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Barriers to Rural Treatment of Opioid Addiction and Alcoholism

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Preface

In the last 20 years there's been a groundswell of much improved modalities for the treatment of addictions, particularly opioid abuse and alcoholism. Gone are the days when treatment for alcoholism was simply acute detoxification with minor relief of symptoms with a variety of antiemetics, alpha blockers and benzodiazepines with the standard IV bags of folate, B12 and dextrose.

Although from a practical approach, we are not as advanced as we might suppose with the medications we now have at our disposal.

Let us not forget that the rural setting is already rife with its own complications and with his own severe and limiting factors with regards to accessing healthcare of any sort. Killeen et al. [1] mentioned some of the issues that can face just baseline conditions such as being disabled in rural settings, let alone actually accessing care, therapy or services:

"Interviewees reported substantial difficulties finding physicians who understand their disabilities and sometimes feel that they must teach their local doctors about their underlying conditions. Interviewees described needing to travel periodically to large medical centers to get necessary specialty care. Many are poor and are either uninsured or have Medicaid coverage, complicating their searches for willing primary care physicians. Because many cannot drive, they face great difficulties getting to their local doctor and especially making long trips to urban centers. Available public transportation often is inaccessible and unreliable. Physicians' offices are sometimes located in old buildings that do not have accessible entrances or equipment. Based on their personal experiences, interviewees perceive that rural areas are generally less sensitive to disability access issues than urban areas."

Also, although heterogenous, we do have many indicators that patients simply do not receive the quality of healthcare that do patients in urban centers. "Patients receiving care from rural practitioners were less likely to receive services, either recommended or not, than those in urban locations" [2].

Anecdotally, only 10% of opioid addicts ever even see a healthcare professional for their addiction, and the numbers for alcoholism, with its broad social acceptance, are probably even worse.

Hutchinson et al. [3] studied 78 Family Medicine physicians who were specifically trained and granted waivers to prescribe buprenorphine containing products for the treatment of opioid addiction. Of that group only 22 (28%) actually prescribed buprenorphine products for opioid addiction. The rest of this especially trained group did not. To quote the article, "a lack of institutional support was associated with not prescribing the medication (P=.04). A lack of mental health and psychosocial support was the most frequently cited barrier by both those who prescribe and who do not prescribe buprenorphine."

It should however be noted that the results of research examining rural populations (Huchinson et al.) may or may not be generalizable across population densities (personal communication), it is clearly obvious from this author's experience that in urban and other population models of various densities there is an obvious lag in development of addiction treatment services. One need only view the month by month and year by year pressure with which SAMHSA churns out grant offerings and unique programs in their effort to better encounter the opioid and other substance health problems to feel a certain "institutional panic", not unique to SAMHSA by any means, to find programs that work robustly against substance abuse; victories that are so far elusive.

Thus, although buprenorphine is a successful treatment for opioid addiction (personal communication), working quickly and well to restore the patient to functionality, work and family, less than 30% of specifically trained Family Medicine specialists actually prescribed this treatment. Whereas, it is true that greater than 70% of the trained practitioners did mention lack of institutional, psychosocial and mental health support for a treatment whose success is proven, for their reluctance to prescribe this treatment, it must be mentioned that it is notable that so high a proportion of trained, buprenorphine waiver holding residency trained Family Medicine practitioners would refuse to participate in the administration of this treatment. What does this suggest in terms of the apparent inertia of implementing substance abuse treatment even when there are providers locally who have been trained and qualified? Thus, despite the effective treatment of buprenorphine containing medications, so very few sufferers of opioid addiction actually encounter the treatment.

This is the barrier we face not just in the rural environment, but in urban societies where this treatment is readily available and there is ready availability of mental health professionals, counselors and support groups such as Alcoholics Anonymous and Narcotics Anonymous.

It is no surprise that only 10%, anecdotally, of opioid addicts ever encounter a treating health professional, when specifically trained physicians drop out or never initiate treatment of patients over 70% of the time even in a highly motivating atmosphere.

The Problem

Unstated in this overview, is the stigma of treating, and having, addiction. It is very clear that there is considerable stigma when more than 70% of especially trained physicians simply will not institute this treatment in communities where there is obvious need, in the US where the opioid 'epidemic' is front and center in almost every community healthcare discussion, and yet it is evident that we cannot

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even mount a reasonable response to this illness despite training, support and money.

Indeed, addiction is strongly associated with very negative imagery in every organized society. It is implied that being a 'drug addict' is associated with crime, filth, disease, a lack of desire to quit their substances they are abusing, and as such, they are 'moral failures.' They do not 'possess the will or the desire to not be an addict or alcoholic.'

Brondani, et al. [4] examine stigmatization of substance abuse sufferers in dental practices directed towards sufferers of substance abuse. The severity and the frequency of this type of social abuse and neglect was remarkable and does indeed point toward stigmatization of substance-abuse suffers even within the programs that are specifically designed to treat them and their illness. This is another potential slowing point in the treatment of substance abuse and in the effective deceleration of the opioid epidemic.

It is no doubt that this thinking is rife both in the medical and treatment community, and likely even among the addicts and alcoholics themselves. Certainly, societal prejudice based on seeing addiction as 'the fault of the addict' rather than a disease process is larger than even we as treating professionals suspect. When greater than 70% of trained physicians make a choice to not offer treatment for this disease it is very telling that the prejudices of society are greater and much more deeply ingrained that we expect. This is likely a very large factor in that the opioid epidemic in the US continues to worsen despite the mass certification of physicians to treat addiction, and despite all the money being poured into educational, preventative and numerous treatment centers and facilities.

Another lesson from the American experience is that the waiver certification to prescribe buprenorphine for narcotics addiction is cumbersome and limiting in adequately treating this illness. In the first year of certification the practitioner is limited to 30 addicted patients for the year. In the second year, if one can actually negotiate the bureaucratic maze and gain approval, the practitioner is limited to 100 patients for that year. It is only after a laborious approval process in the third year is the practitioner able to treat 275 patients. And this is obviously problematic because Family Medicine specialists are expected in the course of a regular practice to treat 700 to 1500 patients in their practice. Limiting addiction treatment professionals to such low numbers when people are overdosing and dying strains the limit of understanding of the bureaucratic process.

Due to onerous restrictions on providing buprenorphine treatment not only are there societal prejudices to deal with, but the practitioners are severely limited in their ability to care for enough patients to seriously make a difference in proper coverage of care for their geographical area. Even when telemedicine is factored into the plan of care for addiction sufferers the limitations on numbers of patients still hamstring the outreach of treating professionals to the vast numbers of addicts and alcoholics out there.

McClelland [5] makes the salient point that addiction and alcoholism (drug and alcohol addiction) should be treated as chronic diseases such as diabetes, asthma and hypertension, and that we are doing ourselves, and our patients, a disservice by 'measuring' the success or failure of addiction treatment by whether it eventually fails, instead of by viewing addiction as a chronic disease which is naturally going to have a number, a large number, of patients who discontinue their medications, who do not follow their behavioral guidelines and who may be lost to follow up for some time. Indeed, "…almost all addiction treatments (methadone maintenance and AA may be the only exceptions) are expected to produce lasting reduction in symptoms following termination of treatment."

He makes the point that when compared to the 'usual' chronic diseases the time course of addiction may certainly be no worse than diabetes, asthma and hypertension where 50% of patients go off their medications for extended periods of time and a lesser percentage abandon their lifestyle recommendations.

It is our failure to treat addiction in a cohesive and rational manner that limits our effectiveness in controlling what is clearly a chronic illness and is known to respond with about a similar path and trajectory as other chronic illnesses.

There is not widespread acceptance even of what appear to be proven improvements in distributing addiction care across wide rural areas. The University of New Mexico Medical College [6] provided an intense telemedicine outreach across the rural providers and facilities in a remarkably thinly spread but sizable rural population. They indicate considerable success in this endeavor for both acute and chronic disease and addiction treatment. Indeed, they did address the most stubborn causes of inequality of medical care (after simple lack of health insurance for large swaths of the American public). This model did well and was robust in supporting widespread increase in treatment of chronic disease and addiction. However, without widespread adoption of effective modalities in treating and equalizing the quality of care across both urban and rural centers, the inequality in the quality of care and well as the availability of care is not effectively maintained. Again, in the American experience, as in this example, an excellent modality in one state may not be 'transferable' to another state. The latter state is often bureaucratically resistant to a model developed in another state and for reasons both political and local and they will not adopt even an excellent and workable model developed in another state. This failure to work together regionally and politically, as well as the severe restrictions on the availability of treating providers who can provide buprenorphine products for opioid addiction is extremely hampering to effective treatment of the American "opioid epidemic." This limitation on the number of certifications available for buprenorphine treatment and limitations on patient numbers per provider in itself limits the reach of treatment for other addictions, most notably alcohol addiction, which also has a number of viable and effective medical treatments such as Acamprosate and naltrexone implants, injections and oral preparations, as well as other medications as well as known effective psychological and sociological support modalities. Restricting the number of providers and numbers of patients per provider is proving to be hampering to the treatment of opioid addiction in this country, and it is clear that it is these very restrictions on opioid treatment also reduce the availability of alcohol addiction treatment. And alcohol addiction is often an illness that permeates societies much more severely and globally than opioid addiction. Thus, alcohol addiction must proceed hand in hand with opioid addiction treatment.

What Can be Done

Recommendations from the American experience in addiction treatment

- There are numerous medical providers in rural areas, far fewer than in urban areas, but still numerous. They must have access to the same funding that practitioners in urban areas enjoy.

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- Rural medical providers must be trained en masse in addiction treatment. It is critical that all primary.
- Care providers be reached with this training, and they must have materials in order to treat the addictions they face completely and competently. Counselors and support personal must not be neglected in rural funding and training. Narcan for emergency resuscitation in overdose is mandatory.
- Outreach from urban medical centers and medical schools is highly recommended. Both rural and supporting physicians from urban centers must be enabled to conduct telemedicine to reach distant patients and also for supporting medical centers to interact with their rural counterparts as well as with patients with addiction and perhaps other chronic disease. The 'playing field' must be leveled from urban to rural areas to equalize quality of care and to offer excellent care distantly. The experience of New Mexico Medical College in extending excellent support services throughout thinly populated rural areas is most instructive.
- The infrastructure is already in place. Rural patients sometimes have smartphones and internet access; often, this may be all that is needed to conduct secure visits between the patient and the treating provider, irrespective of whether that provider is rural or urban in location.
- Telemedicine has been found to be equivalent to personal visits, and preferred when with the patient's own doctor [7] in monitoring addiction treatment as well as being equivalent in monitoring general medical care. Also, drug testing for addiction treatment monitoring involving shipping of sealed toxicology collection devices and uniquely numbered sealed shipping containers that can insure the accurate and secure submission of biological fluids for toxicology testing from remote locations is now coming available (personal communication and demonstration).
- Distribution of medications unique to the treatment of addiction must be available to rural patients as well as those in city centers. Drug testing and other modalities necessary to the treatment of addiction must be available rurally as well and centrally. These are not insurmountable barriers; laboratory testing corporations and local facilities already cover rural America thoroughly.

Conclusion

We live in an age where even the most remote corners of the earth are accessible to internet and cellphone service. It is imperative that we meet the challenges of modern medical care, and medical illness, with the utilization of information technology. We are within reach of our patients, and they us, at all times, day and night, weekend and weekday, holidays, vacation days and even our sick days. We have an opportunity to reach out and take that which is offered by technology and use it to treat our patients, to monitor our patients, to assess and to guide our patients. We no longer have to meet physically face to face at all times; we even have in development sensors by which we may remotely examine and diagnose even more completely than we do in person.

But do not think that medical practice should all become virtual. There will always be those situations and those illnesses, those conditions where it is vital to be face to face, person to person. The "laying on of hands" wherein as we examine the patient personally we can glean information greater than that obtained simply through the exam itself. When have we not come upon a difficult diagnosis by the long sitting at the bedside, talking to the patient, the family, the neighbors, the friends and careful examination?

I do not suggest that we give up the traditional practice of medicine. I say that we amplify it, that we take in the many available channels of information we now have to care for both individual and populations. Let us take technology and use it appropriately; use it to enhance, to broaden, to speed up our evaluations and to increase the competence of our craft, not to reduce it. We are physicians and caregivers, let us extend our reach, let us do more for more, and let us do it more rapidly.

But let us not forget the words of Sir William Osler, "Listen to the patient. He is telling you the diagnosis."

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