Underutilization of Primary Care Providers in Treating Opiate Addiction

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ABSTRACT

There are inadequate numbers of care providers or treatment programs to treat opioid abuse. Although many primary care nurse practitioners care for patients who are dependent on or abuse opioids, they are not allowed to prescribe the schedule 3 medications to treat them. This option is available to primary care physicians with additional training. This article discusses the effectiveness of opioid substitution therapy in a primary care setting, the patient populations, patient satisfaction, and barriers preventing primary care providers from providing treatment to opioid patients. Nurse practitioners can help overcome some of these barriers and improve access to this underserved population.

Keywords: buprenorphine, nurse practitioners, opiate addiction, opioid abuse, opioid dependence, opioid treatment, primary care providers

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Opioid abuse is a worldwide problem for both industrialized and developing countries. Specifically, the abuse of prescription opiates is on the rise and is a major public health problem in the United States.[1] Opioid abuse is defined as using an opiate for a nonmedical purpose or using a prescribed opiate differently (amount, frequency, person prescribed, and rationale) than it was prescribed by the provider. In 2008, more than 33 million Americans used a pain reliever for a nonmedical purpose.[2] According to the Substance Abuse and Mental Health Data Archive, 13.7% of Americans reported abusing pain relievers in their lifetime, whereas 1.6% reported using heroin in 2010.

Opioid abuse doubled from 1977-1982, then increased 4-fold from 1987-1996.[3] "From 1999-2007, unintentional drug overdose deaths associated with prescription opioids (POs) rose by 395%."[4] Opioid abuse is now common among adolescents, and the Centers for Disease Control and Prevention estimates that $9.5 billion was spent in 2005 on costs associated with prescription opioid abuse (POA). They estimate that societal costs in 2010 had risen to more than $55 billion.[4] This places pain reliever abuse just below cocaine abuse, second only to marijuana.[5] Primary care providers (PCPs) are frequently faced with this problem as they treat patients.

Historically, opioid addiction has been managed in the US in specialized treatment centers, where providers replace the abused opioid with methadone. This has been effective in reducing illicit opioid abuse and retaining patients in treatment.[4,6] Currently, methadone for opioid addiction can be prescribed only in treatment programs certified by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA).[7] However, the availability of these treatment centers has failed to meet the increasing demand created by the prescription drug dependence explosion. In 2008, only 35% of the 1.7 million opioid-dependent people in the US were in treatment,[8] with a total annual cost of $8.6 billion.[9] One-third of methadone maintenance clinics have lengthy waiting lists, and many states do not have any clinics at all, especially in rural areas.[2,10,11]

Studies estimate only 20% of Americans who suffer from opiate addiction have access to methadone maintenance therapy (MMT).[2,10] Communities often limit these clinics from opening or expanding, and patients feel stigmatized attending them.[2] In response the Drug Addiction Treatment Act of 2000 (DATA 2000) was created, which enables qualifying physicians to obtain a waiver allowing them to practice medication-assisted opioid addiction therapy in primary care practice. To qualify, a physician must

have a current state medical license, a valid Drug Enforcement Agency (DEA) registration number, and at least 8 hours of training in the treatment and management of opioid-addicted patients or have special addiction certifications.[12]

In 2002, 2 schedule 3 controlled medications, Subutex (buprenorphine hydrochloride) and Suboxone (buprenorphine hydrochloride and naloxone hydrochloride), received Food and Drug Administration approval for the treatment of opioid addiction.[12] There is "extensive empirical evidence" that suggests buprenorphine is safe and effective for treating opioid addiction in a primary care setting,[13] and it has a much lower risk of overdose than methadone. Buprenorphine is a mu-receptor agonist and a kappa-receptor antagonist; therefore, it has an opioid effect with no additional effect beyond a certain point (ceiling effect) with increased dosing. It has slow onset of action and high affinity for receptor sites, and the drug attaches tightly to receptors. This gives it a long half-life and patients do not experience sedation or euphoria when taking it.

However, buprenorphine replaces other opioids at receptor sites, triggering withdrawal symptoms in patients who are physically dependent on opioids. As a result, treatment should not be started until the patient begins withdrawal symptoms.

When buprenorphine is combined with naloxone, the potential for abuse is decreased further. Naloxone is an opioid antagonist and reverses opioid effects at the mu and kappa-receptor sites. However, it is not absorbed well when ingested orally; therefore, it has no effect when taken sublingually as prescribed. If a person attempts to abuse Suboxone by crushing it and injecting it, the naloxone creates a rapid reversal of the opioid effect. This acts as a natural deterrent to abuse and prevents the drug from being used in ways not prescribed or intended.[7,14,15]

Despite the adoption of DATA 2000 and buprenorphine therapy, primary care opioid addiction therapy is severely underutilized. Few physicians have the waiver to prescribe the medications[16] and half of those are addiction specialists.[17] Many people would benefit if a wider array of physicians would provide this treatment.[17] Under the current legislation, nurse practitioners (NPs) and physician assistants (PAs) are prohibited from prescribing these medications, even in the states with controlled substances prescription authority. This further limits the availability of treating a population already suffering from a "treatment gap."[18]

This article discusses why PCPs are underused in treating opiate addiction by comprehensively reviewing research that identifies the patient populations best suited for opiate addiction therapy in a primary care setting, the effectiveness of PCPs in treating opiate addiction, patient preferences of treatment centers, and the barriers preventing primary care physicians from practicing opiate addiction therapy in their practices. The article also discusses how involving NPs can help overcome these barriers, improve access and cost effectiveness, and reduce the "treatment gap" for people suffering from opiate addiction.[18]

LITERATURE SEARCH

An electronic search with the terms *opiates* or *opioid*, *drug abuse* or *drug addiction* or *drug dependency* or *substance abuse*, *rehabilitation* or *treatment* or *therapy* or *recovery*, and *primary care* or *general practice* was conducted in CINAHL, MEDLINE, and PsycINFO databases. The search was limited to peer-reviewed articles published in English from 2006 to April 2013. Abstracts of 303 articles were reviewed to identify relevant research studies, resulting in 11 on patient populations, 4 on patient satisfaction, 12 on effectiveness, and 6 on barriers.

An electronic search with the terms *nurse practitioner* or *physician assistant* or *advanced practice*, *prescribe*, and *buprenorphine* was also conducted to identify articles calling for a policy change addressing the lack of privileges of NPs to prescribe buprenorphine from 2006 to April 2013 in the same databases. The search, limited to peer-reviewed articles published in English, resulted in 5 articles.

The review of literature showed 4 themes evaluating opioid substitution therapy (OST) in a primary care setting: the patient populations best suited for primary care, the effectiveness of OST in primary care, patient satisfaction with primary care service, and the barriers preventing PCPs from providing treatment to opioid-dependent patients.

PATIENT POPULATION

Research shows that patients seeking office-based buprenorphine treatment are a new type that have not

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