Buprenorphine from page 1

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 have made 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 [of whom are addicted to prescription opiates],” said Dr. Cindy Parks Thomas, a researcher at the Brandon University Health Policy Institute in 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 current practice,” “It would change the patient mix undesirably,” and “Prescribing is too complex.”

They also worried about the cost of initi- ating such treatment and the fi- nancial 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 Sub- stance Abuse and Mental Health Services Administration (SAMSHA) and actually begin treating patients.

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Some psychiatrists, ironically, might have feared that too many patients were being treated for buprenorphine, despite limits on the number of patients that qualified physicians can treat in their practices.

“They didn’t want drug-addicted pa- tients 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-to-20 minute visits for re- newal of their prescriptions and brief, structured treatment, much of which could be handled by “people who work a lot cheaper,” such as social workers, family therapists, or psychologists.

In contrast to many psychiatric pa- tients 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 cir- cumstances to be able to truly shift away from an addiction lifestyle and toward fo- cusing 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 ad- diction 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 physi- cians are more accustomed to the quick- visit model for patients with chronic dis- ease 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 es- tablished, 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 govern- ment-supervised buprenorphine pro- gram 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.

“I mean, if someone has applied for the waiver [that permits them to prescribe buprenorphine to pa- tients 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 SAMSHA pain and addic- tion courses and is on the speakers bu- reau for Reckitt Benckiser.

By Betsy Bates. Share your opinions at cpnews@cleveirc.com.

Program Trains Generalists in Opioid Risk Management

BY RENEE MATTHEWS

Bethesda, Md. — Generalist chief residents who were trained in opioid risk management in immersion programs were significantly more confident in managing the risks, provided better care, and were more willing to pass on their knowledge to their trainees than were those who did not receive the training, according to a study of chief residents show.

Such programs, known as Chief Resident Immersion Training (CRIT) programs, are one way of addressing the need for primary care providers in a growing 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 res- idents 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 pub- lic health problem. However, the access of chief residents to training in these areas is inadequate despite screening and monitoring recommenda- tions 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 base- line (pre-CRIT) and 6 months after they had completed the program (post-CRIT).

The 43 chief residents were from 36 residency programs. Eighty percent were in internal medicine, 9% in family medicine, and 5% in emergency medicine. All of them com- pleted the baseline survey; 1 did not complete the 6-month follow-up, and 2 of the remaining 41 did not provide complete re- sponses for all of the questions.

The changes in confidence, clinical practices, and teaching prac- tices 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 training high-risk patients with chron- ic pain were significant. Confi- dence 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 <.0001 for both). One CR did not complete the post-CRIT confidence questions. Future research should focus on the impact of the CRIT pro- gram on those who are trained by chief residents, Dr. Al- ford said.

He and his colleagues had no financial disclosures. The study was funded by the National In- stitute on Drug Abuse.

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