

Barriers to Buprenorphine Treatment Examined

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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 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 ap-

istered 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.

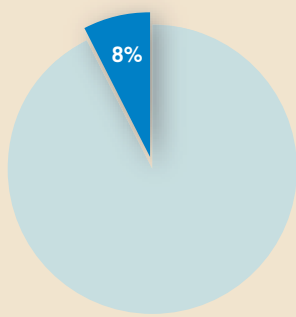
► **Medical marginalization.** Treatment of addiction "seems like something outside of medicine, a subspecialty of psychiatry," one physician said. "It's something we weren't really taught about," another doctor commented. Others speculated that the implementation of buprenorphine treatment would mean 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

Eight Percent of Opiate Addiction Patients Receive Methadone or Buprenorphine

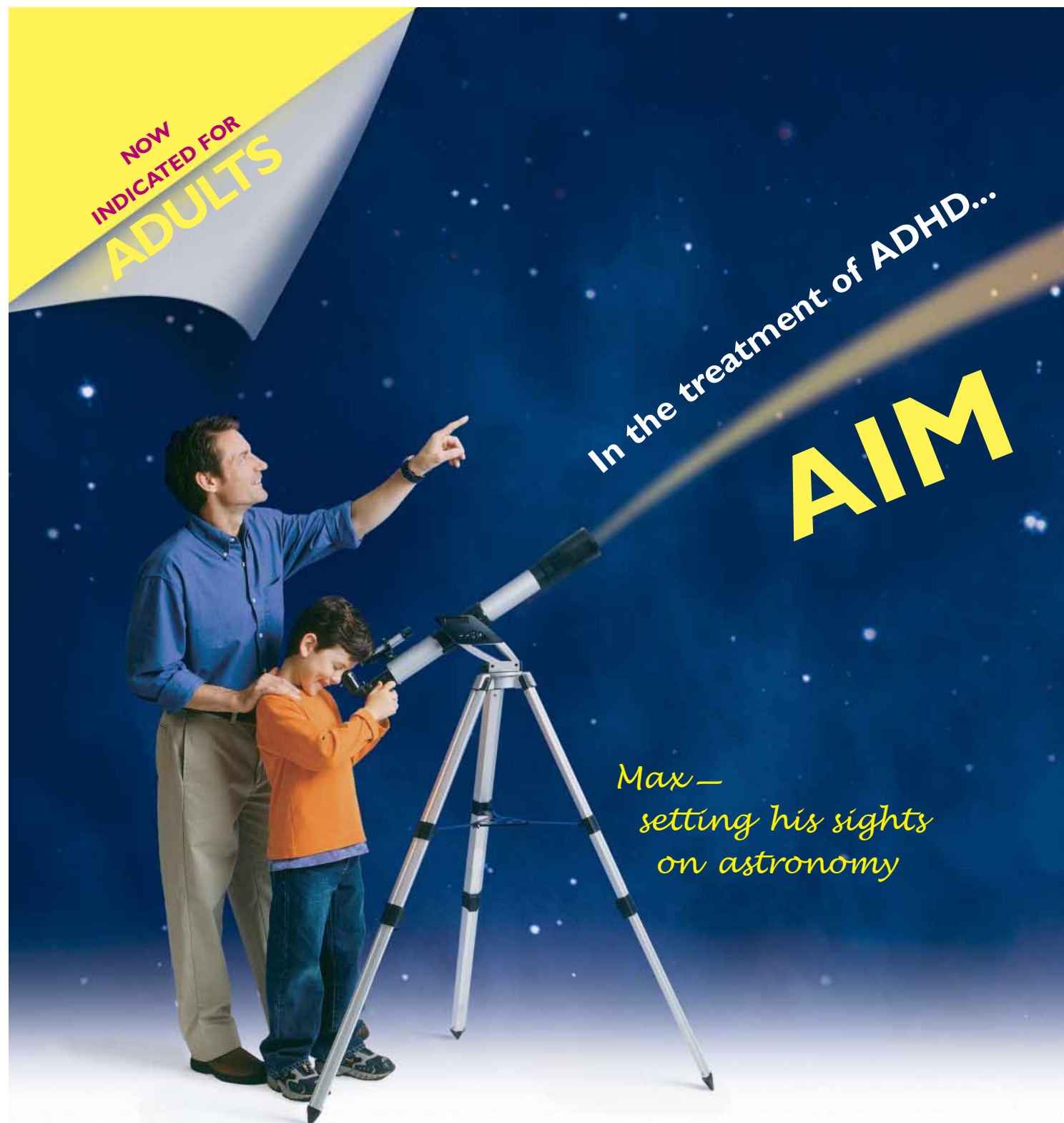


proved narcotics for the treatment of opioid dependence. Buprenorphine was approved for this purpose in 2002. Physicians can qualify to provide treatment by participating in an 8-hour training program on caring for opioid-dependent patients.

As of 2004, approximately 65,000 physicians have received the training. Of these, 4,000 have notified the Substance Abuse and Mental Health Services Administration (SAMHSA) that they want registration to prescribe buprenorphine, and 3,600 physicians have received their registrations. Of these, 80% have 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 in treating opioid addiction and the number 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 reg-



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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 avail-

able to whom they can pose questions after the training. Concerns about undesir-

able 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." ■

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