anxiety, irritability, rapid heartbeat, vomiting and paranoia. While some people are able to get past this initial stage of recovery, opioids have already made lasting impacts on the brain.

“Research has shown that long-term drug abuse results in changes to the brain that persist long after a person stops using drugs. These drug-induced changes in brain function can have many behavioral consequences, including an inability to exert control over the impulse to use drugs despite adverse consequences – the defining characteristic of addiction” (National Institute on Drug Abuse, 2018, p. 9).

It is necessary to understand the treatment options currently available to those with Opioid Use Disorder before discussing the barriers people face in linkage to treatment. The opioid epidemic is not a crisis we face only in America; opioid abuse is a pervasive issue affecting people worldwide. Due to its prevalence, treatment availability is increasing. Treatment options for people with Opioid Use Disorder include two key components: counseling and medications.
B. Available Treatment Options for Opioid Use Disorder

Counseling aims to change attitudes towards use and integrate life skills that will help an addict make healthier, smarter decisions. Counseling comes in many forms and truly depends on the person and what level of care they may need. Cognitive Behavioral Therapy (CBT) is one well-known counseling method often used in addiction treatment. CBT allows addicts to identify and stop negative patterns of behavior. Other therapies focus on motivation and positive behavioral incentives. Individual counseling options allow for an individual to set goals and openly express what they are experiencing. Group counseling is another aspect of treatment that may be necessary and is very powerful in that it allows addicts to feel connected and understood. Many times, it is seen as a place to express without judgement and receive feedback from other addicts who have been in similar situations. In more severe cases, more intensive care is required, and residential or in-patient treatment may be necessary. For many people who lack housing and support, this option is truly a blessing. It allows for a person to stay connected and have live-in supports, as well as learn important life skills. While these types of therapies have proven to be successful for some individuals, it is not enough for others. In these cases, medication may also be necessary.

A lesser-known form of treatment is Medication Assisted Treatment (MAT). “Medication Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery” (Medication and counseling treatment, n.d., para. 1). Among the options for MAT are methadone, buprenorphine, and naltrexone.
Methadone is an opioid analgesic prescribed by physicians at Opioid Treatment Programs. Methadone is unique in that, patients who are prescribed this medication, must take it under supervision at an opioid treatment program. Patients attend the programs daily to receive their medication.

“There is increasing evidence that long-term methadone use in patients who are dependent on opiates has substantial societal benefits, including diminishing illicit opiate use, reducing the transmission of HIV and hepatitis, and decreasing criminal activity and healthcare costs in this population. A number of obstacles to methadone treatment exist. These include restrictive governmental regulations, the stigma of opiate addiction, and the lack of healthcare practitioners and clinics sanctioned by Food and Drug Administration that are capable of providing therapy to all patients who may benefit” (Anderson, 2000, para. 19).

Buprenorphine is another medication used to treat Opioid Use Disorders. Buprenorphine is an opioid partial agonist. Unlike methadone, buprenorphine provides the euphoric feelings of opioids with a “ceiling.” “Professional treatment with buprenorphine can be difficult for patients to get. Prescribers need a special waiver to prescribe the medication, and federal rules limit the number of people they can treat, a cap that is specific to buprenorphine” (Harper, 2018, para. 21). Treatment with this medication is phased and monitored carefully from induction to maintenance. Once the patient has stabilized and is no longer abusing opioids or feeling withdrawal and cravings, they can begin the maintenance phase. Maintenance allows for patients to engage in counseling while preventing relapse. “The length of time of the maintenance phase is tailored to each patient and could be indefinite. Once an individual is
stabilized, an alternative approach would be to go into a medically supervised withdrawal, which makes the transition from a physically dependent state smoother” (*Buprenorphine*, n.d. para. 20).

Both methadone and buprenorphine are controlled, potentially addiction-producing substances. An alternative MAT option is Naltrexone. Naltrexone is an opioid antagonist, meaning, it blocks opioid receptors in the brain from being able to absorb opioids. One important note about Naltrexone, which makes it harder to begin, is “to reduce the risk of precipitated withdrawal, patients are warned to abstain from illegal opioids and opioid medication for a minimum of 7-10 days before starting naltrexone” (*Naltrexone*, n.d., para. 2). This medication blocks the effects of opioids which make them addictive (e.g. the feelings of sedation and euphoria) while also, reportedly, reducing cravings. If relapse occurs on this medication, it will prevent a person from getting high, and the body will simply excrete the opioids. It is important to note, “patients who have been treated with extended-release injectable naltrexone may have reduced tolerance to opioids and may be unaware of their potential sensitivity to the same, or lower, doses of opioids that they used to take” increasing the likelihood of overdose if a relapse occurs (*Naltrexone*, n.d., para 7).

As discussed above, MAT options are available in various forms, each carrying their own inherent challenges. The central thing to note within all of these options is the importance of comprehensive programs that provide clients with the psychological support needed to achieve recovery and maintain sobriety. Sadly, people living with addictions to opioids are not receiving the support and treatment that they need.
C. Clinician Identified Barriers to Treatment

Bunting, Oser, Staton, Eddens, and Knudsen (2018), authors of Clinician identified barriers to treatment for individuals in Appalachia with Opioid Use Disorder following release from prison: a social ecological approach, saw an increase in the prevalence of Opioid Use Disorder within the last 10 years. During this time, there has been “increasing rates of overdose mortalities, emergency room visits, and HIV/HCV prevalence” and involvement in the criminal justice system, resulting in the spending of one trillion dollars to provide health, social and criminal justice services to individuals (Bunting et. al. 2018, p. 2). They interviewed clinicians to determine what barriers exist for persons seeking treatment for Opioid Use Disorder, specifically following their release from prison. They found that individuals struggling with Opioid Use Disorder experience barriers to treatment on both social and ecological levels. While this study focused on clinicians who work with addicts near or upon their release from prison, it is important to identify that these same barriers apply to individuals in the general public who are also suffering from an Opioid Use Disorder. On an individual level, working with individuals who present an Opioid Use Disorder was described as pointedly challenging due to the high risks associated with this class of drugs. Clinicians are finding that more and more young people are presenting with Opioid Use Disorders and these clients are at significantly higher risks of overdosing and relapsing. While this is common knowledge among this population, there are also issues concerning stigma and lack of motivation among clients. Clinicians identified many of their clients as being dishonest, lacking motivation, and using other common barriers as excuses for not participating in their treatment. Bunting and her colleagues do, however, note that these traits can “stem from embarrassment and stigma” (2018, p. 3). Clients are shocked to
find themselves in these situations, addicted, when they were initially prescribed an opiate for legitimate health reasons, and struggle to be honest with themselves and others about this.

These clinicians also identified interpersonal issues to be barriers, suggesting drug use is normative among their client’s friends and family members, making it difficult to quit. One clinician stated, “they don’t have sober friends or a sober support system and a lot of it is generational use. Even their family is not a good support system because it is so embedded” (Bunting et.al. 2018, p. 4). This makes it difficult to prioritize and access an environment which would allow an individual, no matter how dedicated, to achieve sobriety.

The communities themselves also hold barriers for individuals attempting to access treatment. With ease of access to drugs like heroin, it is difficult to engage clients who continue to use. Not only are there issues with getting clients to follow through with treatment, but there are also significant problems with availability of treatment. Many times, individuals who do want help, are subject to limited resources; “lack of physicians providing treatment, limited amount of specialty inpatient and outpatient treatment programs, long waiting lists, and the limited availability of self-help group meetings” (Bunting et. al 2018, p. 5). This could be due to a number of issues, including: location of clients within rural areas, lack of acknowledging Opioid Use Disorder as a chronic relapsing condition requiring professional help, or simply that community members do not want addicts served in their communities.

The last set of barriers faced by individuals with Opioid Use Disorder are systematic in nature. Two common obstacles are transportation and the costs associated with treatment. Lack of transportation was identified by nearly all clinicians who participated in this study. Many clients have to travel to find a treatment facility, and oftentimes, being recently released from prison, these individuals lack a driver’s license, vehicle, or the funds to pay for transportation.
This leads them to rely on friends and family, provided that they do have supportive networks to begin with. However, with frequency of treatment needs, this can be a source of stress among clients and their families. Many individuals with Opioid Use Disorders also struggle with the costs of their treatments, specifically Medication Assisted Treatments. These medications can cost $300 to $1,000 a month, depending on insurance. Unfortunately, not all providers or clients are familiar with options concerning MAT, whether it be generic brands of suboxone or payment assistance programs, which can help reduce cost significantly.

Bunting, Oser, Staton, Eddens, and Knudsen, did note, individuals with Opioid Use Disorder, both recently released from prison and within the general public, face significant barriers to treatment. These barriers occur at the individual, interpersonal, institutional, community, and systematic levels. Though the information portrayed in this study was not given through interviews with individuals suffering from Opioid Use Disorder, it was gathered through interviews with the clinicians who work most closely with these individuals. Their one-on-one sessions give them the knowledge to report on the subject of treatment barriers.

Pullen and Oser, authors of *Barriers to Substance Abuse Treatment in Rural and Urban Communities: A Counselor Perspective*, chose to conduct focus groups with clinicians. The four focus groups looked at rural and urban barriers separately but found many similarities among the two. Four main themes diverged from this study’s findings. The first theme related to inadequate funding. Reports by clinicians suggested that they were not provided the financial means to obtain educational or material resources for themselves or their clients, which could be detrimental to an individual’s success in treatment. One counselor delved further into the issue of funding, as regards to retention of clinicians, stating:
“There are a limited number of skilled trained professionals who are out there who are providing these services and we have this bumper crop of new folks who are coming in all the time and learning and leaving and that kind of thing, so I think from a resource perspective that is another resource that we can’t take advantage of because we can’t pay them enough to stay. So, you can pay people enough to retain them in this field and work with the clients that we work with and that’s a barrier, to me” (Pullen and Oser, 2014, p. 6).

With current caseloads, staffing issues, and financial barriers, counselors do not feel they can provide the adequate or proper care to clients.

Another theme that re-emerged in this study, was transportation challenges. Individuals struggling with an Opioid Use Disorder have often encountered criminal or financial difficulties that have deprived them of their driver’s license privileges or access to a vehicle. This creates real problems for clients attempting to get to narcotics anonymous meetings or other treatment. While some clients do have supportive family or friends willing to offer help, this is not a long-term solution, especially given the length of an individual’s recovery. Transportation is a key barrier to treatment utilization.

Barriers related to a lack of interagency cooperation were also identified by the focus group. Effective treatment is a whole-client approach. Substance users, specifically opioid users, require a variety of services, such as detox and mental health services. They require a continuum of care, “a tailored, tiered approach in which a client is seamlessly moved through the treatment levels based in their progress” (Pullen and Oser, 2014, p. 10). The networks between agencies need to be further developed in order to keep clients from falling through the cracks. This study builds on the barriers discussed by Bunting et. Al. The counselors who participated in these
focus groups cited lack of funding and counselors, transportation, and inability to provide a whole-client approach as barriers to treatment.

D. Barriers identified by opioid addicts

Rapp, Xu, Carr, Lane, Wang, and Carlson (2006), authors of Treatment barriers identified by substance abusers assessed at a centralized intake unit, recognized that “substance abusers themselves are the most direct source of information about the barriers that impede linkage with treatment, although their views have not always been considered” (Rapp et. al. 2006, p. 2). Rapp and his colleagues identify that substance abuse treatment is generally correlated with positive results. However, there are difficulties getting individuals to enter treatment in the first place. The view that substance abusers hold the most accurate views of their personal barriers to treatment is a valid ideal. The emerging themes of this study were enabling and inhibiting barriers, as well as systematic barriers; seven barriers were discussed in total. The first barrier reported by participants was the belief that there was an absence of a problem. This appeared in the form of an individual not thinking they have a problem, needing to be told they have a problem, not thinking the issue required treatment, or believing that treatment would not make their lives better. The second theme to emerge was negative social supports, meaning that individuals often have social networks that also participate in using behaviors, and it is difficult for them to defy their friends or family. On the other end, some family members are embarrassed by seeking treatment for a drug use disorder in their community. The third barrier discussed by Rapp et. al. is a fear of treatment. Within this set, embarrassment is also an issue. Individuals are afraid they will encounter someone they know, exposing personal information about themselves. This point leads to the fourth barrier – privacy concerns. Many treatment regimens involve outpatient groups. It can be difficult to share personal stories and struggles with strangers;
treatment puts individuals in a very vulnerable position. The fifth barrier is time conflicts. For those who have access to treatment, finding time can be a real challenge. It is difficult, and virtually impossible, for individuals with reliable jobs to miss work in order to attend treatment. The sixth and seventh barriers are poor treatment availability and admission difficulties. Individuals who are able to find their needed treatment are met with long waitlists and difficult entry requirements. Rapp, Xu, Carr, Lane, Wang, and Carlson found that the biggest barrier to treatment overall, among heroin users specifically, was social networks.

Mowbray, Perron, Bohnert, Krentzman, and Vaughn (2010) conducted the study: Service Use and Barriers to Care among Heroin Users: Results from a National Survey, which examined barriers among heroin users through a national study. This study recognizes the serious consequences of heroin use as it relates to the individual user and the community as a whole, identifying that effective treatments for Heroin Use Disorder do exist. However, utilization of those services is not widely used. One issue that was identified is that people struggling with drug disorders, and are injecting, “experience a large gap between the services they receive and the services they need” (Mowbray et. al. 2010, p. 306). “Of the sample of heroin users, 44% reported at least one barrier to receiving treatment” (Mowbray et. al, 2010, p. 308). The majority of respondents reported the following barriers: not wanting to go to treatment, feeling they can handle it on their own, and thinking the issue would get better on its own. Almost half of heroin users reported that they were not in treatment simply because they wanted to keep using. One model used by Mowbray and his colleagues showed that an individual with heroin dependence is more than 10 times more likely to encounter a barrier to treatment than those who use other substances (2010). It is important to note that this study did find that more individuals with an opioid use in their lifetime, reported treatment than not.
III. THEORETICAL FRAMEWORK: SOCIAL BOND THEORY

A. Social Bond Theory

Social connections are what drive people to live happy and healthy lives. However, as humans, we are naturally attached to pleasurable and selfish activities. Many of these activities can be considered anti-social or deviant. The main question, then, is what keeps people from participating in activities that defy community norms? Travis Hirschi proposes that there are four key elements that deter people from deviant behaviors: attachment, commitment, involvement and belief.

Attachment is the relationships an individual has with others. Generally, a person’s first form of attachment is with their parents. Parents teach their child how to bond appropriately and this will determine the depth and quality of future relationships with teachers, peers and significant others. Strongly bonded individuals consider what their parents or peers will think of their behaviors. Commitment is the conformity to conventional activities such as school, church, or work. Involvement is similar to commitment, but more specifically, it is the active participation in school, church or work. Commitment and involvement allow individuals to aspire towards something while also taking time, energy, and effort to complete. The last element Hirschi acknowledges is belief. Belief in what people and institutions are teaching plays a vital role in preventing delinquent behaviors. Belief determines a person’s overall behaviors and actions, such as respect for and following of laws. When attachments, commitment, involvement, and beliefs are weakened or severed, a person is free to (but may not always choose to) turn to the use of drugs.

There are several risk factors related to drug use that correlate directly with a lack of social bond. People who lack a bond with their parents, whether they were loosely monitored,
rejected, lacked discipline, or experienced familial conflict, are at a greater risk of drug use. Since this is the first point of social bonding, it affects all other forms – commitment, involvement, and belief. Education can be another significant risk factor for individuals. If a school-aged person performs poorly, does not attend school regularly, or lacks formal support, they will not experience the commitment to, or the involvement in, activities that are considered conventional to society.

Unfortunately, people turn to drugs for a number of reasons, not realizing or caring about the consequences they may hold. Many people turn to drugs to provide the answers to their problems, believing that drugs will help manage emotions, alleviate trauma, or create a general feeling of well-being. However, drugs, specifically opioids, create lives that are organized around the pursuit of drugs and keep individuals from seeking any kind of conventional bond to friends, family, work, jobs, or the community.

Research has shown that drug addiction impacts social connections and the brain. Jill Suttie, Psy.D., of the University of California, wrote an article in Berkley’s magazine, *Greater Good*, focusing on recent research which connects the importance of social connections on the brain and opioid use. She suggests that social bonds are strengthened by the release of endorphins in the brain that allow an individual to trust and feel connection. These same endorphins are released when opioids are introduced to the brain. Suttie writes, “Lots of research shows that people really need their social networks when they’re dealing with major stressors – addiction being a major stressor. So, if the drug prescribed to help someone overcome addiction is also reducing how connected they feel toward others or reducing the time they spend with other folks, that’s not a great outcome” (Suttie, 2017, para. 13). This research recognizes the connection between a person’s ability to bond and their opioid use. An individual who feels a
sense of connection and trust on opioids is less likely to quit due to the fact that their original struggle with social dysfunction is painfully present once opioids have left their system. People who feel lonely or socially isolated, due to lack of attachment, commitment, involvement, and belief, feel they can turn to drugs to fill that void.

Social bonds are a barrier to treatment. “The process of recovery is supported through relationships and social networks” (Recovery and recovery support, n.d., para. 4). According to the Substance Abuse and Mental Health Services Administration, recovery must consist of health, home, purpose, and community. Health allows an individual with an Opioid Use Disorder to overcome their addiction and make better choices. Home entails “having a stable and safe place to live” (Recovery and recovery support, n.d., para. 3). An individual must also have meaning and participation in society while also having “relationships and social networks that provide support, friendship, love and hope” (Recovery and recovery support, n.d., para. 3). While these services and supports may seem easily achievable, a person who lacks social bonds lacks the systems needed to manage their addictions, creating an internal barrier to treatment.
IV. RECOMMENDATIONS

America as a whole, is facing the crisis of the opioid epidemic. It has impacted society, the economy, and the health of many individuals. It is clear that with the call for a state of emergency, communities, governments, and health care organizations have taken a stand to increase treatment options available to those struggling with opioid use and abuse. However, utilization of both counseling and Medication Assisted Treatment remains low. Understanding what these barriers are is critical in determining what can be done to increase treatment utilization, specifically among opioid users.

Treatment for Opioid Use Disorder is associated with reduced risk of use, infectious diseases, and overdose. However, based on the information gathered, there are a number of significant barriers faced by addicts outside of the treatment environment. A large indicator of a person’s success in treatment, is their physical capital. Physical capital in this sense, is housing, employment, and transportation. One counselor, who took part in the focus groups, indicated that it is difficult to focus on treatment when basic needs are not being met, stating, “just basic needs of healthcare, transportation, housing – it’s hard to think about your mental or emotional health when you have nothing. You don’t know where you are going to sleep… it’s the hierarchy of needs” (Pullen and Oser, 2014, p. 11).

The first recommendation is introducing case management services for opioid-related addictions. Individuals with Opioid Use Disorder have ongoing needs that prevent treatment entry, and these needs will not be remediated through treatment. Case managers can work to provide solutions focused on programming in order to overcome these barriers. While case managers can help clients with their personal barriers and motivation, social networks, and transportation, treatment availability would not be directly affected.
This leads us to the second recommendation of increasing staff availability for assessments and counseling. There are a limited number of programs already available which utilize this two-part approach in order to address the opioid crisis, one of them being the Opioid Treatment Center (OTC) in Wisconsin. The OTC will be discussed and recommended as a model for future programs.

The United States Government has made millions of dollars in grant monies, which are available to state and local governments, in an effort to address the opioid crisis. The grants are aimed at addressing “the opioid crisis by increasing access to MAT using the three Food and Drug Administration (FDA) approved medications for the treatment of Opioid Use Disorder, reducing unmet treatment needs, and reducing opioid overdose-related deaths through the provision of prevention, treatment and recovery activities for Opioid Use Disorder” (U.S. Department of Health and Human Services, 2019, n.p.). These grants may allow for the reduction of barriers while also allowing for the necessary increase in staff. One of those programs made possible by the grant money, is the Opioid Treatment Center of Dodge and Fond du Lac Counties. The mission this program is built on is:

“Dodge & Fond Du Lac Counties are working together to provide a Solution Focus Program to address the ongoing needs of individuals dealing with Opioid Use Disorder. At the Opioid Treatment Center (OTC) our goal is to provide a comprehensive array of recovery treatments, and psycho-social rehabilitation services to assist individuals in utilizing professional, community, and natural support systems to address their needs. We cannot achieve these goals alone; our community is in need and together we can effect change” (Mission statement, n.d., para. 1).

This programs design can be used as a guide for further, evidence-based change.
The Opioid Treatment Center is a local program that collaborates with Dodge County Human Services and Fond du Lac County Human Services in Wisconsin to provide increased availability and immediacy of treatment. Like many other places throughout the United States, these counties recognized a high need for services to address their significant opioid issues. This voluntary program takes referrals from the county, family, friends, probation agents, individuals with opioid use, or others within the community. The program employs an intake specialist who then reaches out to the individual who was referred, determining program eligibility, explaining the program, and scheduling an assessment. In order to be eligible for this program, the individual must have current or recent opioid use and be 18 years or older. The unique aspect of this program is that its employees its own Alcohol and Other Drug Abuse (AODA) counselors, allowing for the elimination of waitlists. Clients who agree to come in for an assessment are scheduled within 48 hours of their intake. Compare this to many other counties and locally run programs, which are booking out three weeks to three months for assessments. Eliminating wait time is critical in the beginning stages of recovery, and this aspect to treatment is what makes the Opioid Treatment Center extremely effective in reducing this barrier. During the assessment, the AODA counselor completes the same paperwork that is needed for entering treatment with the county: a psychosocial assessment to determine diagnosis and history, ASAM to determine placement, and consents are signed and completed. “With the assessment completed, treatment begins. The immediacy is important, as it lessens time for people to relapse, overdose, or change their mind” (Razner, 2018, para. 13). The AODA counselor then consults with the county’s clinical supervisor to assign level of treatment and they begin treatment with the county immediately. Treatment for each person looks different and is dependent on their individual needs. This may include: outpatient treatment, residential treatment, or aftercare. While the
Opioid Treatment Center is extremely effective in addressing the time barrier specifically, the program does seek to reduce other barriers as well. “The grant allowed for another gap to be filled in the process: that of a recovery support specialist. Through this, those in the program can receive assistance in finding housing, employment, transportation and behavioral health services, addressing other areas of life affected by opioids” (Razner, 2018, para. 16).

A Recovery Support Specialist (RSS) provides case management services for clients in the OTC program. This position was created to assess an individual’s social, clinical, and criminal needs and help them to develop their own path to recovery. In terms of specific barriers visited in this paper, the RSS position plays an essential role in solving issues of support, transportation, and motivation. The RSS offers case management services which address these hurdles specifically and also provides an additional form of support throughout the recovery process. They can help an individual identify formal and informal supports in their lives, as well as establish self-realization, encouraging the client to set their own goals and timelines for recovery. Connecting clients with the types of resources mentioned above are essential for opioid users to achieve recovery.
V. SUMMARY AND CONCLUSIONS

There were several common themes that emerged, including misconceptions about an individual’s own use, social networks, treatment availability, and transportation. Individuals with Opioid Use Disorder tend to have several excuses for not participating in treatment, and these excuses alone, are an individual barrier that can be of great impact to the decision to enter treatment. Many clients hold the belief that they do not have a problem with opioids, especially those who were initially prescribed opiates as medications for pain. This lack of self-honesty, likely due to embarrassment and stigma, prevents clients from seeking out help for their problem, despite the dangers of use. The common misconception that opioid recovery does not require treatment is an example of a lack of education related to the compulsivity and physical dependence of the disorder.

Social ties are a major barrier of concern as well. Opioid users often lack appropriate social supports. A widely-reported barrier by substance abusers, was fear of losing their friends, stating that their friends discourage them from seeking treatment. This is largely due to the fact that drug use is often considered normative among an individual’s friends and family. Those who have intimate relationships with friends who use substances, are statistically more likely to use substances themselves. When an individual is part of a homophilous network that normalizes drug use, it is difficult to prioritize certain places or behaviors, making recovery difficult. As humans, we seek connections or social bonds, and while these bonds are not always healthy, they are important to the individual who may lose them. When considering the Social Bond Theory, one can see that an individual who experienced a lack of appropriate attachment in their childhood, will carry those behaviors and tendencies into future adolescent and adult
relationships. An individual must sever these ties in order to process their past experiences and achieve recovery; they can then learn to have healthy, sober relationships.

Some opioid addicts do have supportive networks within their family or friend groups, but even these individuals can experience barriers on this front as well. These barriers are generally the result of either a lack of knowledge and understanding from family and friends, or from embarrassment on the individual’s part. There are many misconceptions related to drug use and Medication Assisted Treatment. It is a common belief that drug addicts, including those who use heroin, choose to use substances and can quit anytime they please. This is certainly untrue; opioid use can turn into a diagnosable disorder that changes the chemistry of an individual’s brain. The chronic, relapsing nature of the disorder often requires professional help. Families often struggle to understand how addiction works, more education is needed for families and communities to understand the necessity of treatment and MAT services for loved ones addicted to opioids. Further barriers are created by the embarrassment an individual may feel when seeking treatment in the community. Mowbray et. al. (2010), specifically, reports that heroin users fail to seek treatment due to their family members being embarrassed of what people in the community will think.

The third common barrier, expressed by both clinicians and substance users alike, was a lack of transportation. Many times, individuals in need of treatment do not get the help they need simply because they cannot get to their program location. One common consequence of substance abuse and involvement in the criminal justice system is the revocation or suspension of an individual’s license. Furthermore, as discussed earlier, opioid use may cause economic strain. Those at or below the poverty level can exhaust 50% or more of their monthly income on drugs. Considering this, it is unlikely that an individual has the means to pay for fuel, let alone a
vehicle. One option for those with strong support systems, is to get a ride to their treatment facility. However, this is oftentimes an unreliable answer to the problem at hand, as it creates stress for both clients and their families and friends. For those who lack a supportive network, transportation services are usually available through state and local agencies at no cost to the client. However, people are oftentimes unaware of the resources available to them, and these services are underutilized.

The last common barrier to treatment is an overall difficulty in accessing treatment. Clinicians are time-challenged and burnt out. Many things can get in the way of spending time with clients, and as a result, counselors may have to pick and choose which client is the most in crisis. This does not allow for optimal treatment, which is key in preventing more opioid-related overdoses. This is not only felt by counselors, but clients as well. Individuals in treatment are often looking for help; someone they can meet with one-on-one to discuss their problems. However, when clients have to wait anywhere from three weeks to a month between appointments, it is difficult to develop the rapport that is necessary for individuals to open up, something that is especially challenging for those who lack a support system at home. Clients are thrown off by the “lack of physicians providing treatment, the limited amount of specialty inpatient and outpatient treatment programs, long waiting lists, and the limited availability of self-help group meetings” (Bunting et. al., 2018, p. 5).

This paper examined existing treatment options for those with Opioid Use Disorder, the barriers many individuals face in accessing these treatments, as well as provides recommendations for remediating these barriers. Many, if not all, can be rectified by programs similar to the Opioid Treatment Center, which recognizes and addresses several common barriers that impede linkage to treatment. Using this program as a model for others to follow could
eventually lead to greater treatment success, allowing individuals to achieve total recovery and once again become productive members of their families and society as a whole.
VI. REFERENCES


