How Legislation Affects Substance Use Treatment: An Interview with Dr. Sophia Peng from Rush University Hospital

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The rise in fatalities resulting from excessive substance use has been well-documented by American media outlets within the past two years. Chicago is no exception to this rise in fatalities, and for the city to properly address this public health crisis, it is crucial to recognize the humanity within each of these victims and transform societal attitudes towards those with substance use disorders to be focused on compassion, rather than judgement. To gain a better understanding of this issue, I interviewed a leading member at Rush University Hospital who has been at the forefront of initiating positive change in substance use in Chicago, Dr. Sophia Peng.

Dr. Peng is an Assistant Professor of Medicine in the Hospital Medicine Division of Rush University Medical Center. She has joint appointment at Rush Substance Use Disorder Center of Excellence to improve treatment for patients with substance use disorders. Her passion for improving health outcomes stems from experience when she began practicing internal medicine in 2015 when fentanyl flooded the markets and she felt discouraged by her inability to help patients with substance use disorders. She sought training in addiction medicine and now uses these skills to train other medical learners and colleagues. She has developed an addiction curriculum at Rush's Internal Medicine Residency program and is helping Chicago community hospitals and emergency departments adopt opioid treatment practices.

Dr. Peng and I discussed the current state of care for patients with opioid use disorder that marginalizes this population, stigmatizing legislation and attitudes, and improving treatment for patients with opioid use disorder.

It is important to understand the significance of this issue as this is a health justice issue. People with substance use disorders for a long time have been overlooked. In Chicago, Black people have higher rates of opioid overdose death rates, and as Dr. Peng further elaborates on the issue, "…people who are Brown, Black suffer worse health consequences… [and] they don't really get the same standard of care treatment [as other racial groups]". Black patients with substance use disorders have the highest

health inequities of any group. Therefore, a key component of alleviating health inequities, is ensuring this marginalized population receives appropriate treatment. As Dr. Peng states, “If you want to address health disparities, you have to treat substance use disorder.”

There are various barriers to adequately treating patients with opioid use disorders, which are due to societal attitudes towards this population, legislation, and inadequate training for medical professionals. Dr. Peng explains how legislation has created a “separation between the medical community and people who use drugs” leading to a general attitude within the medical community of “we don’t deal with [people who use drugs]”. Dr. Peng refers to the Harrison Narcotics Act of 1912, which outlawed using opioids to treat opioid use disorder. However, Dr. Peng explains, “there’s been a lot of evidence-based medicine developed that shows suboxone, methadone, and Narcan can actually reduce the morbidity and mortality.” Legislation such as the Harrison Narcotics Act of 1912 and subsequent laws have made it difficult to properly treat patients with opioid use disorder, since it has only been in more recent times that appropriate treatments for opioid use disorder are being implemented in patient care.

Legislation since the Harrison Narcotics Act of 1912 has slowly developed to allow physicians and the medical community to become more involved in opioid use disorder treatment. Dr. Peng describes the Drug Addiction Treatment Act of 2000 (DATA 2000) as allowing physicians to treat patients with opioid use disorder using buprenorphine (also known as Suboxone), an opioid medication treatment. To be able to do so, physicians needed to complete an 8-hour training to receive the waiver that would qualify them to be able to use these narcotic medications. However, “it’s really hard to do an 8-hour training session…” Dr. Peng explains, “…even people who got their X waiver didn’t know how to prescribe it anyways because no one really knew how to use it”. In 2020, Congress made receiving this X waiver more accessible by eliminating the training requirement, which allows physicians to simply register for the waiver. Yet, despite this change in legislation, “not a lot of people are leaping at the opportunity to get their X waiver”. This reluctance to seek treatment options for patients with opioid use disorder demonstrates that barriers exist beyond Congressional legislation.
(UPDATE: *As of January 2023, Congress has removed the X-waiver requirement entirely meaning that all providers will have the ability to prescribe buprenorphine.*)

Dr. Peng believes physicians are not using buprenorphine to treat opioid use disorder due to the stigma created by previous legislation and the lack of training in medical institutions. Dr. Peng recalls the frustration she felt when she began practicing medicine and couldn’t help her patients with opioid use disorder, “I got zero training on [treating opioid use disorder]”. Besides the lack of training on addiction medicine, Dr. Peng also blames the stigmatizing nature of legislation related to substance use disorders: “All of the suboxone legislation actually created more stigma, because

there's this scary, mysterious drug that you need a special training and license to prescribe.” Treatment of opioid use disorders has been kept separate from the medical community, contributing to how we see and deal with people with opioid use disorders today.

Through her work on addiction medicine, Dr. Peng has developed a 1-hour training session for her colleagues and other medical professionals. The training covers proper prescription and use of suboxone. More consistent prescription of the treatment will help reduce the concerns surrounding opioid medication and encourage them to prescribe suboxone.

However, as Dr. Peng, continues to explain, the division between opioid use disorder treatment and the medical community continues to exist. Patient privacy laws for treatment of opioid use disorder with methadone have reinforced this division in terms of the medical community’s access to information from methadone clinics regarding their patients with opioid use disorder. Methadone clinics, where patients treating their opioid use disorder receive treatment, do not function as regular hospitals and pharmacies that are interconnected, as these are kept separate. Dr. Peng clarifies upon the difficulties she and the medical community experience with methadone clinics: “…unlike other hospitals and pharmacies, where I can just easily log into my computer and our electronic medical records connect, I can’t see [these] records [from methadone clinics]. I have to call the clinic between the hours of 8am to 2pm during a weekday in order to figure out what exactly they're doing… that separation has made it really difficult for us to understand their treatment process… it prevents us from partnering with that community.”

Besides this division of care created by methadone clinics, Dr. Peng also discusses their stigmatizing nature. Methadone clinics, as Dr. Peng explains, are very inaccessible: “They have extremely strict rules. You don’t show up for a few days, then they decrease your dose of methadone significantly, or if you don't show up for a certain amount of time, you have to re-enroll, and you're cut off completely. And people go into opiate withdrawal and go back to using heroin.” While methadone clinics are useful, the manner in which they operate make it difficult for patients to receive the treatment they need as patients must pick up their medication daily, and it isn’t only until years later that they may be allowed to take home more than one dose. Dr. Peng also goes on to state, “…it’s kind of stigmatizing. You have a special medical disease where you have to go somewhere, and you're not trusted to take the medication at home and get doses whereas anyone can go to the pharmacy for other medical problems and pick up medications.”

The manner in which opioid use disorders are treated by methadone clinics is vastly different to how other illnesses are treated, which makes treatment for this population more difficult, as Dr. Peng further explains, “That's a lifestyle… for example, if you have diabetes, you have to give yourself insulin, at least that's

something you can do at home… But for you to go somewhere every morning to do that. I think that's a huge commitment. And I think it makes it really difficult for people to hold jobs…" Separating methadone clinics from the medical community serves to marginalize this population of patients. This marginalization stems from ideas that opioid use and substance use are a choice and not an actual medical illness, which is not correct. On top of this, Dr. Peng elaborates, "…methadone clinics are [sparsely] located in rural places, and there's not enough of them in urban places [to cover their treatment needs]."

As we have come to understand, hospitals often miss the opportunity to effectively aid patients with substance use disorders, as these patients are often not treated with the standard of care. Instead, most emergency departments and hospitals still practice "detoxification and release". Patients may be provided with a list of treatment resources, but do not receive any form of medications to treat their opioid use disorder nor rescue medication such as Narcan to prevent opioid overdose. However, as Dr. Peng states, "…studies have shown that people who actually take that information and get treatment is extremely low. Less than 10% of patients with an overdose actually leave with Narcan in hand…" This current standard of care is not effective in ensuring that these patients receive the help they need with their opioid use disorder. Prescribing suboxone and ensuring patients are following up at these treatment centers would be more beneficial to the health of these patients, which is why it is important to reduce stigmas surrounding substance use disorders and prepare medical professionals to treat these patients through education, such as that which Rush and Dr. Peng are working to provide.

Rush's Substance Use Intervention Team (SUIT) is a consult team that consists of physicians, social workers, and peer navigators who initiate medication for treatment of opioid use disorder while patients are in the hospital and connect patients to post-discharge treatment. Dr. Peng understands that stabilization is necessary for these patients if they are to receive help with their substance use disorder. Therefore, Dr. Peng believes it is important to have patient navigators and social workers that will assist these patients and ensure they are receiving the care they need. SUIT has a "social worker that can actually help the patients [with] housing…mental health services…[and] social economic challenges". Dr. Peng works to help community hospitals in Chicago's South and West Sides to begin developing a protocol to incorporate evidence-based practices that, while not exactly like SUIT, can provide more assistance to these patients. It's about "meeting [the] hospital where [they] are", Dr. Peng explains, and helping them distribute Narcan, ensure they make appropriate referrals, and providing education about how to start medications such as Suboxone.

Dr. Peng's and Rush's work is incredibly important, as well as the work of many other community organizations involved in substance use prevention and treatment. We need to continue transforming our perceptions and treatment of people with

substance use disorders to eliminate barriers they face daily that influence their continued substance use.