Physicians Sluggish to Treat With Buprenorphine

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WASHINGTON — Buprenorphine was approved for the treatment of opioid dependence in 2002, but many physicians are hesitant to prescribe it despite being licensed to do so.

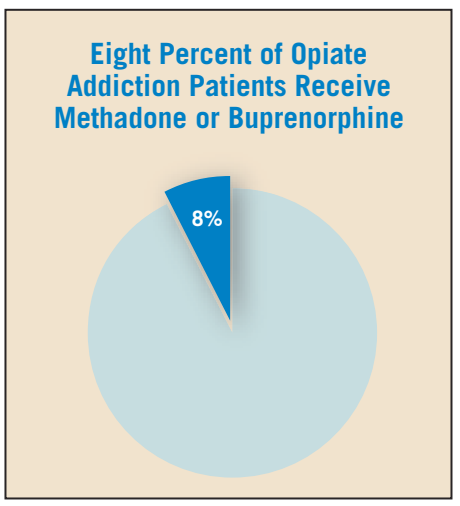
Of more than 2.5 million opiate addiction patients in the United States, only 200,000, or 8%, are receiving opiate agonist treatment with methadone or buprenorphine, David Fiellin, M.D., reported at the annual conference of the Association for Medical Education and Research in Substance Abuse.

"There is clearly a need to evaluate the provision of treatment in alternative settings, such as physician offices," said Dr. Fiellin of the department of internal medicine at Yale University, New Haven.

In 2000, Congress passed the Drug Addiction Treatment Act, which allows qualified office-based physicians to use approved narcotics for the treatment of opioid-dependent patients. Buprenorphine was approved for this purpose in 2002. Physicians can qualify to provide treatment by participating in an 8-hour training program on caring for opioid-dependent patients.

By the end of last year, approximately 65,000 physicians received the training. Of these, 4,000 notified the Substance Abuse and Mental Health Services Administration (SAMHSA) that they want registration to prescribe buprenorphine, and 3,600 physicians registered. Of these, 80% agreed to be listed on a Web site so patients and colleagues can locate them.

The gap between the number of physicians who have been trained by SAMHSA and those who are prescribing suggests a need to examine barriers to treatment. Kevin Irwin and his colleagues at Yale University conducted a study, supported in part by the Robert Wood Johnson Foundation, to assess barriers that keep physicians from incorporating buprenorphine, and Dr. Fiellin presented the results.



The investigators conducted in-depth interviews with physicians in one of four categories: general internists with no specific interest in providing buprenorphine treatment, those who received training but weren't registered with SAMHSA, those who were registered but not prescribing the drug, and those who were registered and were prescribing it.

Barriers described by physicians fell into four categories:

► **Physician discomfort.** "People do get sort of difficult," commented one physician during the interview. Several physicians expressed similar concerns about addiction patients becoming combative. Others said that they weren't in the habit of treating addictions, and that they did not think their staff members were prepared to handle such patients.

► **Medical marginalization.** Treatment of addiction "seems like something outside of medicine, a subspecialty of psychiatry," one physician said. "It's something we weren't really taught about," another doctor commented. Others speculated that the implementation of buprenorphine treatment would mean a culture shift in the office, reflecting a shift in how addiction patients are treated compared with methadone clinics.

► **Need for support.** Physicians said that they would be more inclined to provide buprenorphine treatment if they had an avenue of communication to an addiction specialist. "It would be helpful to know ahead of time what can go wrong," one doctor commented. Other physicians acknowledged that treating addiction is more than writing a prescription, and that some type of partnership with a specialist would be helpful.

► **Policy restrictions.** The physicians who were treating addiction patients with buprenorphine mentioned this issue more frequently. The current policy states that a maximum of 30 patients can be treated in any medical practice. The number 30 is arbitrary, and some physicians expressed frustration. "I prescribe all kinds of things that are much more dangerous," one doctor commented. The intent of the limit was to prevent any one office from becoming a prescription mill, but no evidence supports a specific number of patients as appropriate for one office to manage.

These concerns may explain the sluggish adoption of buprenorphine treatment, Dr. Fiellin said. "We have been working on a physician clinical support system to provide physician mentors," he noted.

Office-based buprenorphine treatment has promise, and clinical support in the form of a mentorship program may help expand care.

An outreach plan, the Physician Clinical Support System, funded by SAMHSA, calls for medical societies to have information for physicians at buprenorphine training events, with local mentors available to whom they can pose questions after training. Concerns about undesirable patients are unwarranted, because patients with addiction problems are often already part of any patient population, Dr. Fiellin said.

Location of training programs is another concern. Most buprenorphine prescribers are in the Northeast and on the West Coast. Although locations have not always been convenient for physicians, online training courses are also available.

Cost is an issue as well. The science behind buprenorphine is solid, but the financing remains in flux, in part because the cost has not been standardized. Payment for the treatment varies, with some providers taking insurance and others taking cash.

Despite the potential problems, doctors who initiate buprenorphine treatment continue to prescribe it because they see the good they can do for patients, Dr. Fiellin said. "If you talk to physicians who have implemented buprenorphine treatments, you find the rewards outweigh the barriers." ■

Extensive Interaction Enhances Opioid Dependence Management

WASHINGTON — A team approach to managing opioid dependence with buprenorphine kept 32 of 37 patients (86%) on buprenorphine therapy at 4 months' follow-up, Daniel Alford, M.D., reported in a poster at the annual conference of the Association for Medical Education and Research in Substance Abuse.

The patients, aged 18-52 years, were mostly male (62%) and white (92%). The treatment protocol included an average of two in-person contacts and 15 phone contacts from a nurse care manager (NCM) in the first 2 weeks, followed by one to four contacts per week. Follow-up visits included random urine samples, pill counts, and observations of dosing.

The team approach featured extensive interaction between patients and nurse care managers, with physician assessments and consultations. The nurse made the initial assessment of each patient's substance use, medical and psychiatric history, and social support system by telephone.

The treatment protocol included an average of two in-person contacts and 15 phone contacts from a nurse care manager in the first 2 weeks.

Physicians reviewed and further assessed patients before enrolling them in the study and prescribing buprenorphine. The physicians also performed physical exams at enrollment and 4 months after treatment started.

The nurse care manager also obtained initial lab tests, educated the patients about buprenorphine, and reviewed patient responsibilities. The NCM devised an induction schedule based on physician guidelines, and was in frequent contact with the patients until they reached their stable maintenance doses. Patients had access to the nurse care managers by cell phone, he said at the conference, also sponsored by Brown Medical School.

After 4 months, only 13% of opioid urine tests were positive, compared with 100% at baseline, said Dr. Alford of Boston Medical Center. Ninety-two percent of the patients had social support for their treatment, and 56% were attending counseling sessions or mutual self-help meetings.

A majority of the patients (59%) had a medical comorbidity at baseline, but 68% had no usual source of primary care. ■

Severe Addicts Struggle With Buprenorphine Adherence

WASHINGTON — Patients with severe opioid use immediately prior to treatment may not adhere to buprenorphine in an office-based setting, said Michael Pantalon, Ph.D.

In an ongoing randomized clinical trial, 91 opioid-dependent patients took daily buprenorphine/naloxone maintenance doses in a primary care clinic.

After 24 weeks, the investigators classified the patients as "high-stable" adherence (52), "fluctuating-deteriorating" adherence (23) and "poor-flat" adherence (16). Baseline evaluations included motivation for treatment, severity of psychiatric and addictive symptoms, and urinalysis.

Overall, the 52 "high-stable" patients had spent significantly less money on drugs prior to treatment, and reported significantly fewer days of heroin use prior to treatment compared with those in both the "fluctuating-deteriorating" and "poor-flat" groups, Dr. Pantalon and his colleagues at Yale University, New Haven, reported in a poster presented at the annual conference of the Association for Medical Education and Research in Substance Abuse.

The "high-stable" patients also were significantly less likely to name heroin as their major problem, compared with oxycodone (OxyContin) or other opiates, and they were significantly less likely to test positive for opioids before starting buprenorphine treatment.

The data from this study suggest that office-based treatment alone may not be sufficient for severe addicts, the investigators noted.

The conference was sponsored by Brown Medical School. ■