Barriers to Medication-Assisted Treatment:

Recommendations for Professional Counseling Practice

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Abstract

The purpose of this paper is to provide information about the barriers to Medication-Assisted Therapy (MAT) that may interfere with an individual's treatment and to provide ways in which professional counselors can intentionally adjust their professional practice in order to meet clients' needs most effectively. The thesis of this paper is that professional counselors can positively contribute to client recovery using research and intentional interventions. Based on the results from recent empirical research studies, MAT has proven to be effective in treating opioid dependency. However, there are barriers to MAT such as stigmatization, discrimination, polydrug use, co-occurring disorders, lack of resources, medical, financial and legal issues, amongst many others, that can disrupt an individual's journey to sobriety. To achieve optimal outcomes in MAT, it is imperative for mental health counselors to identify barriers at the onset of treatment to help with retention rates, as well as to gain cultural awareness of the common themes that contribute to addiction and subsequent barriers to treatment. Additionally, providing individuals seeking treatment with appropriate community resources, along with educating families, communities, and healthcare professionals on substance disorders can help destigmatize MAT.

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A holistic approach to treating individuals with substance use disorders may increase the effectiveness of treatment for individuals experiencing addiction (Substance Abuse and Mental Health Services Administration, 2020). Medication-assisted treatment (MAT) is a form of treating individuals with drug addiction in a holistic manner. MAT combines behavioral health therapy with medications to treat substance use disorders (Substance Abuse and Mental Health Services Administration, 2020). Behavioral health therapies that have been found effective with addictions include cognitive behavioral interventions, motivational interviewing, and interpersonal skill building interventions (McHugh et al., 2010; Substance Abuse and Mental Health Services Administration, 2020). Pharmacologic therapies reduce the risks of overdose, HIV contamination by injection, and illegal actions committed by drug users (e.g., crime or prostitution) when purchasing illicit substances (Perreault et al., 2015). When combined, behavioral health interventions plus pharmacological therapies provide the strongest intervention strategy to support individuals who are addicted to substances (Substance Abuse and Mental Health Services Administration, 2020).

Opioid use is the most common reason why individuals enter addiction treatment. In 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2021) reported an estimated 2 million people have been diagnosed with an opioid use disorder. Opioid use accounts for nearly 50,000 deaths per year (Centers for Disease Control and Prevention, 2020; National Institute on Drug Abuse, 2020). In North Carolina, a total of 1,783 deaths involved opioids, accounting for roughly 80% of drug overdose deaths within the state (National Institute on Drug Abuse, 2020). In recent years, deaths related to prescription opioids have

decreased both nationally and locally; however, deaths involving heroin and synthetic opioids other than methadone (including fentanyl and fentanyl analogs) continue to rise to nearly 28,400 deaths nationwide and have remained stable across the last few years in North Carolina (National Institute on Drug Abuse, 2020).

Focusing specifically on MAT for opioids, methadone maintenance treatment (MMT) programs provide pharmacologic therapies such as buprenorphine/naloxone, naltrexone, and methadone opioid agonist therapies that are specifically used to treat opioid use dependency (Substance Abuse and Mental Health Services Administration, 2020). Methadone, an oral synthetic opioid, helps stabilize drug users by reducing the rates of withdrawals and cravings associated with opioid use (Smye et al., 2011). Additionally, combining medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medication, can provide individuals in opioid treatment programs the proper resources and tools to treat opioid dependency (Substance Abuse and Mental Health Services Administration, 2020).

Much research has been conducted regarding retention in MMT. Perreault et al. (2015) conducted a study to determine the role of psychological variables and judicial problems that may impact a client's retention in treatment. A total of 106 participants were utilized who attended a low-threshold methadone clinic in Montreal, which alleviated common barriers to treatment variables associated with for profit MMT providers. Participants met criteria of retention if they remained in treatment at the one-year mark. Variables accounted for in this study included already researched barriers to treatment including sociodemographic variables, Methadone dosage, and the transtheoretical model, Stages of Change. Of notable importance were the variables of criminal justice involvement, self-esteem, and psychological distress.

Results of the study validated previous research as to the importance of Methadone dosage in retention (Perreault et al., 2015).

Perreault et al. (2015) found that criminal justice involvement severity and low self-esteem were found to be barriers to retention as well. A limitation of this study includes the method of determining psychological distress and self-esteem ratings based upon self-assessments from the participants. Although the Rosenberg Self-Esteem Scale (RSES) and the Psychiatric Symptoms Index (PSI) are valid measures, they are not reliable methods of determining actual versus feigned symptoms and were not conducted longitudinally during the year of research with participants. For criminal justice involvement, the Addiction Severity Index (ASI) was utilized and although it is widely used in the field of addictions, such information provided or withheld within the assessment can be verified using outside sources. Given the prevalence of Opioid Use Disorder throughout the United States, this study shed light on the ongoing barriers to treatment that are often overlooked, unaccounted for, untreated, and undermined in their autonomy as it relates to barriers to treatment (Perreault et al., 2015).

Thesis Statement and Purpose

The purpose of this paper is to provide information about the barriers to MAT that may interfere with an individual's treatment and to provide ways in which professional counselors can intentionally adjust their professional practice in order to meet clients' needs most effectively. The thesis of this paper is that professional counselors can positively contribute to client recovery using research and intentional interventions. After a review of the many factors that may contribute to decreased retention in MAT programs and ultimately hinder one's recovery, practical considerations for addressing these barriers are provided.

Barriers to MAT

Some barriers that are frequently explored in current literature include: difficulty of daily and stigma (Anstice et al., 2009), lack of resources for clients and treatment programs (King et al., 2014; Li et al., 2013; Smye et al., 2011), the effects of client comorbidity, and ongoing substance use (King et al., 2014; Kunøe et al., 2010; Smye et al., 2011). Internal and external factors (i.e., judgement, feelings of discrimination, and negative interactions with others, transportation) have influenced experiences of stigma (Anstice et al., 2009, Smye et al., 2011). Lack of resources such as adequate housing and access to transportation create additional obstacles for individuals in MAT programs (King et al., 2014; Li et al., 2013). Additionally, co-occurring disorders and ongoing substance use can lead to increased distress and a reduced response to psychiatric and methadone maintenance treatment (King et al., 2014). These factors can contribute to patients' addiction issues and retention rates within MAT programs.

Stigma

Anstice and colleagues (2009) conducted a Canadian study to examine methadone maintenance treatment (MMT) clients' experiences of supervised methadone consumption. This qualitative study conducted between 2002–2003 was comprised of four methadone programs, two of which dispensed methadone onsite and two programs that did not have on-site dispensaries where clients received supervised methadone at local pharmacies. All programs provided methadone prescribing, counseling, amongst other resources. Out of the 64 there were 42 females and 22 males. Participants were asked open-ended questions regarding their experiences to program goals, philosophy, rules, policies and procedures, formal and informal roles and duties, methadone dispensing method, decision-making processes, relationships between staff and clients, relationship of the methadone program to other programs and providers within the community, and program strengths and challenges.

Anstice and colleagues (2009) identified the stigmatizing aspects of supervised MMT from the perspective of the clients. Three main considerations for MAT were reflected within this study: convenient access, relationships with staff, and characteristics of the dispensing space. This study revealed that the aspect of daily dosing proved to be challenging for most participants and presented as a barrier to MAT. Additionally, negative interactions with dispensing staff can lead to feelings of discrimination, which may discourage clients from receiving MMT.

The setting in which methadone was dispensed also impacts the stigmatization of MMT (Anstice et al., 2009). Clients reported feeling more demeaned at the pharmacy than the on-site dispensary. Although the challenges of providing non-stigmatizing dispensing services for MMT clients were outlined, one limitation of this study is that the convenience sampling was used to recruit clients and findings are not generalized to clients in other MMT programs. As a counseling researcher, it is important to take the clients' experiences and perspectives into consideration in order to improve outcomes and decrease barriers to MMT participation.

Smye et al. (2011) conducted a qualitative study to investigate the various ways harm reduction and MMT are experienced based on sociopolitical and cultural factors in aboriginal patients by using intersectionality to examine the conditions in which harm arises and how experiences of oppression impact experiences of harm. This study consisted of 39 participants over the age of 19 who had no cognitive impairment. Information was gathered via 30 to 60-minute interviews and transcribed using NVivo, a computer software program. The purpose of this study was to gather information in order to gain an understanding of how to improve mainstream mental health and addictions services and better serve the needs of Aboriginal clients. This study outlined the need for harm reduction approaches that address the many factors that play a role in addiction issues and resistance to MAT in Aboriginal patients.

Smye et al. (2011) concluded that harm and benefit are experienced differently by clients based on their histories and social location/position. Client participants in this study presented with significant levels of co-occurring illnesses and mental health disorders, polydrug use, suicidal ideation, poverty, and PTSD associated with complex trauma. Additionally, clients expressed mistrust with the healthcare system due to everyday experiences of stigmatization, marginalization, and racism as a result of ongoing colonial practices. These factors have contributed to the patient's addiction issues and resistance to seeking treatment in opioid treatment programs. One limitation of this study is that its sole focus is on the treatment of Aboriginals and does not provide insight into how to better serve other demographic populations. MAT alone is not enough to reduce the harm of drug use.

The history, sociocultural and political factors, and institutional structures and processes of each client need to be taken into consideration when providing methadone maintenance treatment to Aboriginals. Smye et al.'s (2011) study is important in reminding counselors of the many complex factors that influence an individual's addiction. Furthermore, the need for advocacy and increased clinical attention, along with MAT, can increase harm reduction in MAT Aboriginal clients.

Lack of Resources

Researchers from the Declaration of Helsinki conducted an observational study in Baltimore, Maryland approved by the Johns Hopkins Institutional Review Board consisting of 156 patient participants who had at least one current co-occurring psychiatric disorder and expressed interest in receiving treatment for the psychiatric condition. This study describes the effectiveness of referring patients receiving methadone maintenance with at least one co-occurring psychiatric disorder to a psychiatric program. All 156 participants were offered

referrals from the methadone maintenance clinic to a community psychiatry program including psychiatrist appointments, individual and group therapy, and access to psychiatric medications for 1 year. Additionally, psychiatric distress assessments were completed monthly via the Symptom Checklist (SCL-90-R).

King et al. (2014) found that although 80% of the sample initiated psychiatric care, they only attended 33% of all scheduled appointments and 84% did not complete a full year of care. Additionally, the results showed that cocaine and alcohol use disorder and current employment were associated with worse psychiatric treatment retention. Additionally, this study outlined the potential barriers to successful application of this parallel treatment approach of methadone maintenance treatment and psychiatric treatment. This study concluded that "the presence of psychotic comorbidity in this population is associated with increased psychological distress, poorer quality of life, and reduced response to substance abuse treatment" (King et al., 2014, p. 60).

Furthermore, King et al. (2014) found that the barriers to MAT and simultaneous psychiatric treatment are program-related (e.g., inadequate staff training and support), systems-related (e.g., inconvenient and poorly coordinated psychiatric care), and patient-related (e.g., economic and transportation disadvantages). Also, referral of patients with co-occurring psychiatric disorders receiving methadone maintenance to a community psychiatry program is ineffective, despite efforts to reduce common barriers. The barriers outlined within this study further contribute to decreased attendance and retention in MAT programs. This study is vital in developing strategies to reduce drug use, improve abuse treatment retention, and increase psychiatric treatment involvement and retention for opioid dependent individuals in MAT programs.

Housing, or a lack thereof, might also affect the effectiveness of MAT (Li et al., 2013). A quantitative study was conducted in Vancouver, BC over the span of 2 years within a 24 bed, mixed-gender detox unit receiving methadone maintenance treatment. The purpose of the study was to determine what variables may be predictors of dropout rates between Aboriginal and non-Aboriginal clients (Li et al., 2013). Concerns of equal access to services and cultural idiosyncrasies drove the study based upon statistics of high prevalence between Aboriginals within Vancouver who are substance use dependent. This study included 2,231 clients who were either self-referred or referred by a medical professional for treatment to Vancouver Detox (VD) using the ACCESS1 phone referral system. Twenty percent of the participants were Aboriginal and presented with specific features in comparison to non-Aboriginal participants including: younger population, female, no fixed address (NFA), HCV, and poly-drug user. Pretreatment and during treatment AMA dropout were the dependent variables. The Chi square test and Wilcoxon rank-sum tests were used, also utilizing a 95% CI.

Li et al. (2013) concluded that Aboriginals experienced pretreatment dropout at 41% vs their counterparts of Non-Aboriginals at 32.7%. For treatment AMA dropouts, Aboriginals accounted for 25.9% dropout rate vs. a 20% dropout rate for non-Aboriginals. Based upon the findings, Aboriginals were found to have NFA as the only predictor for pretreatment dropout rates. Treatment AMA dropout variables for Aboriginals were females and HCV diagnosis. Researchers of this study acknowledged shortcomings within their study based upon previous studies involving Aboriginals within BC. Personal concerns within this study include low Aboriginal population within the study (20%) and considerations of population differences of Aboriginals from rural (reservation residing Aboriginals) and urban settings (i.e. Vancouver).

Ongoing Substance Use

The Norwegian Centre for Addiction Research conducted a six-month study that investigated the use of opioids among 60 opioid-dependent patients receiving MAT. This study also looked at the subjective experience of drug 'high' after opioid use and factors associated with opioid use. This study examined other factors that impact opioid dependent individuals in treatment such as polysubstance use, depression, and other social adjustment problems that may present as barriers to medicated-assisted treatment. Opioid use was measured using the European version of the fifth Addiction Severity Index (ASI) and on a 0-3 frequency scale (0 = no use; 1 = one to three times per month; 2 = one to three times per week; 3= daily or almost daily). All patients were asked about opioid dosage and patient's 'high' was assessed via patients' verbal reports. The ASI was also used to analyze data on non-opioid substance use, criminal activity and employment situation. The Beck Depression Inventory was used to assess depression, while the Temporal Satisfaction with Life Scale's 'present' items was used to assess life satisfaction, and the Hamilton Symptom Checklist 25 (SCL-25) to assess general mental health. Blood samples were used to verify naltrexone levels and hair samples were taken to measure the presence of opioids.

Kunøe et al. (2010) concluded that pharmacologic therapies such as naltrexone are effective in treating opioid use dependency. However, the continued use of opioids, as well as the use of non-opioid substances showed poor outcomes in treatment and can contribute to additional social adjustment problems and criminal activity. This study concluded that these additional factors prove to be a barrier to MAT in that the use of opioids and other illicit substances while receiving sustained release antagonist treatment is likely to be associated with several other serious problems contributing to decreased retention in MAT programs.

One limitation of this study is the use of self-report ratings and questionnaires to assess the experiences of the patients. The results suggest the need for more clinical attention in MAT programs. While MAT assists individuals with opioid use dependency, the use of other substances, as well as social problems that are associated with substance use are not addressed. Therefore, increasing clinical support may assist patients with behavioral problems and with relapse prevention skills to improve overall effectiveness of MAT programs.

Future Counseling Practice

Extensive research has been conducted on the effectiveness of MAT on opioid use dependency. MAT offers individuals the proper resources and tools to treat opioid dependency including medical, counseling, vocational, educational, and other assessment and treatment services reducing the risks of overdose, HIV contamination by injection, and illegal actions committed by drug users (e.g., crime or prostitution) when purchasing illicit substances (Perreault et al., 2015; Substance Abuse and Mental Health Services Administration, 2020). By combining behavioral health therapies such as cognitive behavioral interventions, motivational interviewing, and interpersonal skill building interventions and pharmacologic therapies, MAT provides the strongest intervention approach to supporting individuals addicted to substances (McHugh et al., 2010; Substance Abuse and Mental Health Services Administration,2020). While existing research has been able to illustrate some of the barriers to MAT, additional research needs to be conducted on how to combat those barriers. With Methadone treatments being amongst the most common forms of intervention for opioid addiction and the rate of opioid addiction steadily increasing (Perreault et al., 2015), additional research on the barriers to MAT and ways to combat those barriers can provide further insight into how opioid treatment

programs can increase retention rates, address co-occurring illnesses, and improve overall treatment of opioid dependency.

Although MAT assists individuals with opioid use dependency, the use of other substances, as well as social problems that are associated with substance use are not addressed. Therefore, increasing clinical support may assist patients with behavioral problems and with relapse prevention skills to improve overall effectiveness of MAT programs.

Conclusion

Based on the results from the recent empirical research studies annotated in this paper, MAT has been shown to be effective in treating opioid dependency. However, there are barriers to MAT such as stigmatization, discrimination, polydrug use, co-occurring disorders, lack of resources, medical, financial and legal issues, amongst many others, that can disrupt an individual's journey to sobriety. To achieve optimal outcomes in MAT, it is imperative for clinical and mental health counselors to identify barriers at the onset of treatment episode to help with retention rates, as well as gain cultural awareness of the common themes that contribute to addiction and subsequent barriers to treatment. Additionally, providing drug users seeking treatment with appropriate community resources, along with educating families, communities, and healthcare professionals on substance disorders can help destigmatize MAT.

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