A Cross-Sector Approach to Removing Legal and Policy Barriers to Opioid Agonist Treatment

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The Network for Public Health Law

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EXECUTIVE SUMMARY

The opioid overdose epidemic is one of the most urgent public health issues in the United States today, killing nearly 50,000 people every year and contributing to a variety of other health complications. Opioid agonist treatment (OAT) is the provision of medications that activate the opioid receptors to prevent withdrawal and reduce cravings for opioids and is the safest and most effective treatment for people with opioid use disorders. Currently, the two medications approved for OAT are methadone and buprenorphine. Opioid agonist treatment is credited with dramatically reducing risk of opioid overdose deaths and improving other health outcomes.

Despite its demonstrated effectiveness, barriers to OAT access arise in various areas of law and policy, restricting access for many in need. The Network for Public Health Law convened the Cross-Sector Attorneys for Health, a group of more than a dozen public health attorneys seeking to bring cross-cutting areas of legal and policy expertise to address critical public health issues. The group identified the overdose crisis and OAT access as a high priority requiring immediate attention and met monthly over the past 18 months to develop the findings and recommendations in this paper. We hope advocates across different legal and policy areas will utilize it to address OAT access barriers in their areas of work.

This paper identifies barriers to OAT access and potential solutions to improve OAT uptake in eight sectors. We do not represent this document as comprehensive of all that must be done, but we do believe the barriers described are the most significant and the solutions proposed would be the most impactful. The eight sectors and recommendations are as follows:

Health Care System

- Repeal or reform the requirements for OAT access through opioid treatment programs.
- Repeal or reform the X waiver requirement for prescribing buprenorphine.
- Ensure state laws are no more strict than federal requirements.
- Remove insurance barriers to OAT.
- Expand access to and utilization of telehealth.
- Increase connection to OAT in emergency departments.
- Expand the OAT provider workforce and OAT utilization within it.
- Utilize community health workers and peers to assist with access to OAT.
- Establish medical-legal partnerships.

Criminal Legal System

- Decriminalize possession of unprescribed methadone and buprenorphine.
- Expand diversion programs to connect people to OAT.
- Require drug courts and other specialty courts to allow OAT.
- Facilitate OAT access in jails and prisons.
- Connect individuals reentering the community with OAT providers.
- Reduce returns to incarceration due to probation and parole violations.
- Provide education for legal professionals.

Family Law

- Require family courts to allow OAT access.
- Prohibit custody removals and terminations of parental rights based solely on positive drug tests for OAT.
- Increase access to family-centered OAT.

Housing

- Ease federal and state requirements to evict people for drug possession and use.
- Increase partnerships between homeless service providers and OAT programs.
- Prohibit recovery residences from excluding OAT.
- Support Housing First and permanent supportive housing approaches.
- Allow approval of opioid treatment programs without conditional use permits if emergency demonstrated.

Zoning

- Require OAT access as a component in comprehensive development plans.
- Provide for state review of opioid treatment program siting denials.
- Allow approval of opioid treatment programs without conditional use permits if emergency demonstrated.
- Ensure established law is enforced when necessary.

Transportation

- Increase mobile OAT provision.
- Improve access to non-emergency medical transportation to OAT providers.
- Reduce driver's license revocations for reasons unrelated to road safety.
- Increase public transportation options.

Education & Youth

- Reduce federal restrictions on youth methadone access.
- Expand OAT access on college and university campuses.
- Implement screening, brief intervention, and referral to treatment for youth.
- Increase research on OAT safety and efficacy in pediatric populations.

Employment

- Enforce anti-discrimination laws to prevent bars to employment.
- Expand leave allowances to access substance use disorder treatment.
- Increase use of employee assistance programs.

We hope this document will inform and inspire stakeholders to combat barriers that prevent OAT access in their various areas of legal and policy expertise. An all-hands-on-deck approach is needed to address one of the nation's most pressing public health concerns.

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INTRODUCTION

The opioid overdose epidemic is currently one of the most urgent public health issues in the United States. Opioids are a class of drugs that include heroin and some legal prescription pain medications such as oxycodone (Oxycontin™), hydrocodone (Vicodin™), codeine, morphine, and others. Deaths due to overdoses involving opioids have risen sharply over the past two decades.[1] The rate of death from any opioid-involved overdose increased fivefold from 1999 to 2018. Nearly 50,000 people died from overdose involving opioids in 2018, more than any other cause of unintentional death, including car crashes.[2] On average, 130 people die from an overdose involving opioids every day.[3] Since 2013, overdose deaths involving synthetic opioids have exploded, primarily due to fentanyl, a potent opioid that is increasingly mixed in heroin and other drugs.[4] Opioid overdose deaths are a major issue in all areas of the country, though overdose deaths rates are particularly high in rural, predominately white areas in the Midwest, and Black and Indigenous communities are experiencing more rapid rate increases than people of other races.[5]

In addition to overdose, people living with an opioid use disorder are more likely to experience comorbid health conditions, including HIV, Hepatitis C, pneumonia, and tuberculosis.[6] They are also at risk of being arrested and incarcerated due to the criminalization of nonmedical use of opioids and for offenses committed to secure access to more opioids. Incarceration is associated with increased risk of multiple health conditions and with a significantly increased risk of fatal overdose after release.[7] People living with opioid use disorders are also more likely to utilize high-cost health care delivery systems such as the emergency department and inpatient hospital stays.[8] The negative impacts associated with opioid use disorders are experienced not just by the individual, but by their loved ones, their community, and throughout society.

Opioid agonist treatment (OAT) is the safest and most effective method for treating opioid use disorders.[9] OAT is the use of medications that activate the opioid receptors to prevent withdrawal and reduce cravings for opioids. People who have an opioid use disorder can use OAT to stabilize their lives and reduce harms related to their opioid use. Currently, the federal Food and Drug Administration has approved two opioid agonists for opioid use disorder treatment: methadone and buprenorphine. Research spanning more than five decades has consistently demonstrated that these medications:

- Reduce risk of all causes of death, including overdose;
- Reduce use of other opioids;
- Decrease injection drug use;
- Reduce risk of HIV and Hepatitis C transmission;
- Reduce criminal legal system involvement;
- Improve social functioning; and
- Improve quality of life.[10]

People who use OAT are encouraged to access and are connected with other services, including counseling, but research demonstrates that quick access to medications with as few barriers as possible should be the first line of treatment.[11] Doctors treating patients with severe hypertension often supplement medications with advice to change lifestyle habits, including more exercise and better diet, but it would be considered unethical to deny the medication if the patient did not follow the doctor's advice. Similarly, patients seeking OAT should have access without being required to participate in other services, though those services are beneficial for many and should be made available for anyone who wants them.

Barriers to Opioid Agonist Treatment

Despite its overwhelming effectiveness, a multitude of structural and policy barriers prevent people with opioid use disorders from accessing OAT. In fact, fewer than half of people with opioid use disorders who enter treatment receive OAT due to stigma and structural barriers.[12] Many of these barriers stem from the purposeful design of a system that only allows access to OAT under severely restrictive circumstances. When prescribed for treating opioid use disorder, methadone and buprenorphine are subject to stricter regulations than any other medications, including opioid painkillers like oxycodone, even though methadone and oxycodone are both Schedule II controlled substances. These regulations are an outgrowth of the stigma against people with substance use disorders and severely hinder treatment access for many in need.

> Methadone is a long-acting synthetic opioid agonist. When used in proper doses, methadone relieves withdrawal, reduces opioid cravings, and blocks or reduces the effects of opioids like heroin without creating euphoria, sedation, or analgesic effects. Methadone is classified as a Schedule II controlled substance, which are drugs deemed to have medical uses but have a high potential for abuse that can lead to severe psychological or physical dependence.
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> Buprenorphine is a long-acting synthetic partial opioid agonist, meaning it does not activate opioid receptors as much as full agonists like methadone. The effects of buprenorphine reach a ceiling, and increasing doses will not produce increasing euphoric or pain-relieving effects. Its limited activation of opioid receptors also means that non-prescription buprenorphine use is less likely than methadone to result in fatal overdose. Like methadone, buprenorphine blocks opioids like heroin from producing their effects. Due to its ceiling impact, buprenorphine is generally most appropriate for patients with less severe opioid use disorders, whereas methadone may be appropriate for all patients with opioid use disorders. Buprenorphine is classified as a Schedule III controlled substance, which are drugs deemed to have medical uses but have a potential for abuse that can lead to moderate or low physical dependence or high psychological dependence.

Methadone is only available through opioid treatment programs that are specially registered with the Drug Enforcement Administration (DEA).[13] Individuals must satisfy certain criteria to be admitted, and they must comply with strict requirements. Among the most onerous is the need for most patients to come to the opioid treatment program every day to take the methadone under clinical supervision. Subsequent sections of this document examine how other opioid treatment program requirements pose barriers or are exacerbated by laws and policies in other areas.

Buprenorphine may be accessed through an opioid treatment provider with fewer restrictions than methadone or through a physician or certain other health professionals who have obtained a waiver from the DEA to prescribe it from their office (commonly called the X waiver or a DATA 2000 waiver).[14] To obtain the X waiver, the physician or other health professional must meet certain qualifications, generally requiring completion of a minimum number of hours of specialized training. Even when the physician or health professional obtains an X waiver, they are generally limited to providing buprenorphine to only 30 patients in the first year, then 100 patients after at least one year, and 275 patients after at least one year of having a waiver to treat 100 patients.[15] Some providers can prescribe to 100 patients in their first year after obtaining the X waiver if they satisfy certain conditions, but they are still ultimately limited by patient caps. Consequently, the regulatory structures required to provide and access methadone and buprenorphine severely limit their availability for people with opioid use disorders.

This document highlights various policy and legal barriers to OAT access. Brief descriptions of the barriers are followed by policy or legal solutions to improve access. The intent of this document is to identify areas of overlap for professionals who may be experts in areas other than OAT but who want to improve public health and reduce the individual and societal burdens of opioid use disorder.

After a brief description of the Cross-Sector Attorneys for Public Health collaboration and the process it undertook, this document addresses barriers to OAT categorized in eight areas. We emphasize utilizing a cross-sector approach to improve OAT access. Barriers and/or solutions in one area may impact other areas, areas not included in this paper, and other public health issues. Advocates should be mindful of how their work may interface with issues faced in other sectors and should make an effort to work across sectors and expand partnerships to address these issues in a coordinated, impactful manner. The eight areas highlighted in the paper are:

- Health Care System;
- Criminal Legal System;
- Family Law;
- Housing;
- Zoning;
- Transportation;
- Education & Youth; and
- Employment.

Stigmatization of Substance Use Disorders

We note that there are many cross-cutting issues that do not fit neatly into one of our delineated areas but that are nonetheless important to highlight. First, many of the barriers addressed and attitudes that inform policies towards OAT arose out of longstanding stigma associated with drug use and people with substance use disorders. The criminalization and demonization of people who use drugs and of entire communities in the name of the war on drugs has resulted in decades of laws, policies, and perceptions that have justified dehumanizing treatment and denials of access to basic necessities, including treatment for the very condition for which people are being shunned. Many of these hostile views reinforce racial and socioeconomic inequalities, with Black, brown, and Indigenous communities bearing the brunt of the negative consequences. Stigma against drug use extends to OAT, which many people see as simply replacing one drug with another. Advocacy should keep this stigma in mind and incorporate effective means of education to change the attitudes that underly policy and prevent new ways of perpetuating stigma.

Social and Structural Determinants of Health

Additionally, whether a person develops a substance use disorder, including opioid use disorder, and whether a person will have access to effective treatment is inextricably linked to social and structural determinants of health, factors about where a person lives and works and what communities they belong to that can directly impact their health status. Inequities created and reinforced through prejudicial distribution of money, power, and resources manifest through disparities in access to affordable housing, education, economic opportunity, nutritional food, and health and social services. In turn, these disparities negatively impact individual and community health through a variety of means, including through increased risk of medical problems and lack of access to health services. Disparities tend to be most pronounced in communities of color and in non-urban areas, signifying that special attention should be paid to ensure the health needs of these communities are addressed.

One determinant of health that is particularly important in the context of substance use disorders is having an adverse childhood experience, a stressful or traumatic event experienced during childhood. The correlation between having one or more adverse childhood experiences and developing health conditions is well-established. Adverse childhood experiences are associated with use of drugs at an earlier age and a higher risk of developing a substance use disorder throughout a lifetime.[16] Research also suggests a correlation between a high number of adverse childhood experiences and an increased likelihood of relapse during or following substance use disorder treatment.[17] However, a recent study among 87 adult patients accessing OAT and counseling showed that the likelihood of relapse declined with each treatment, suggesting OAT may be an effective way to address some of the health effects of adverse childhood experiences.[18] To truly address the public health crisis associated with opioid use, we must collectively address social and structural determinants of health, including adverse childhood experiences, that increase risk of developing a substance use disorder and simultaneously restrict access for disadvantaged populations.

COVID-19 and Access to Opioid Agonist Treatment

The COVID-19 pandemic has resulted in enormous changes to almost every aspect of life, including access to substance use disorder treatment. Fatal overdoses are rising sharply during the pandemic. Federal and state governments have responded to the needs of the public health emergency by increasing access to opioid agonist treatment in several temporary ways, including:

- Allowing new patients to begin buprenorphine treatment without an in-person examination;
- Allowing existing methadone and buprenorphine patients to meet with their provider using telehealth;
- Increasing take-home medication allowances;
- Allowing for delivery of medication to isolated patients' residences; and
- Allowing opioid treatment providers to use the same off-site mobile location to provide take-home medication without separately registering that location with the DEA.

We highlight these changes in the following sections as they relate to barriers and solutions that we recommend for permanently increasing opioid agonist treatment access.

Cross-Sector Information Sharing

Finally, limited sharing of information across different sectors may serve as a barrier to ensuring streamlined access to health services, including OAT. Federal and state laws govern the sharing of data to protect individuals' privacy; however, misinformation about what laws actually require may limit the sharing of data unnecessarily in some cases. Although education to improve data sharing when appropriate to streamline access to care while protecting privacy should be a priority, specific recommendations in this area are outside the scope of this document.

Advocates can use this document to educate themselves on the various barriers to OAT and determine which solutions to prioritize given their diverse expertise in the areas covered. It will take the dedication of stakeholders with a variety of experiences, including those directly impacted by opioid use disorder, to effectively address all the barriers that prevent OAT access. Nothing less is needed to address one of the nation's most pressing public health concerns.

Cross-Sector Attorneys for Health: The role of a cross-sector approach

Cross-sector collaboration is paramount to tackling the major public health issues of today. In 2018, the Network for Public Health Law convened a group of more than a dozen attorneys working in different sectors, such as transportation, urban planning, mental health, drug policy, and civil rights. The collaborative sought to bring cross-cutting areas of legal and policy expertise to identify opportunities and challenges for improving health and to address critical public health issues.

Public health issues traditionally are addressed within silos such as health institutions, courts, schools, social services, and state and local health departments. The Cross-Sector Attorneys for Health collaborative created a forum where attorneys across sectors could come together to discuss public health issues from varied legal perspectives. Through the course of our collaboration we realized that we are better able to create workable solutions when attorneys from different sectors partner with one another.

For example, a community's zoning policy may impose structural constraints that affect strategies to address a wide range of public health issues: the placement of substance use disorder treatment centers (opioid addiction), access to parks and other recreational facilities (obesity), exposure to ambient pollutants (asthma), or the number of shelter beds (domestic violence, homelessness). By having land-use attorneys partner with attorneys with expertise in other areas, we can see issues from a range of perspectives and are better able to create workable solutions. Public health attorneys also can partner with advocates to improve the effectiveness of a community campaign and to ensure that proposed legal and policy solutions are tailored to the community's actual needs.

In 2019, the Cross-Sector Attorneys for Health collaborative chose to focus on the topic of removing legal and policy barriers to opioid agonist treatment, recognizing that this public health issue is both significant and affected in some way by many different sectors. The group recognized that attorneys in each of these sectors can play an important role in improving access to opioid agonist treatment and reducing stigma associated with drug use. Over the past 18 months, the group met monthly to identify and propose solutions for the broad range of legal barriers that could interfere with effective access to opioid agonist treatment, with each attorney bringing to bear the expertise and knowledge from his or her own area of practice. The result of our collaboration is this white paper. While our menu of solutions is not comprehensive, it represents a multifaceted approach to the problem, with a particular focus on health equity and social justice. The paper highlights proposals that have the greatest potential for across-the-board success in increasing access to effective treatment for those that want and need it.

In the future, the collaborative will continue to meet to share expertise and develop resources on other public health law issues.

Cross-sector collaboration is paramount to tackling the major public health issues of today. Cross-Sector Attorneys for Health is a cross-disciplinary group of attorneys that seeks to bring cross-cutting areas of legal and policy expertise to identify opportunities and challenges for improving health.

Section 1. Health Care System

People living with substance use needs often encounter barriers to treatment that are perpetuated by the health care system itself. This is particularly true for people trying to access OAT because it is far more heavily regulated than medications and treatments for most other health conditions. The opioid treatment program (OTP) and X waiver requirements are a result of the stigma directed at people with substance use disorders by society, including by health care providers.[19] These regulatory structures significantly restrict access to OAT by those who could benefit from it and further perpetuate stigma.

In addition, people with substance use needs experience other common barriers to the health care system, including shortage of providers, lack of flexible options for seeing providers, care that is not tailored to specific cultural needs, insurance restrictions, and affordability concerns. This section addresses some of the most pertinent barriers to OAT access embedded in the health care system and offers solutions for each.

Recommendation 1.1—Repeal or reform the requirements for OAT access through opioid treatment programs.

People who may benefit from methadone can only do so through DEA-registered OTPs and must comply with strict requirements. These include coming daily to the OTP to receive a dose of medication under supervision for new patients, participating in counseling services, and submitting to random drug tests. Noncompliance can result in dismissal from treatment. Patients can only start to "earn" take-home doses after three months of daily attendance, gradually increasing the amount of take-home medication allowance to a maximum of one month after two years of continuous treatment.[20] Because OTPs generally exist outside of mainstream healthcare systems, their services often are not covered by insurance, meaning many individuals who access methadone have to pay for it out of their pocket.

Of course, these are only issues for people in areas where an OTP exists. Some regions of the country do not have an OTP or existing OTPs are far from where many in need reside. For example, as of the time of this writing, not a single OTP operates in Wyoming, and only one exists in South Dakota.[21] The OTP structure limits access by only allowing specialized, often non-mainstream health providers to provide methadone and to do so in a highly regulated, stigmatizing way that presents often insurmountable barriers for people in dire need.

The simplest way to expand access to methadone would be to eliminate the requirements to receive it through an OTP. Standing OTPs could continue to operate but ending the requirement that people receive services through one of these establishments would allow all providers with current DEA-registration for prescribing controlled substances to prescribe methadone. This could vastly increase access points for methadone, especially in areas where there are no or few OTPs. It would also allow individuals to fill a prescription at community pharmacies, which tend to be more accessible than OTPs.[22] Eliminating the OTP requirements would mean individuals do not need to come daily to receive their dose of medication. Instead, they could receive a prescription and use methadone like any other prescription medication at home, reducing transportation issues and interference with employment and education. Allowing access through mainstream health care providers would also likely lead to an increase in private insurance coverage of these services, alleviating financial burdens to patients. Finally, it would allow people more freedom to choose providers who can accommodate their counseling needs. Although counseling is beneficial for many, providing medication alone results in significant health benefits, and requirements to attend counseling deter some from accessing treatment.[23]

Short of repealing the requirements to receive methadone through an OTP, several steps could be taken to increase access through established OTPs. The Substance Abuse and Mental Health Services Administration (SAMHSA) can relax regulations that restrict take-home medications, allowing people to attend in-person less frequently. In fact, SAMHSA has temporarily done this in response to the COVID-19 public health emergency and the need to limit in-person congregations. The DEA and SAMHSA could also update regulations to allow community pharmacies to dispense methadone. Many people would have an easier time accessing OAT through a pharmacy than through an OTP, because pharmacies tend to be more integrated into communities.

During the COVID-19 pandemic, the Substance Abuse and Mental Health Administration (SAMHSA) issued emergency authorizations allowing opioid treatment providers to dispense up to 28 days of medication to patients it considers "stable" and up to 14 days' worth for patients considered "less stable."[24] The agency could make these changes permanent, ensuring increased access to take-home medications after the pandemic ends. The same logic behind increasing take-home medication allowances during the pandemic also supports allowing people to obtain their medication from a community pharmacy. In-person contact is reduced when people do not need to congregate at the same time at an opiod treatment provider, and travel distance to a pharmacy is likely shorter than to an opioid treatment provider, which is important during the enforcement of stay-at-home orders.

Recommendation 1.2—Repeal or reform the X waiver requirement for prescribing buprenorphine.

Physicians and certain other health professionals who have completed the required training to obtain an X waiver can prescribe buprenorphine for treating opioid use disorder outside of an OTP, but they are restricted to serving only a limited number of patients. The X waiver is an unnecessary burden that stigmatizes OAT and limits the number of professionals able to provide it. Providers who treat other health conditions are not subject to patient limits, and no other medication requires a special waiver.

The tight restrictions that the X waiver requirements impose on buprenorphine reflect an exaggerated fear of diversion that further drives stigma. SAMHSA has admitted that diversion and adverse clinical events associated with the X waiver have been minimal, while the initial 30-patient limit has contributed to the low number of physicians prescribing buprenorphine.[25] Recognizing that the patient cap limits access, SAMHSA raised the limit in 2016 to 275 patients for X-waivered providers who have been authorized to provide to 100 patients for at least one year. While a positive step, the cap still limits access and the X waiver requirements deter new providers from prescribing buprenorphine.

The Office of the Inspector General for the Department of Health and Human Services recently found that although the number of X-waivered providers has greatly increased in the past five years, about two-thirds of counties either have low or no patient capacity to provide buprenorphine, including more than half of counties identified to have high treatment needs.[26] The report also found that nearly three quarters of X-waivered providers can only serve 30 patients. Unsurprisingly, access is more limited in rural areas. Even where providers exist, real-world access may lag behind potential capacity. Studies have shown that many X-waivered providers do not prescribe to their patient limit for a variety of reasons, including stigma, insurance obstacles, and lack of support.[27]

Congress should eliminate the X waiver requirements and allow health providers to prescribe buprenorphine outside of OTPs without having to receive additional training. Providers should not have a limit to how many patients they can serve. Removing the X waiver will help to reduce stigma and potentially increase access to providers, as all otherwise qualified providers would be able to prescribe the medication. Educational efforts should continue to increase the number of providers actually prescribing buprenorphine.

Short of repealing the X waiver requirements, the federal government can take several steps to reform the requirements and increase access to buprenorphine. Congress could eliminate the patient caps to allow all X-waivered providers to provide to as many patients as they are able. Congress or SAMHSA through regulation could increase the caps for X-waivered providers, no matter how long they have been waivered.

While the X waiver requirements remain, federal agencies can allocate resources to increase the number of X-waivered providers, particularly in rural and other underserved areas, and to increase utilization of buprenorphine for already X-waivered providers. This may require addressing other barriers to utilization, including reimbursement and other insurance barriers. Targeting efforts to high need, low capacity areas may yield high returns in terms of access.

Recommendation 1.3—Ensure state laws are no more strict than federal requirements.

Many states have statutes and/or regulations that restrict access to OAT beyond what federal law requires. These can come in a variety of barriers, including requiring adults who seek OAT to experience multiple documented failures at detoxification treatment, increasing the minimum amount of documented time demonstrating addiction, limiting what type of facilities can become OTPs, establishing burdensome OTP application requirements, and capping the number of OTP providers that can operate in the state.[28] States could eliminate any additional barriers to OAT access by reforming statutes and regulations to be uniform with, and not go beyond, the requirements of federal law. California recently finalized new regulations removing state-imposed barriers that limited OTP access beyond what is required by federal regulations.[29]

During the COVID-19 pandemic, states should fully adopt guidance from the Substance Abuse and Mental Health Administration (SAMHSA) and the DEA allowing increased use of take-home medication. In Ohio, the state has capped take-home methadone allowances to 14 days, despite guidance from SAMHSA authorizing up to 28 days' worth for patients deemed "stable."[30] Policies like this that unnecessarily restrict access could be reformed to promote safety and access to medications during the public health emergency.

Recommendation 1.4—Remove insurance barriers to OAT.

Private and public health insurance plans vary in the way they treat OAT medications, including whether and what medications are covered and on what cost-sharing tier. If OAT is not covered, or covered but requires significant out-of-pocket costs, utilization will be limited due to affordability.Further, insurers may require prior authorization for beneficiaries to begin OAT. Insurers use prior authorization requirements in an effort to encourage lower-cost options before more expensive options are used. However, these requirements often delay access to treatment and result in patients falling out of care because of withdrawal from treatment or relapse.[31] The American Medical Association has called for the elimination of prior authorization requirements for OAT, and some major insurers have announced plans to eliminate prior authorization requirements for OAT.[32] In addition, some states have negotiated with private insurers to reduce prior authorizations. However, there remain insurers and states that still require prior authorization before OAT prescription.[33]

States can enact legislation that requires private and public insurance to cover OAT and to do so on the lowest cost-sharing tier. States could also use regulatory action to ensure that their Medicaid programs provide coverage for these medications. Further, state legislation can prohibit private and public health insurers from requiring prior authorizations before covering OAT. When a person is ready to access treatment, it is important that insurance does not impose any barriers that would delay or deny treatment.

As of April 2020, 17 states have enacted laws limiting state-regulated commercial health insurance plans from imposing prior authorizations on opioid agonist treatment, and 13 states and the District of Columbia limit Medicaid from doing so.[34]

Recommendation 1.5—Expand access to and utilization of telehealth.

Telehealth refers to the use of technology to support clinical health care over distances. Technologies used include videoconferencing, telephone, and store-and-forward imaging, which allows for the electronic transmission of medical information via secure email connection. Telehealth represents an important opportunity to increase access to individuals who have difficulty with transportation or otherwise attending in-person appointments, including many who live in rural or provider-shortage areas. Telehealth can be used to increase access to OAT, and the recent COVID-19 pandemic has further highlighted its potential value.

In general, federal law requires health care providers to conduct an in-person medical evaluation prior to an initial prescription for a controlled substance.[35] Due to social distancing requirements of COVID-19, the DEA and SAMHSA have waived this in-person requirement for new buprenorphine patients, allowing them to begin treatment after consultation with a provider by video teleconference or telephone.[36] Waiving the in-person requirement has the possibility to vastly increase access in underserved areas, as people who live there can now receive treatment through providers who do not provide in-person services near them. However, SAMHSA has clarified that new methadone patients still need to complete an in-person examination, putting themselves and providers at risk of COVID-19 transmission. The agency's rationale is that that patients cannot receive escalating doses of methadone for induction as take-home medication, because it may result in people being given "subtherapeutic doses" for an extended period.[37] However, SAMHSA could use its emergency powers to waive this requirement as it has done with buprenorphine requirements, allowing patients to begin methadone treatment without an in-person examination. SAMHSA has encouraged OAT providers to use telehealth for care with established methadone and buprenorphine patients.[38]

The temporary changes made to ensure access to opioid agonist treatment during the COVID-19 pandemic could be made permanent. The allowance to use telehealth more widely has resulted in major increases in access to opioid agonist treatment, especially for buprenorphine. To restrict that access after the pandemic ends would be counterproductive and unethical. In addition, the in-person examination requirement for methadone could be waived, just as it has been for buprenorphine. The rationale to limit in-person contact applies to people who would benefit from methadone as well, and the Substance Abuse and Mental Health Administration has the authority to make this possible.

States should follow the federal government's lead and reduce statutory and regulatory barriers to OAT and other health services via telehealth during the pandemic and beyond. States should also make permanent any necessary changes to allow reimbursement for telehealth services through Medicaid and Medicare programs. Federal and state governments should also work together to craft practical, lasting solutions to ensure the privacy and security of personal health information and to address health care provider licensure when telehealth arrangements would cross state lines.

To truly make telehealth accessible, federal and state governments should ensure that low-income communities have access to technology that will make telehealth possible. This can be supported through subsidies for mobile devices and broadband internet infrastructure and services. Agencies should ramp up education efforts for existing programs that provide discounted access, including the Lifeline program administered by the Federal Communications Commission and the Distance Learning and Telemedicine grant program administered by the Department of Agriculture.[39]

Recommendation 1.6—Increase connection to OAT in emergency departments.

People living with opioid use disorders (OUDs) often receive emergency department services due to overdose or other acute health conditions related to their use. However, very few patients presenting in emergency departments with symptoms of OUDs are connected with substance use disorder (SUD) services, including OAT access. A 2018 study of Massachusetts emergency departments showed that between 2012 and 2014, only 13 percent of patients who overdosed and were revived by emergency medical services or in an emergency department received buprenorphine in the 12 months after a non-fatal overdose.[40] This occurs despite research that offering buprenorphine initiation to patients presenting in emergency departments has been shown to increase treatment engagement and reduce self-reported illicit opioid use and inpatient SUD treatment.[41] The missed connection to OAT can precede tragedy: more than 5 percent of patients treated in a Massachusetts emergency department for an opioid overdose between 2011 and 2015 died within a year of that treatment.[42]

In response, many jurisdictions are requiring or encouraging emergency departments to provide connection to OAT and other services for people who present with opioid-related harm. Policymakers should support these efforts through increased funding and by removing any barriers to implementation, including assuring adequate reimbursement for rendering these services in emergency departments.

Massachusetts enacted a law that requires emergency departments to have the capacity to initiate opioid agonist treatment after treating an opioid-related overdose and connect the patient to continuing care prior to discharge.[43] In California, the CA Bridge initiative seeks to make buprenorphine accessible in emergency departments and all other hospital departments across the state.[44]

Recommendation 1.7—Expand the OAT provider workforce and OAT utilization within it.

There are far too few providers available to prescribe OAT, resulting in a gap between those in need and access. The recommendations described above concerning reforms to the OTP and X waiver requirements (1.1 and 1.2) would increase the pool of available providers, but further outreach and education are needed to increase OAT utilization in all health care settings.

Although patients may seek help from a primary care doctor rather than an addiction specialist, many primary care physicians lack addiction training and do not feel qualified to provide or even begin treatment, even if they would like to.[45] Equally problematic, some studies have found that only about one-third of X-waivered providers surveyed prescribe buprenorphine.[46] There are several reasons for this reluctance. Provider stigma surrounding drug use and addiction, to which the X waiver requirement itself may contribute, deters providers from prescribing buprenorphine.[47] Payment issues are another concern, including whether the provider will encounter insurance barriers like prior authorization requirements (see Recommendation 1.4).[48] Providers also tend to be concerned with inadequate clinic space, limited time, and not enough support staff.[49]

Stigma can be reduced in part through widespread education and exposure to SUD issues for populations that may not be familiar with these disorders, including medical students and students in other health-related professions. Medical, nursing, and physician assistant schools should integrate addiction medicine into their curricula and increase the number of fellowships and residencies that specialize in addiction medicine. Every new graduate should have the basic training needed to identify a potential SUD and know how to respond to a patient that presents SUD symptoms. Policymakers can support these goals through increased funding or educational mandates.

Educating primary care and emergency department doctors and staff members about appropriate SUD services, including OAT, is critical. Hospitals and clinics should make it standard practice for their providers to obtain X waivers and compensate them for doing so. Primary care clinics and emergency departments in particular should encourage and create incentives for their staff to obtain the certification, and further provide the administrative support to actively prescribe buprenorphine. Federal and state policymakers can encourage providers to obtain X waivers by allocating funding and directing agencies to provide education to potential providers.

The University of Pennsylvania offered to pay for online X-waiver training for its physicians and sent emails encouraging completion. As of early 2019, roughly 75 percent of full-time emergency staff at Penn had obtained the X waiver.[50]

Congress and state governments could also financially support providers willing to practice addiction medicine. A loan forgiveness program, for example, in exchange for a period of this specialized service, could inspire a new generation to accept the challenge of providing SUD services, including OAT. The National Health Service Corps offers the Substance Use Disorder Workforce Loan Repayment Program for health professionals with student loans who work in the SUD field.[51] Innovative programs like this should be expanded and replicated.

Recommendation 1.8—Utilize community health workers and peers to assist with access to OAT.

Many people with SUD have complex physical and mental health needs and lack medical insurance, stable housing, and family support. These factors can dramatically reduce patients' abilities to attend appointments, make pharmacy visits, and maintain a care regimen, including medication and OAT adherence. Community health workers (CHWs) are well-connected community members, often with lived experience with SUD or other health conditions themselves, who can link people with SUD needs with appropriate health and social services and greatly enhance their continuity of care.

Despite evidence that CHWs can improve health conditions and improve patient autonomy for many health conditions, CHWs are not generally paid for by mainstream healthcare funding streams and tend to rely on a patchwork of funding sources.[52] Some healthcare providers have partnered with health insurance entities to "bundle" care. This way of paying for services gives the provider a lump sum of money to improve care, some of which can be used to employ CHWs. Other states have provided for Medicaid reimbursement of peer services, which could serve as a sustainable source of funding for CHWs.[53]

State governments and insurance companies should incentivize utilization of CHWs and peers to facilitate access to health services, including OAT, for vulnerable populations. This could be done through payment models that allow providers spending flexibility or through direct reimbursement mechanisms for CHW and peer services. Investing in these services will increase utilization and continuity of care for populations with serious health needs, leading to better health and economic outcomes.

Recommendation 1.9—Establish medical-legal partnerships.

Health providers have realized that many of the people who come to them for services are dealing with social issues that negatively impact their health but are outside the provider's ability to intervene. The person's health needs may result from other social determinants of health, and the provider is often only able to help address the medical manifestations of the health-harming social needs of that individual. Frustrated with treating the aftermath of these issues, creative health providers have partnered with civil legal service providers to form medical-legal partnerships (MLPs). An MLP "is a collaborative intervention that embeds civil legal aid professionals in health care settings to address seemingly intractable social problems that contribute to poor health outcomes and health disparities."[54]

MLPs can help to uncover underlying issues that contribute to adverse health outcomes, including lack of housing, access to food, and discrimination. For people who benefit from OAT, MLPs can help to ensure that they are not discriminated against in housing, employment, or otherwise. Some MLPs also confront criminal issues, including outstanding charges related to an individual's SUD with the intent to address medical, mental health, and social needs and reduce criminal legal system involvement.

Policymakers should support and fund the formation of MLPs. Health insurance, hospitals, and civil legal service providers should collaborate to form MLPs to improve the health of their populations and ultimately reduce health care costs.[55]

Section 2. Criminal Legal System

Many people with SUDs have been involved in the criminal legal system, largely due to increased enforcement of laws prohibiting drug possession (particularly in communities of color) and behaviors that some people undertake to support an addiction. Nearly two-thirds of incarcerated people have a diagnosable SUD.[56] Involvement in the criminal legal system is associated with negative health outcomes, both for the individual and their family and community.[57] It is also the strongest predictor of whether an individual will have subsequent involvement with the criminal legal system, highlighting why it is important to prevent initial involvement.[58] Unfortunately, the criminal legal system has taken on the role of intervenor for many people living with substance use needs.

This is worrisome given the system's explicit focus on punishment and often hostile views of people with SUDs and OAT, despite evidence that OAT reduces further involvement with the criminal legal system.[59] Many people with SUDs who enter the criminal legal system are not connected with treatment at all or are not afforded access to OAT.[60] Below we examine barriers that present at various levels of the criminal legal system and offer solutions to address them and link people to OAT.

Recommendation 2.1—Decriminalize possession of unprescribed methadone and buprenorphine.

As this paper highlights, there are numerous barriers that make access to OAT extremely difficult for many. Because of these barriers, some people buy the medications on the street instead of going through the sanctioned channels to receive methadone or buprenorphine. Doing so is illegal and can result in arrest and a charge of illicit drug possession. However, research demonstrates that most people who obtain methadone or buprenorphine without a prescription do so in an attempt to treat their own OUD, not for pleasure or resale.[61] Instead of criminalizing people for self-medicating when legal access is so restricted, policymakers could decrease the barriers that make it so difficult to access OAT in the first place. Arresting and prosecuting people for unprescribed methadone or buprenorphine possession punishes them for trying to address their health needs and disrupts any stability they gained while using the medications.

Recommendation 2.2—Expand diversion programs to connect people with OAT.

An encounter with law enforcement presents an opportunity to divert a person with substance use needs away from incarceration and prosecution and towards services more suited to address their underlying health issues. The goal should be to divert people out of the criminal legal system at the earliest opportunity, ideally prior to arrest or booking. Unfortunately, diversion programs still tend to rely on the criminal legal system as the point of access to health services. Accordingly, these programs should serve as an adjunct to expansion of mobile health services and other points of access in the community that are mentioned elsewhere in this paper. Further, funding for these programs should primarily or entirely be allocated to service providers, not law enforcement.

The Law Enforcement Assisted Diversion program that began in Seattle diverts people arrested for low-level drug and sex work offenses to health and social services, including opioid agonist treatment prior to booking them into jail. The program has resulted in significant reductions in criminal legal system involvement among participants and associated costs while improving participant social outcomes.[62]

Recommendation 2.3—Require drug courts and other specialty courts to allow OAT.

Research published in 2012 found that less than half of drug courts surveyed nationwide made OAT available to individuals going through the drug court program.[63] Of those that did, methadone was much less likely to be made available than buprenorphine. The number of drug courts allowing OAT may have increased after the federal Bureau of Justice Assistance stopped providing funds to drug courts that deny access to federally approved medications for addiction treatment in 2015.[64] However, many drug courts and specialty courts (courts designed to address underlying social problems or for specific populations, such as veterans) across the country still deny access to OAT for people in their programs, including people who were on methadone or buprenorphine prior to entering a program.

Denying OAT to people in drug and specialty court programs runs counter to the evidence of the health benefits of OAT, the advice of drug courts' own professional organization,[65] and likely violates disability laws.[66] Drug and specialty courts should remove any bans on OAT and facilitate access for any individual who may benefit. States can ensure this by enacting legislation requiring access to OAT in all courts. Further, defense and civil rights attorneys should work together to identify when denials to OAT access occur and challenge them as violating state and federal disability laws.

Recommendation 2.4—Facilitate OAT access in jails and prisons.

Whereas OAT access in drug courts is limited, access in jails and prisons is even more so. Only a handful of jails and prisons across the country allow access to OAT (except for pregnant women), even for people who had previously been on OAT prior to incarceration. The vast majority of jails and prisons have strict policies that require withdrawal from any substances, including OAT, despite evidence that providing OAT during incarceration improves health and criminal legal system outcomes.[67] Additionally, denying OAT likely violates disability laws, subjecting jails and prisons to liability.[68]

Federal and state government agencies that oversee prison systems can implement rules requiring OAT access in all facilities. Because jails are typically operated by localities, action by state oversight bodies or legislation could be the most streamlined route to ensure OAT access in jails.

A model program can be found in Rhode Island, where the state began providing opioid agonist treatment in its unified jail and prison system in 2016. This program was credited with dramatically reducing overdose deaths for people after release.[69]

Recommendation 2.5—Connect individuals reentering the community with OAT providers.

The risk of death due to overdose is up to 12 times higher for people leaving incarceration.[70] Connecting people with necessary health services upon release is crucial to improving health outcomes and reducing returns to the criminal legal system. However, coordination between jails and prisons and health providers in the community is rare and disjointed where it does occur. Streamlining connections to care is important so that people can continue on needed medications, including OAT, and address critical needs during an often-tumultuous transition.

Jails and prisons should work with incarcerated people and community providers to ensure a plan is in place for when a person is about to return to the community. These plans should consider how a person with substance use needs will access services, including OAT. State and local governments should encourage these types of programs and work with community providers to ensure immediate connection to health services, including OAT, for people leaving incarceration.

The Transitions Clinic Network is a network of primary health providers who specialize in care for people with chronic health conditions returning to the community after incarceration. People who are connected with Transitions Clinic Network programs tend to have fewer emergency department visits and hospitalizations compared to those who were not connected.[71]

Recommendation 2.6—Reduce returns to incarceration due to probation and parole violations.

Nearly half of state prison admissions nationwide are due to probation and parole violations, and nearly one quarter are due to technical violations alone.[72] A technical violation is an act deemed in violation of the terms of supervision but that does not itself constitute a crime (e.g., missing an appointment or testing positive for drugs or alcohol). Incarcerations based on probation and parole violations can take people who may have been relatively stable and return them to the chaotic environment of jail or prison, potentially disrupting any healthcare regimen they are on. Disruption of OAT, in particular, is likely because it is largely unavailable in jails and prisons. While OAT reduces risk of relapse, SUDs are chronic health conditions where relapse is common.[73] Returning someone to incarceration for a relapse disrupts connection to treatment providers and can negate positive progress made.

With the threat of COVID-19 heightened in correctional facilities, some jurisdictions are rethinking incarceration for probation and parole violations. In New York, the governor ordered the releases of more than 1,000 people incarcerated on technical violations.[74] A coalition of probation and parole chiefs issued a call for states and counties to suspend or severely limit incarcerating people for technical violations during the COVID-19 pandemic.[75]

Federal, state, and local governments could limit returns to jail or prison based on probation and parole violations, especially for technical violations where the person has not committed a new offense. Instead, individuals could be afforded additional support to address their needs and improve stability. While individual agencies could implement their own policies, legislation may be a more efficient tool to ensure all the probation agencies within a state minimize the practice of sending people back to jail or prison for violations.[76] This recommendation is especially timely given the high risk of exposure to COVID-19 in correctional facilities and the corresponding desire to diminish the prison population.

Recommendation 2.7—Provide education for legal professionals.

As with the other areas included in this paper, misinformation and stigma around OAT in the criminal legal system present a barrier to access. Judges may decide that they will not allow people in their court to use OAT. Prosecutors may argue that people using OAT are not following court orders to remain drug free. Defense attorneys may not know about OAT and how to advocate for a client that benefits or could benefit from it.

Educating legal professionals could help to reduce stigma and increase OAT utilization among people involved in the criminal legal system. Similarly, education regarding substance use disorders could help to reduce violations and returns to incarceration upon relapse, as judges and prosecutors may be more understanding that relapse is to be expected. Some organizations have provided educational materials for legal professionals. For example, The National Center for State Courts has accumulated several resources for educating judges on OAT, and the Legal Action Center has developed resources for defense attorneys.[77]

Section 3. Family Law

In addition to the criminal legal system, people with SUDs often interact with the civil legal system. In particular, people with SUDs may confront family law issues, including interpersonal violence, parental rights and custody, and child support. Decisions made in family courts can often be harmful to individuals with SUDs and to their families, especially young children who can be removed from their parent's custody.

Family court could be an access point for treatment, including OAT, to assist people in addressing their family law issues. Although many family courts around the nation are creating specialty courts that focus on addressing underlying issues, including SUDs, people with SUDs may confront new barriers to OAT access when involved in family law issues. Below, we present some barriers and solutions to improve OAT access in family courts.

Recommendation 3.1—Require family courts to allow OAT access.

Similar to criminal courts, many family courts impose prohibitions on OAT for people in their programs. This may even require people who were accessing OAT prior to their case to stop their treatment. Denying OAT to people in family court runs counter to the evidence of the health benefits of OAT, the advice of family courts' own professional organization,[78] and likely violates disability laws.[79] Family courts should remove any bans on OAT and facilitate access for any individual who may benefit. States can ensure this by enacting legislation requiring access to OAT in all courts. Further, family law and civil rights attorneys should work together to identify when denials to OAT access occur and challenge them as violating state and federal disability laws.

Recommendation 3.2—Prohibit custody removals and terminations of parental rights based solely on positive drug tests for OAT.

Family courts often use positive drug tests to support orders that remove children from a parent's custody and/or terminate parental rights, despite the absence of evidence demonstrating any causal link between parental drug use and child maltreatment.[80] Judges have ordered these consequences based on the parent's use of OAT, even when lawfully prescribed.[81] This harmful practice, which is generally based more on a positive drug test than on any demonstrated harm to the child, results in trauma to the parent and child and can precipitate negative health consequences, including increased substance use.

Family courts could ensure they do not use positive drug tests as the sole basis for custody removal or terminating parental rights, especially where the indicated substance is a legally prescribed medication for SUD. State laws could explicitly prohibit this practice and provide guidance on appropriate factors to consider for custody and parental rights determinations. Federal and state agencies could issue guidance to courts indicating that positive drug tests alone, especially for OAT, should not be used as grounds for custody removal or termination of parental rights. Federal and state attorneys general should enforce disability laws to ensure parents are not facing negative family law consequences for utilizing OAT.

Recommendation 3.3—Increase access to family-centered OAT.

The need to find childcare can be an additional barrier for parents with SUDs, which can be especially difficult when parents are required to report daily to receive methadone and are subject to additional legal requirements of family court orders. Approaches that incorporate the special needs of parents and pregnant women are needed to ensure OAT access for these people.

In a growing number of states, evidence-based child development and parenting skills education has become an important component of OAT, as a means of increasing adult engagement and preventing adverse childhood experiences in the next generation.[82] However, the U.S. Department of Health and Human Services found that only 11 states have statewide initiatives that incorporated family-centered treatment, and only six of those have family-centered OAT programs specifically for pregnant or parenting women.[83] Many of these programs are funded through grants or as pilots, though some utilize Medicaid funding.

An initiative to provide family-centered opioid agonist treatment to pregnant and parenting women in Ohio resulted in higher utilization of such treatment and lower instances of maltreatment.[84]

More states should identify providing family-centered OAT to pregnant and parenting women as a priority and develop plans for increasing access. States should seek federal approval to use Medicaid to pay for these services, including the use of flexible funding streams to pay for the services best suited for this population.

Section 4. Housing

Homelessness and lack of access to safe and stable housing is a serious and longstanding concern. On a single night in 2019, approximately 568,000 people were experiencing homelessness in the United States.[85] Both Black and Latinx people are more likely than white people to experience homelessness, reflecting longstanding structural inequalities including but not limited to criminal legal policy, housing policy, unequitable distribution of wealth, and access to prevention and treatment services.

The relationship between SUDs and housing is complex. Having an SUD is associated with loss of housing, becoming homeless at an earlier age, and being homeless for a longer period of time.[86] Lack of housing hinders an individual's ability to successfully engage in SUD treatment and makes it more difficult for a person with an SUD to maintain successful recovery. Because relapse is common, drug use can prevent an individual with an SUD from accessing or maintaining housing. Laws and policies that restrict individuals who have or have had an SUD from accessing stable housing can contribute to harm among individuals with SUD and those in recovery, further reducing economic opportunity and health outcomes in a vicious cycle.

People experiencing homelessness are particularly susceptible to harms related to substance use, including overdose and transmission of HIV and Hepatitis C virus.[87] In Boston, for example, overdose is the leading cause of death among homeless adults, with the risk of death due to overdose up to 24 times higher than the general population.[88]

Access to stable housing is an important determinant of whether people with SUDs receive evidence-based treatment, including OAT. Individuals are more likely to engage with OAT when they are stably housed, and conversely, OAT tends to increase housing stability.[89] It is critical to increase access to OAT for people with SUDs experiencing homelessness to reduce harms of use and increase likelihood of securing stable housing.

Unfortunately, many laws and policies make it harder for people with SUD and those in recovery to access stable housing. Below are some prominent barriers and solutions advocates could undertake to address them. In addition to these, people experiencing homelessness may be less likely to access OAT due to perceived or real discrimination when they interact with health care providers. Many have had previous negative experiences and may distrust providers. These barriers are not unique to people experiencing homelessness and are addressed in Section I on barriers in health care.

Recommendation 4.1—Ease federal and state requirements to evict people for drug possession and use.

Federal law requires leases for federally subsidized public housing to include clauses that state that "any drug-related criminal activity," whether or not it occurs on the premises, "shall be cause for termination of tenancy."[90] This restrictive rule extends not only to the renter but also to any member of their household, which may create a barrier not only for a person in recovery accessing public housing themselves, but also to their ability to stay with a friend or family member.[91] Some state laws also allow evictions based on leaseholder, household member, or guest activities involving drugs.[92]

For people with SUDs, including those using OAT, relapse is expected. Due to these severe housing restrictions, many people who are using OAT in public housing can be evicted and lose their stability. Importantly, because people are more likely to access OAT if they are stably housed, evicting people for using drugs will make access to OAT less likely. Although the federal government has provided some protections from evictions during the COVID-19 pandemic, these do not apply to evictions based on drug use, and people may still be evicted for this reason.[93]

Federal, state, and local restrictions on the use of drugs in public housing could be eased. As relapse is an expected part of treatment, such policies discriminate against individuals with SUD, interfere with access to OAT, and threaten to remove stability that could increase risk of harm. Further, rules leading to evictions of entire families due to one household member's drug use are inherently unfair and punish not only the person with SUD for having a health condition but their family members as well.

Recommendations 4.2—Increase partnerships between homeless service providers and OAT programs.

People experiencing homelessness may not have access to providers capable of prescribing OAT in the areas where they tend to live.[94] Homeless shelters often are located far from OTPs, and the shelters may not have relationships with OAT providers to facilitate access. Theft of belongings, including prescribed buprenorphine, is a common concern among those who are living in shelters and other unstable environments.

Homeless service providers should build relationships with OTPs and X-waivered physicians to increase access to OAT at homeless shelters and other places where people experiencing homelessness access services. Homeless service providers should adopt policies that facilitate serving people who use OAT, including providing safe storage of medications. Co-location of services at locations where people experiencing homelessness live can help build trust and increase uptake.

The DEA is currently considering a regulation that would increase the ability of OTPs to provide mobile services.[95] This could be utilized to provide mobile services at homeless shelters and other areas where people experiencing homelessness congregate, such as food banks. Such initiatives have proven successful and should be expanded, soliciting the input of people who are experiencing and who have experienced homelessness to determine which additional programs should be implemented. (Mobile services are discussed more fully in Section VI, Transportation, Recommendation 6.1.)

Mobile services have shown promise in San Francisco and King County, WA (Seattle), where opioid agonist treatment providers have established mobile medical programs specifically designed to enroll people experiencing homelessness.[96] A program in Boston reported positive results from providing opioid agonist treatment in the context of a family shelter.[97]

During the COVID-19 pandemic and future public health emergencies, OAT providers should also partner with local governments and homeless service providers to ensure access to OAT for people experiencing homelessness who are quarantined. New York City began a program to deliver methadone to patients isolated in unbooked hotel rooms.[98] Continuity of access will help ensure patients remain isolated to reduce likelihood of coronavirus transmission while maintaining their medication regimen.

Recommendation 4.3—Prohibit recovery residences from excluding OAT.

"Recovery homes" or "sober homes" are typically abstinence-based, and many enforce a strict drug-free policy that forbids residents from utilizing OAT. [99] In many circumstances, individuals are forced to choose between the potential support offered by a group of other individuals in recovery and utilizing OAT.

Use of OAT should not limit housing for people in recovery. State and federal law could prohibit recovery residences from denying people for using federally approved medication that is the gold standard of care for OUDs.

Recommendation 4.4—Support Housing First and permanent supportive housing approaches.

The Housing First model prioritizes providing permanent housing to people experiencing homelessness without first requiring that they engage in treatment or other services. It utilizes a harm-reduction approach to provide voluntary support and resources to individuals to help them reduce and manage their substance use and other health conditions. These programs have demonstrated efficacy in housing retention for people with SUDs, reduced drug use, increased utilization of services, and reduced use of emergency healthcare.[100] However, capacity of these programs remains well below that which is needed to address the need.

Federal and state governments should prioritize funding for the construction of permanent supportive housing and the creative use of available units to house people with SUDs and provide connections to OAT. Once housed and stable, people are more likely to engage in OAT and other services to further improve their health.

Section 5. Zoning

Zoning is an exercise of government police powers to protect the health, safety, and general welfare of the public. Most states delegate zoning powers to local governments such as municipalities and counties. A typical zoning ordinance divides the community into districts where uses are permitted, either by right (subject only to a building permit or certificate of occupancy) or through discretionary review (such as a conditional use permit or special use permit that requires a public hearing and case-specific conditions). Zoning regulations control how land can be used, including things like what type of building may be built (e.g., business or residence), maximum building height restrictions, and special standards for designated uses, such as hours of operation or buffer zones. Many states require communities to study their needs for various land uses and develop a comprehensive plan to address those needs, sometimes subject to state approval.

Because zoning is a function of local legislation, it typically reflects the views and policies of the voters who elected the city council or county commission. As such, zoning serves a variety of legitimate public purposes – such as protecting property values, avoiding uses that are out of scale with a neighborhood, and minimizing the adverse impacts of uses. However, zoning can also hinder access to services and resources by segregating communities and limiting where needed services can be located. Further, when a building use requires approval, community members may make strong showings of dissatisfaction that sway policymakers from approving, even if independent analyses confirm the need is great. This public sentiment is often referred to as "not in my back yard" or NIMBYism. NIMBYism may pose an even larger obstacle in rural areas where public opposition can be more vocal and alternate locations are sparser.

Zoning can be a major factor in whether individuals have access to opioid agonist treatment. If opioid treatment providers are only allowed to operate in a few zoning districts and/or districts that are far from residences and without access to public transportation, people who seek opioid agonist treatment will not have access or will strain to obtain it.

Where OTPs are subject to siting approval, community backlash in the form of NIMBY attitudes may prevent OTPs from being approved in accessible areas or at all. Community members may say that putting an OTP in their neighborhood would lower property values, but a recent study found no evidence that SUD treatment facilities, including OTPs, lower property values.[101] Here are our recommendations to remove potential zoning barriers to OAT access.

Recommendation 5.1—Require OAT access as a component in comprehensive development plans.

Many states establish statewide comprehensive planning requirements that obligate localities to create comprehensive zoning plans. This can be a tool for ensuring that localities consider local needs and plan adequate zoning for certain services. For example, California and Florida require comprehensive plans to include housing elements that assess and plan for the housing needs of everyone in the community.[102] This model could be used to ensure that localities plan for and address the communities' and regions' needs for OAT access. The state could develop standards for OAT access to provide minimum benchmarks that localities could build on.

Recommendation 5.2—Provide for state review of OTP siting denials.

Some states, such as Massachusetts and New Jersey, provide for state review or special court proceedings for projects (such as affordable housing) that are initially denied or burdened by local zoning restrictions.[103] This sends project review to an agency that considers regional or statewide considerations. This process could be utilized for OTP siting denials at the local level. A statewide agency could consider the need for OAT access in the locality or region and override the denial if necessary while attempting to address local concerns.

Recommendation 5.3—Allow approval of OTPs without conditional use permits.

States may establish statewide standards for siting facilities that override local zoning controls. One example is California's housing element law, which requires localities to establish a zone or zones where emergency homeless shelters are permitted to operate without needing to obtain conditional use or other discretionary permits.[104] States could adapt this approach to require localities to identify zoning districts where OTPs are allowed to operate without obtaining discretionary approval.

Recommendation 5.4—Ensure established law is enforced when necessary.

Because the zoning standards are adopted legislatively, courts loath to interfere with them. However, several courts have interpreted federal laws protecting the rights of people with disabilities to prohibit zoning regulations that ban or seriously restrict community placement of OTPs or require discriminatory notice requirements.[105] Advocates should be watchful for local policies that ban or severely restrict OTP siting, and where they find them, partner with attorneys to fight discriminatory policies that do not comply with established disability law.

Section 6. Transportation

Lack of access to transportation is a well-known barrier to health care access,[106] including access to SUD treatment. One study found that 20 percent of people in treatment reported difficulty getting to or from treatment as a reason for nonattendance.[107] Travel to OTPs to access OAT can also be burdensome. One study found that 26 percent of patients traveled more than 15 miles to their OTP, and six percent traveled more than 50 miles.[108] People who lived in the Southeast and Midwest and in non-urban areas were more likely to travel greater distances.

Although often overlooked, transportation policy can play a key role in helping to mitigate the crisis of opioid-related harm, particularly through improving access to treatment, employment, and other necessary services. Several transportation policies also hinder people's ability to travel to treatment. We address several major barriers and offer solutions below. In addition, options that reduce the need of people seeking OAT to travel, such as telehealth, may also help to alleviate transportation barriers. Telehealth is addressed more fully in Section I, Recommendation 1.5.

Recommendation 6.1—Increase mobile OAT provision.

Instead of requiring people to travel to treatment, an alternative is to bring treatment to where people are. Mobile OAT provision could increase access by alleviating transportation barriers. Unfortunately, policy and financial barriers prevent widespread adoption of mobile delivery methods. OTPs are required to dispense OAT through a DEA-registered brick and mortar location and typically are not allowed to use mobile sites, such as a van, to deliver OAT. Only 19 OTPs currently operate a DEA-approved mobile unit.[109]

During the COVID-19 emergency, the DEA is allowing all existing OTPs to use the same non-registered location to provide mobile take-home OAT.[110] In addition, the DEA has proposed a rule that would allow OTPs to operate mobile components without requiring separate registration, even beyond the pandemic.[111] If finalized, this regulation would allow OTPs to expand mobile OAT access, potentially reaching people who would otherwise not have access.

Federal and state governments could support expansion of mobile OAT if the rule is finalized by providing funding for new and existing OTPs to increase reach through mobile delivery, including any needed changes to make mobile OAT Medicaid reimbursable. States with statutory or regulatory barriers for provision of mobile OAT that are stricter than the federal government should act to remove these.

Buprenorphine is less strictly regulated than methadone and could be made available via mobile delivery more easily. X-waivered physicians could participate in mobile street medicine teams, partnering with other health professionals to reach high-risk populations, evaluate for OUDs, and prescribe buprenorphine. With the relaxed telehealth requirements for buprenorphine during the COVID-19 pandemic, reaching and providing mobile delivery to high-risk people is possible even when the physician is not physically present. Outreach workers could identify interested people with OUDs and use a telephone or smart device to connect them with an X-waivered physician, who can complete an evaluation and prescribe buprenorphine to new patients without the typical requirement of completing an in-person evaluation. This approach has been used to provide buprenorphine access to people experiencing homelessness during the emergency. Policymakers should strive to retain these gains in access even after the pandemic ends by making the policy changes permanent. Federal and state governments should provide street medicine and similar models of care with appropriate funding, including through Medicaid reimbursement.

Recommendation 6.2—Improve access to non-emergency medical transportation to OAT providers.

Public and private health insurers can reimburse for the expense of direct transportation to OAT treatment. For example, non-emergency medical transportation (NEMT) under Medicaid is a critical benefit for many people without transportation alternatives to access Medicaid-covered services. One survey of people who used Medicaid-funded NEMT to attend SUD, dialysis, or diabetic wound treatment found that 58 percent would be unable to reach treatment without that transportation option.[112] In addition to NEMT under Medicaid, other services, such as those provided by the Department of Veterans Affairs and paratransit provided under the Americans with Disabilities Act (ADA), offer transportation options for those who meet the qualifications.

State Medicaid programs are required to cover NEMT, but several issues may prevent its use for accessing OAT. First, if OAT is not a covered Medicaid benefit, then NEMT does not need to cover transport to those services. Second, states may request waivers to exempt them from the requirement to provide NEMT to all Medicaid beneficiaries. For example, Kentucky recently received federal approval to exempt NEMT for beneficiaries who would use it to access methadone.[113] Third, state policies and practices may limit access to NEMT even if it is a covered service. If the state is not adequately funding or coordinating transportation, it may become unavailable or so inconvenient that beneficiaries lose interest in seeking OAT. The National Council of State Legislators found in 2015 that 28 states do not coordinate transportation with their Medicaid agency at all, often leading to inefficient use of resources.[114]

To alleviate these barriers, states could ensure that OAT is a covered Medicaid service and that NEMT benefits extend to transportation to OAT services for all beneficiaries. States should also improve coordination among health agencies, public and specialized transportation providers, and other stakeholders to maximize transportation fund efficiency. Implementing technology, such as digitally integrated transportation networks that allow for simple ride scheduling and trip assignments by various stakeholders, can help to increase communication and identify and address inefficiencies.

In 2018, West Virginia increased transportation access to opioid agonist treatment for all Medicaid beneficiaries with implementation of a federal waiver that expanded Medicaid-covered substance use disorder services.[115]

Recommendation 6.3—Reduce driver's license revocations for reasons unrelated to road safety.

In much of the United States, having a driver's license and access to a car is the primary means of travel, including travel to health services. When the ability to obtain a driver's license is foreclosed, access to a wide variety of services becomes very limited. Not having a license often disconnects the only access to healthcare, SUD treatment, employment, education, and other essential services to help people gain stability.

Many states impose significant license-suspension periods on drivers who are found guilty of operating a motor vehicle with a statutorily prescribed amount of illegal drugs in their blood, regardless of whether the driver is impaired. Twelve states impose the suspension after a conviction of having any amount of illegal drug in the driver's blood.[116] These laws can and have been applied to people with legally prescribed methadone or buprenorphine in their system.[117] Convictions under these laws can result in a person losing the right to drive for extended periods of time.

Federal law also encourages states to enact and enforce laws requiring drug offender's driver's license suspensions regardless of whether the offense had anything to do with driving. States that do not enact these laws must pass a legislative resolution and gubernatorial certification of opposition or lose federal highway safety funding.[118] Eleven states and Puerto Rico have laws that comply with the federal standard.[119] Some states prohibit issuance or renewal of a driver's license to people deemed to have a SUD, even if they are not convicted of any offense.[120] Communications between the licensing authority and the driver's medical providers are then required to remove the barrier to obtaining a license.

In addition, unpaid fines and fees can prevent people from obtaining or reinstating a driver's license.[121] Criminal legal system fines and fees are of primary concern, but unpaid child support can also serve as reason for a license denial.[122] In some states, the loss of driving privileges is more likely to be debt related than driving related.[123]

States could remove barriers to obtaining and reinstating driver's licenses where driver impairment and road safety are not an issue, especially since having one can make the difference between accessing treatment or not. Revocations for convictions could be limited at least to convictions where impairment due to intoxication is proven. This may require changes to state statutes to prevent convictions and revocations based merely on presence of drugs in a person's system. States could also remove restrictions on obtaining driver's licenses due to unpaid fines and fees. These policies essentially punish low-income people and prevent them from driving to work and the necessary resources they need, including treatment, to achieve stability. When the government does suspend someone's driver's license, they should consider providing alternative means of transportation, such as vouchers to use public transit or ride-share options like Uber.

Recommendation 6.4—Increase public transportation options.

Public transit can provide a means for people to access treatment, but it is not available in most communities. Approximately 45 percent of the United States population has no access to transit whatsoever.[124] This is, in part, due to the fact that U.S. and state policies treat transit as a local affair; transit is only provided or assisted in communities that request assistance and pick up the lion's share of the risks and costs of operating the system. The result is spotty availability of transit in communities willing to bear the financial risk. Racism and other factors may play a role in suburbs not participating in a transit system, making it difficult to reach suburban facilities from an urban center.[125]

Where public transportation does exist, the time required for this option can be problematic, especially for working people. A trip that might require ten minutes by car might take an hour or more by indirect bus connections. Traveling to work and to a treatment provider may be impossible for many who rely on public transportation, especially if required to travel to an OTP daily.

Federal and state investments are needed to ensure equitable access to public transportation, especially for communities that could not bear the financial burden on their own. States, counties, and municipalities could determine and execute transportation plans to increase access across their jurisdictions, including for lower-income areas that may benefit more from increased public transit options. Governments could implement technology to provide feedback on utilization and for data analysis to determine what improvements are needed to make public transit more feasible and attractive.

Section 7. Education & Youth

OAT is an important and underutilized intervention for youth with OUDs engaged in the educational system.[126] Many young people in the U.S. start opioid use while in school: a recent analysis of opioid surveillance data found that over half of people seeking treatment for OUD initiated regular opioid use while in an educational program, most often high school or early college.[127] Characteristics of college settings – e.g., social norms, increased independence, stress, anxiety, and depression – are associated with developing an SUD.[128]

OUD impacts educational engagement and attainment. In a recent study of treatment-seeking opioid users, a majority reported that opioid use negatively impacted their education and that they prioritized drug-seeking over attendance and academic performance.[129] In addition, the study revealed that those who develop OUD attain lower levels of education than the U.S. population as a whole. This begins a downward spiral: lower educational attainment may result in jobs with low financial compensation and subpar healthcare benefits or jobs more likely to include manual labor, which are associated with increased risk of OUD and potential relapse.

As with adults, opioid agonist treatment use among youth improves outcomes and saves lives.[130] Teenagers who utilize opioid agonist treatment remain in treatment longer and engage in fewer risk behaviors like drug injection.[131] Despite this, and despite the fact that recommended treatment standards in the U.S. include providing youth with access to opioid agonist treatment, youth are less than one-tenth as likely as adults to receive such treatment.[132]

The need for increasing OAT access for youth and those in educational settings is clear, but many barriers prevent it. Prominent barriers and proposed solutions are explored below.

Recommendation 7.1—Reduce federal restrictions on youth methadone access.

Federal regulations make methadone access more restrictive for youth than for adults. According to SAMHSA regulations, youth are not permitted to access methadone unless they unsuccessfully attempt detoxification and/or drug-free treatment twice within a 12-month period.[133] This requirement is incongruous with clear evidence that methadone increases youth retention in care by nearly 70 percent, even more so than buprenorphine, and has a low incidence of side effects.[134] In addition, the regulations require adolescents obtain written parental consent for methadone treatment.[135] As a result of these obstacles, adolescents use methadone infrequently.[136]

The requirement that youth fail twice at non-OAT treatment in a 12-month period before having methadone access should be eliminated. The most effective treatment should not be withheld until other treatments are shown not to work. This puts youth at increased risk of negative consequences, including risky drug use behaviors and death due to overdose. At a minimum, SAMHSA should revise its regulations to make youth access to methadone the same as for adults. Parity would also mean eliminating the requirements to demonstrate unsuccessful attempts in detoxification and/or drug-free treatment and to obtain parental consent for youth methadone access. States should also revise their laws to allow access without these barriers, including possibly amending minor consent laws.

Recommendation 7.2—Expand OAT access on college and university campuses.

OAT access on college and university campuses is rare and not highly publicized. While colleges have housed recovery programs and dorms for some time, the vast majority are not providing OAT referrals or services.[137] Lack of accessible locations and strict OTP requirements may conflict with school schedules and pose barriers to OAT engagement for youth.

Providing OAT capacity on college and university campuses would be a meaningful way to increase access to these lifesaving medications for youth. A school's medical services could go through the steps to register as an OTP, allowing providers to dispense methadone and buprenorphine to students in need. Alternatively, the medical services could hire physicians who have obtained an X waiver to provide buprenorphine.

Private support from Transforming Youth Recovery, which has provided $1.3 million in grants to 161 colleges for such programs since 2013, could be leveraged to support such a project. Alternatively, the federal government could allocate funding to support OAT access expansion at college and universities. A school's medical program and teaching hospital could be recruited to support OAT engagement by students, increase education of medical students about OAT, and increase the number of providers eligible to prescribe OAT medications both at the university and in the community at large, by increasing the number of trained and X-waivered clinicians.

Recommendation 7.3—Implement screening, brief intervention, and referral to treatment for youth.

Screening, brief intervention, and referral to treatment (SBIRT) is a universal intervention that may lead to faster referral and treatment for SUDs, including OAT.[138] Its adoption is recommended by the American Academy of Pediatrics.[139] Youth are asked about drug use through a validated screening tool through a variety of avenues, including health centers, middle and high schools, colleges and universities, and community-based organizations. If needed, professionals follow up with youth for a structured conversation about their responses. When appropriate, these conversations are followed up with a referral to treatment.

SBIRT can be an effective way to connect youth in need with OAT. Federal and state agencies should promote adoption of SBIRT through the programs and services they offer and support. Public and private health insurance should cover SBIRT services and provide adequate reimbursement so that health professionals are incentivized to provide this service.

Recommendation 7.4—Increase research on OAT safety and efficacy in pediatric populations.

The American Academy of Pediatrics supports providing OAT to youth, and some data suggest that buprenorphine is effective in patients as young as 13.[140] Despite this, limited data on the safety and efficacy of OAT for youth is cited as one reason for low utilization among this population.[141] Federal agencies such as the National Institute on Drug Abuse and SAMHSA should allocate funding specifically to establish safety and efficacy standards and guidelines for OAT in pediatric populations. They should also support implementation research to determine how best to disseminate existing treatment models while optimally supporting prescribers in their efforts to treat adolescents with OUDs.[142]

Section 8. Employment

OAT increases the ability of individuals with OUD to gain and maintain employment, and employment can play an important role in achieving stability by providing income, social contacts, and a sense of purpose.[143] Accordingly, laws and policies should support the compatibility of OAT and employment to the maximum extent possible.

However, people who benefit or could benefit from OAT often face barriers in their employment. The strict structure of OTPs requires people to travel to the OTP to receive their dose (often daily), leaving them to choose between leaving work during a shift or skipping their dose (which in turn could lead to discontinuation of medication). Employees who use OAT may face discrimination in the workplace in a variety of forms. These and other barriers are discussed below, along with proposed solutions to alleviate these barriers.

Recommendation 8.1—Enforce anti-discrimination laws to prevent bars to employment.

The ADA protects people with disabilities from discrimination in a variety of areas, including employment, and affords applicants and employees a legal right to "reasonable accommodation."[144] These protections apply to people who are recovering from SUDs, including people who use OAT.[145] Nonetheless, employers sometimes deny employment or terminate employees based on their engagement in OAT or requests for reasonable accommodation to access OAT (e.g., adjusting work schedule to travel to an OTP during their business hours). This conduct may be unlawful, even where the position is deemed a "safety-sensitive" position, if the employer makes the negative determination based on a blanket policy instead of after conducting an individualized assessment to determine whether the OAT impairs the individual's ability to perform the job requirements.[146]

Employers often do not understand OAT or the law applicable to OAT, and the resulting stigma may lead to negative employment actions. Federal and state agencies should provide resources to educate employers about OAT and their responsibilities for applicants and employees who use OAT. The federal Equal Employment Opportunity Commission should continue to investigate complaints of discrimination against people who use OAT and enforce the law on their behalf, as should state employee protection agencies. These actions would not only support OAT engagement and employment, but also help to destigmatize OAT and addiction.

Recommendation 8.2—Expand leave allowances to access substance use disorder treatment.

Federal and state laws provide employees with paid or unpaid leave to access medical services. The federal Family and Medical Leave Act allows employees to take up to 12 weeks of unpaid leave within a 12-month period for the employee to address his or her own serious health conditions impacting job performance or duties.[147] Employees can use this benefit to access SUD treatment.[148] However, the act does not apply to all employers and employees must meet certain qualifications, including having worked for the employer for at least 12 months.

Some states have laws specifically requiring employers to provide leave to employees who voluntarily seek SUD treatment. If the employee has no accrued sick leave or expends it during leave to seek treatment, the remainder of the leave is unpaid. Many employees live paycheck to paycheck and are unable to take time off, even if that time would be used to address personal health needs.

California requires employers with 25 or more employees to provide a reasonable amount of time off to employees seeking substance use disorder treatment and allow employees to use accrued paid sick time while on leave.[149]

Employers can encourage employees with substance use needs to access treatment by offering leave, especially paid leave, to access needed services. Such leave would allow people who may benefit from OAT to access services and begin a maintenance regimen. OAT is typically used in an outpatient setting, so people who use leave for OAT access would likely not need the entire 12 weeks of leave before returning to work. States can facilitate this access by implementing or expanding leave benefits for attending SUD treatment through legislative action. Criteria should not be so strict so as to make the benefit unavailable, including reducing the amount of time required to work for the employer before qualifying.

Recommendation 8.3—Increase use of employee assistance programs.

Employee Assistance Programs (EAPs) are work-based programs that offer free, confidential assessments, short-term counseling, referrals, and follow-up services to employees struggling with personal and/or work-related problems.[150] EAPs address a wide variety of issues impacting mental and emotional well-being, including substance use needs. For an employee with substance use needs, an EAP may be a tool for connecting that person with OAT. These programs have demonstrated positive returns on investment in the form of improved work performance and employee health and well-being.[151]

Despite their benefits and the fact that most employers have them, employees do not frequently use EAPs.[152] Employees may not understand that an EAP is available to them or the benefits of accessing it, associate stigma with accessing it, or may fear negative repercussions from their employer. Employers should be educated on the benefits of EAPs for their workers and companies and promote use to employees. Managers and supervisors should clearly communicate to their supervisees that confidential EAPs are available to them and that employers are prohibited from taking negative actions against employees who access the programs. Employers should ensure that their EAPs are equipped to respond to people with substance use needs and to connect people who may benefit with OAT providers.

CONCLUSION

OAT is the most effective treatment for opioid use disorders and is credited with dramatically reducing risk of death due to opioid overdose. However, a variety of barriers arising in nearly all sectors prevent OAT access for many in need. This paper has highlighted some of the most pressing barriers in eight different policy and legal areas and offered solutions for which advocates can strive.

In particular, this paper highlighted the need for a cross-sector approach to improving access to OAT. Implementing solutions within individual sectors is not sufficient to address the complex factors limiting access to OAT. A comprehensive approach must involve voices from different sectors and experiences, including community members, advocates, policy makers, and attorneys. These partnerships can better identify common barriers to OAT and empower broad-based collaboration to improve health.

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