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Evaluating Barriers to Opioid Use Disorder Treatment From Patients' Perspectives

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Abstract

Introduction: Utilizing medications to treat opioid use disorder (MOUD) is both highly effective and unfortunately underutilized in the US health care system. Stigma surrounding substance use disorders, insufficient provider knowledge about substance use disorders and MOUD, and historical lack of physicians with X-waivers to prescribe buprenorphine contribute to this underutilization. Our study aimed to elucidate barriers to accessing MOUD in Milwaukee, Wisconsin.

Methods: We conducted semistructured interviews with patients receiving MOUD at a family medicine residency program in Milwaukee, Wisconsin. Interviews were audio-recorded, transcribed verbatim, and analyzed using the qualitative analysis Framework Method. Researchers in our team reviewed transcripts, coding for specific topics of discussion. Coded transcript data were then sorted into a matrix to identify common themes.

Results: Interviews with 30 participants showed that motivations to seek treatment appeared self-driven and/or for loved ones. Eighteen patients noted concerns with treatment including treatment denial and efficacy of treatment. Housing instability, experiences with incarceration, insurance, and transportation were common structural barriers to treatment.

Conclusions: Primary drivers to seek treatment were patients themselves and/or loved ones. Barriers to care include lack of effective transportation, previous experience with the carceral system, and relative scarcity of clinicians offering MOUD. Future studies may further explore effects of structural inadequacies and biases on MOUD access and quality.

Introduction

Opioid use disorder (OUD) rates have increased over the past 2 decades, constituting a public health emergency affecting approximately 2 million people in the United States. [1,2] Medication for opioid use disorder (MOUD) treatments, including methadone, buprenorphine, and naltrexone, have been shown to be safe and highly effective.[2] As of 2019, less than one-quarter of those with OUD received treatment with medications.[3] The expansion of addiction treatment into primary care has previously been shown to be an effective solution to bridge this significant care gap and reduce overdose mortality.[4] Our study took place in Milwaukee County, Wisconsin, which reported 20,000 overdoses between of January 2018 and February 2022.[5-7] In this study, we aimed to highlight various barriers that impact patients' ability to obtain treatment for OUD and maintain their

treatment progress.

Materials and Methods

Study Setting and Design

This study took place at a family medicine residency program in Milwaukee, Wisconsin, which operates a dedicated “MOUD clinic” 1 day per week. We conducted semistructured, 10-minute interviews with patients receiving MOUD between July 2021 and May 2022. This qualitative research method allowed for open-ended data collection with insight into patient thoughts, motivations, sociocultural considerations, and overall experiences. This study was approved by the Ascension Health System Institutional Review Board prior to study activities, including an informed verbal consent process.

Recruitment and Data Collection

Inclusion criteria included individuals: (1) currently receiving OUD treatment, (2) aged 18 years or older, and (3) English-speaking. Convenience sampling was utilized by approaching patients during MOUD appointments. Most patients were recruited in-person while one interviewee participated virtually. The objective of the study was explained to patients by the physician or medical student working with the patient, and patients were verbally invited to participate in the study. Participation was nonincentivized. Participants were assured that their decision regarding participation would not affect their medical care. Patient identifiers were omitted from the data collection.

Data Analysis

Interviews were audio recorded and transcribed verbatim by researchers. The established qualitative analysis of semistructured interviews, “Framework Method,” was utilized to code and sort transcripts.[8,9] To minimize the risk of group bias, each transcript was reviewed and coded independently by at least two researchers. Coded transcript data was then sorted into an excel matrix document. To minimize the risk of an individual bias on analysis, all research team members reviewed the matrix document and generated a consensus of data interpretation.

Results

A sample of 30 patients participated in this study. We observed the following themes emerge within two domains: (1) decision-making leading to treatment utilization, and (2) influences on treatment progress and patient satisfaction (Table 1).

Decision-Making Leading to Treatment Utilization

The patient decision-making process encompasses values, beliefs, influences, and choices leading to their choice to start or continue MOUD. Participants were asked about their primary motivations to seek treatment, decision to come to this clinic, and initial treatment concerns.

Motivations. Some patient motivations involved the desires to improve relationships with their children and loved ones, as well as setting a positive example for their children (Table 2). A larger majority emphasized being self-driven while seeking care. Participants noted seeking care to repair relationships but that this motivation was not enough to succeed and emphasized the importance of readiness to change for themselves (Table 2).

Connections to the Clinic. Many participants endorsed knowing a friend or family member who is currently receiving or had prior treatment at this same clinic. A smaller portion of participants mentioned a referral by

another physician or community organization, while others found the clinic online.

COVID-19 Impacts. Six participants discussed the impact of COVID-19 on their treatment, focusing on social interactions. Two participants referenced the negative aspects of social isolation. Another referenced challenges with virtual therapy as a person with visual and hearing impairments. Two participants stated that the isolation was a positive as it prevented them from interacting with people supporting their drug use. The remaining participant discussed an increased urge to use during the pandemic as well as related cocaine use.

Influences on Treatment Progress and Patient Satisfaction

Participants were also asked about prior treatment experiences, specifically what has and has not worked for them in the past. Additionally, participants were asked about social stressors that challenged their treatment progress.

Previous Treatment Experience. Multiple patients spoke about prior treatment attempts. Interviewees highlighted varying methods of cessation including methadone clinics, inpatient treatment, and attempts at self-cessation. At least six participants endorsed ten or more treatment attempts, though this number is likely higher as some patients did not report previous number of attempts. Of note, several participants cited negative experiences with clinicians a contributing factor to unsuccessful treatment attempts.

Experience With Incarceration. Many interviewees discussed their history with incarceration, reporting avoiding future interactions with the carceral system as a driving factor for treatment, while others were mandated treatment as a part of probation (Table 3). One patient described their past incarceration as a barrier to care, sharing how the stigma of a criminal record interferes with their ability to find a job, afford necessities, and continue treatment. Participants also discussed incarceration as a time of forced sobriety and an experience that interfered with ongoing treatment.

Socioeconomic Influences. Many participants mentioned experience with housing insecurity. Of these individuals, most endorsed having unstable housing currently and with concurrent financial strain, job instability, or lack of insurance. Some attributed housing-related stress to living with people actively using. Patients also discussed transportation inadequacy as a challenge to receiving care or affecting treatment progress (Table 4).

Characteristics of a Family Medicine Residency MOUD Clinic. Of note, four participants spoke about characteristics of the clinic that have contributed to their positive experience. These perspectives can inform clinicians how the attitudes of providers and staff can create environments conducive to success in treatment (Table 5).

Conclusions

In our study, the primary drivers to seek treatment were the patients themselves and their loved ones rather than any external influences. Recommendations from family and friends often prompted patients to seek treatment at the clinic, suggesting the efficacy of word-of-mouth and patient handouts as community-based approaches to recruit patients and improve utilization.

Our study also highlighted the impacts housing instability, transportation availability, and incarceration can have on treatment progress. Felonies and incarceration for drug use make housing and employment difficult to secure.[11-13] Patients without employment or housing are often reliant on unreliable public transit or shared rides. The transportation burden is exacerbated as patients must travel long distances to find care. The barriers identified in this study resonate with previous work discussing the impact of stigma and barriers on accessing substance use disorder treatment. [11-13] Increasing the number of clinicians that prescribe MOUD via education

in residencies and medical schools has been shown to significantly improve availability of quality treatment.[4] Working closely with clinical social workers to link patients to housing, legal aid, and employment services could improve treatment outcomes.[2,5]

Limitations of this study include lack of a broad sampling pool, a single recruitment site, and the influence of mentioned barriers to care on study recruitment. Many potential participants missed appointments or chose not to participate because of needing to catch a bus or utilizing unreliable medical transport services. The barriers reported in this study are likely underreported as participants were actively engaged in care when discussing their barriers. Previous studies have indicated the role of identities such as gender, sexuality, and parenthood status in accessing MOUD; given our study highlighted loved ones as a major motivation in treatment, exploring social identity (eg, demographics of race, gender, zip code, or income level) and family structure could have further elucidated patient experiences in addiction treatment.[14] Additionally, despite following a rigorous qualitative analysis process, it is still possible that bias influenced the coding and thematic analysis process.

This study highlights the necessity of incorporating the thoughts, beliefs, and experiences of people with OUD into primary care addiction medicine. In the face of a worsening opioid epidemic, primary care clinicians must overcome the entrenched stigma against treating addiction.[15] We hope that health care professionals have gained insight and perspective from our patient's stories and feel inspired to provide essential care for this vulnerable patient population.

Tables and Figures

Table 1. Summary of Results of Emerging Themes

Topic domain and emerging theme		Results
Decision-making leading to treatment utilization	**Motivation source**	
	Self	22/30
	Loved ones	21/30
	Referral source	
	Friend	10/12
	Family member	2/12
Influences on treatment progress and retention	Experiences with incarceration	12/30
	Housing insecurity	11/30
	Transportation barrier	8/30
	Financial/job/insurance insecurity	8/30

Table 2. (A) Motivations Driven by Loved Ones, and (B) Self-driven Motivations

(A) Motivation – loved ones	
Participant ID	**Direct quotations**
36	*You know, it's ruined a lot of relationships with my family and my kids and like I am now getting all that back. And I don't want to lose it again.*
42	*For me to be a better mom...it's hard for me to be a good mom and I get irritable and I feel so bad because it's not their fault that mommy is like this.*
11	*I don't wanna leave a footprint in life that my children and grandchildren only know me as using and selling drugs. And I was a gang banger. I don't want that footprint in life...I'm not leaving no type of legacy behind. And I don't want to grow old by myself.*
39	I love my daughter so much. And she like turning into my mama now. She like, "dad, go get you some insurance. Lord forbid something happen to you." She know the lifestyle I was living. "If something happen to you I gotta be able to bury you."...I gotta do better...I love my baby. I love her so much...I gotta get off this. I got to. That's my motivation.
8	*My motivation is my kids...This is my motivation. Cause I don't want them to end up like me, I don't want them to be in this situation.*
(B) Motivation – self-driven	
Participant ID	**Direct quotations**
2	*I wanted to be happy. Actually know who I am, find out who I am.*
9	*Better the person that I am and to be the best me that I can be. I can't do that on drugs.*
10	*I'm scared about my health so now I just want to get my health in order. And just live, live life what I can live while I got the time I got left with God.*
27	*My family. I don't wanna die. Um, my girlfriend. I don't wanna go back to prison. I wanna have a family someday...I got a lot of goals and dreams, success-wise too.*
1	*To get my freedom back...when someone is on this stuff, heroin, you have no life. You have no control of your life no more, it's taken away from you.*
36	*I mean I honestly really do like being sober...I've been in and out of jail for 14 years...addiction makes you do things that you normally wouldn't do...I did end up going to prison just for a very short amount of time...I never want to see the inside of that place again.*
32	*My main motivations myself. You know, I've done it for my daughter. I've done it for my family. I've done it for everybody under the sun. And like, you know, I need to do it for myself...and it took me a long time to realize that.*
31	*Okay, first and foremost I want to do it for myself. Because I don't believe I can help my kids if I don't help myself first.*
44	*I always said the habit wasn't as bad as what everyone said it was but it clearly was. So I wait and then I have people pushing me to go. But yeah, ultimately I did it for myself.*

Table 3. Impact of Incarceration on Treatment

Experiences with incarceration	
Participant ID	**Direct quotations**
25	*I was on probation so I had to go in.*
32	*I guess the stigma for me now is not the addiction itself but being a felon... I could care less if someone viewed me as an addict. What really matters is that they view me as a felon and in society's mind when they hear that they think the worst.*
36	*Addiction makes you do things that you normally wouldn't do...that just you know puts you in the criminal justice system and it's...really hard to get out of that cycle...It's gonna be harder and harder for you to find a job… I kinda had to basically had a mess up on my probation to be able to get the opportunity to you know get a referral for treatment which I think is a really big problem.*

Table 4. Impact of Transportation Barriers on Treatment

Participant ID	Direct quotations
4	*Getting here, yeah...I live in Waukesha and I don't drive. So, the bus takes about two hours and fifteen minutes one way.*
26	*I was buying suboxone on the street...because the clinics were always far away. I didn't have a car at the time.*
27	*I don't drive so to me it was like a big pain in the ass trying to get to the closest clinic to get the suboxone I needed at the certain amount of time...to where like it was just easier like for me to get dope. Like I could get the dope dropped off, you know?*

Table 5. Patient Feedback for MAT Clinic

Participant ID	Direct quotations
10	*It's hard for me to find doctors that I feel like I can be completely honest with and open up with, you know. And let them into my life, which I feel like you need to do if you have a doctor... And it's hard for me to do that with people. So if I find a doctor that I can do that with, I tend to like to stick with them. So, I'm coming from South Milwaukee just to see that particular doctor, you know, because, you know, it's hard for me to feel comfortable enough to do that with a doctor.*
35	*Well, the doctors have a lot to do with it. You know what I mean? Their attitudes are everything.*

Abbreviation: MAT, medication-assisted treatment.

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