Make Expectations Clear

Buprenorphine *from page 1*

exponentially, stigma keeps many people addicted to opiates away from seeking treatment, he said.

"Many of them are not heroin addicts, and they wouldn't be caught dead going to a methadone clinic," Dr. Kosten said.

And yet, the promise of an alternative has failed to take off in the United States, with only about 300,000 people receiving prescriptions for buprenorphine since its introduction in 2002 under the Drug Addiction Treatment Act as the first office-based treatment for opiate addiction.

Buprenorphine is a long-term opioid agonist that has been shown to reduce cravings and block the effects of opioids, while limiting the potential for overdose.

Addiction specialists make up almost half of the current prescribers of the drug, and many of the others who have undergone required government-sanctioned training are primary care physicians.

General psychiatrists continue to be decidedly lukewarm about the idea.

The hope was that "buprenorphine prescribing would expand to a broader population of physicians, to provide better access to a highly motivated group of patients [many of whom are addicted to prescription opiates]," said Dr. Cindy Parks Thomas, a researcher at the Brandeis University Schneider Institute for Health Policy, Waltham, Mass.

But when she and associated researchers questioned in depth 271 addiction specialists and 224 general psychiatrists in 2005 and 2006, they found that the latter group generally lacked familiarity with, and interest in, being a part of what had been conceptualized as a revolutionary shift of addiction treatment from licensed methadone clinics to office practices (Psychiatr. Serv. 2008;59:909-16).

They found that although 90% of addiction specialists were prescribing buprenorphine, less than 10% of general psychiatrists were doing the same.

About 1 in 6 non–addiction specialists reported that they had not heard of buprenorphine, and others reported barriers, including: "It does not fit in with my practice," "It would change the patient mix undesirably," and "Prescribing is too complex."

They also worried about the cost of initiating such treatment and the financial impact of the shift on their practices.

Dr. Thomas explained In a telephone interview that such concerns often are allayed in physicians who train through the Substance Abuse and Mental Health Services Administration (SAMSHA) and actually begin treating patients.

"It was curious … that in our study, so few general psychiatrists were interested, even though our sample was limited to physicians already treating drug addicted patients," she said.

Some psychiatrists, ironically, might have feared that too many patients would come to them for buprenorphine, despite limits on the number of patients that qualified physicians can treat in their practices.

"They didn't want drug-addicted patients calling their offices and sitting in their waiting rooms … next to middle-class families they were treating for anorexia," she said.

In fact, both Dr. Thomas and Dr. Kosten said patients who seek office-based treatment for opioid addiction tend to be quite different from the stereotypes of addicts overdosing in the emergency department or hanging around the parking lot of a methadone clinic, waiting for a fix.

"They say thank you, they don't steal your computers, and they want to change their lives," Dr. Kosten said.

In general, they do well with weekly, then monthly, 15-20 minute visits for renewal of their prescriptions and brief, structured therapy, much of which could be handled by "people who work a lot cheaper than we do," such as social workers, family therapists, or psychologists.

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In contrast to many psychiatric patients who struggle for years with their disorders, patients seeking office-based treatment "feel better almost immediately and in a few weeks, they feel cured," he said.

The trick is to ensure that they have the support to help them make the significant changes in friendships, jobs, and living circumstances to be able to truly shift away from an addiction lifestyle and toward focusing on long-term goals, a process that usually takes 2 years or more.

Primary care physicians have been far more interested in taking on opioid addiction in their practices than have general psychiatrists, and numerous studies have documented success in terms of patient retention and control of opioid use.

One such recent study found that a year into treatment, nearly 60% of 255 patients remained in treatment at a primary care practice, testing opioid negative (during urine screens) 65% of the time (J. Subst. Abuse Treat. 2009;37:426-30).

Dr. Kosten said primary care physicians are more accustomed to the quick-visit model for patients with chronic disease and also more interested in treating the myriad comorbidities that come with opioid addiction, among them chronic pain, hepatitis C, and HIV.

It could take some "rethinking" for general psychiatrists to catch on to the opportunity in what he predicts will be an "onslaught" of patients addicted to prescription painkillers who also might have psychiatric comorbidities.

To be sure, buprenorphine prescribing can be challenging, as Dr. Theodore V. Parran and associates learned when they began implementing such a program at St. Vincent Charity Hospital in Cleveland.

"We found out very early in the process that expectations … had to be made clear and nonnegotiable at the time of initiation of buprenorphine, Dr. Parran, an internist, said in an interview. "Otherwise, patients never did treatment and just wanted medication."

After those guidelines had been established, the program's goal of "full-out patient recovery" was met by nearly 50% of the patients—an "astonishing" success rate, he said.

Dr. Thomas noted that the government-supervised buprenorphine program also was dogged by diversion of the drug for street sales.

Bad publicity on black market sales and abuse patterns might have made some physicians even more reluctant to become involved. However, she said, when psychiatrists see a few colleagues succeeding in treating addiction from their offices, they might be more willing to sign on for a training course and give it a try.

"In a way, a rising tide lifts all boats," she said. "Every year, more physicians have applied for the waiver [that permits them to prescribe buprenorphine to patients in an office setting]."

Dr. Kosten has served as a consultant to Reckitt Benckiser Pharmaceuticals Inc., the maker of buprenorphine; Dr. Thomas said she has no disclosures; and Dr. Parran has been an organizer and presenter for the SAMHSA pain and addiction courses and is on the speakers bureau for Reckitt Benckiser. ■

By Betsy Bates. *Share your opinions at cpnews@elsevier.com.*

Program Trains Generalists in Opioid Risk Management

BY RENÉE MATTHEWS

BETHESDA, MD. — Generalist chief residents who were trained in opioid risk management in immersion programs were more confident in dealing with the risks, showed improvement in their clinical practice skills, and were better prepared and more willing to pass on their knowledge to their trainees than were those who did not receive the training, data from a small study of chief residents show.

Such programs, known as Chief Resident Immersion Training (CRIT) programs, are one way of addressing the need for better physician training in opioid risk management, Dr. Daniel P. Alford said at the annual conference of the Association for Medical Education and Research in Substance Abuse.

Dr. Alford, of Boston University, and his colleagues initially targeted generalist chief residents specializing in internal medicine, family practice, and emergency medicine because providers in those specialties are increasingly prescribing opioids for chronic pain at a time when opioid abuse is becoming a public health problem. However, the access of chief residents to training in risk management is inadequate despite screening and monitoring recommendations from professional bodies.

The researchers expanded the course content in opioid risk management in the 2007 and 2008 CRIT programs in addiction medicine to include addiction-screening tools, controlled substance agreements, and monitoring strategies such as pill counts and urine drug testing. They conducted electronic surveys of the participants about their confidence in dealing with opioid risk management as well as their clinical and teaching practices at baseline (pre-CRIT) and 6 months after they had completed the program (post-CRIT).

The 43 chief residents were from 36 residency programs. Eighty-six percent specialized in internal medicine, 9% in family medicine, and 5% in emergency medicine. All of them completed the baseline survey; 1 did not complete the 6-month follow-up, and 2 of the remaining 42 did not provide complete responses for all of the questions. The changes in confidence, clinical practices, and teaching practices were rated on a 5-point Likert scale, and a *P* value of .05 was deemed significant.

The changes in confidence from baseline to post-CRIT in identifying substance abuse in chronic pain patients and in treating high-risk patients with chronic pain were significant. Confidence in identifying abuse went from 2.8 at baseline to 3.5 at 6 months (1 = not at all, 5 = very confident) and in treating high-risk patients, it went from 2.2 to 3.7 (*P* less than .0001 for both). One CR did not complete the post-CRIT confidence questions.

Future research should focus on the impact of the CRIT program on those who are trained by the chief residents, Dr. Alford said.

He and his colleagues had no financial disclosures. The study was funded by the National Institute on Drug Abuse. ■