Office-Based Addiction Treatment in Primary Care

Approaches That Work

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KEYWORDS

- Primary health care • Opioid use disorder • Alcohol use disorder • Buprenorphine
- Naltrexone

KEY POINTS

- Primary care practices are well-suited for implementing evidence-based treatments to address alcohol and other substance use disorders.
- Effective approaches to treatment largely focus on provision of pharmacotherapy (eg, buprenorphine, naltrexone) in conjunction with counseling-based treatments.
- Studies to identify effective approaches for treating vulnerable populations are needed.

INTRODUCTION

Of the roughly 22 million individuals in the United States suffering from addiction, only 11% receive specialty care.[1] Reasons cited for the treatment gap include lack of provider education with regard to substance use and substance use disorders, perceived lack of need for treatment on the part of the patient, and lack of access to evidence-based treatment.[1,2] Integrating addiction treatment into office-based primary care is an important approach to improving access to care.[3] Primary care settings, including those providing primary care to special populations, offer several advantages to treatment of substance use disorder over specialty settings. These advantages include

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accessibility to patients, ability to tailor services to patient need, reduction of stigma associated with accessing treatment, and the ability to provide many services in one location. Additionally, clinical preventive services are an integral part of primary care medicine, with screening and provision of brief counseling for alcohol use and treatment of tobacco use among the top priorities for the provision of high-quality care.[4]

Through primary care settings, patients may receive a range of evidence-based addiction treatment services, in addition to treatment for tobacco use. These services include US Food and Drug Administration (FDA)-approved medications for alcohol (ie, disulfiram, acamprosate and oral and extended-release [XR] naltrexone) and opioid use disorder (ie, buprenorphine alone or coformulated with naloxone by a certified provider; and oral and XR naltrexone; **Table 1**). Additionally, primary care settings may lend themselves well to the implementation of counseling-based strategies. Specifically, brief counseling may be provided and the Affordable Care Act has supported the integration of additional behavioral health services into primary care. Efforts at treatment expansion have resulted in several proposed approaches for office-based addiction treatment in primary care.

Based on a PubMed and Ovid MEDLINE search designed to identify articles published since 2007 that reported on behavioral and/or medical treatments used in outpatient settings to address alcohol, opioid, and/or stimulant (cocaine, amphetamine) use, we identified office-based approaches to addiction treatment. Herein, we highlight office-based treatment approaches within primary care and a specialty treatment setting (**Box 1**) to address alcohol, opioid, and other substance use.

PRIMARY CARE-BASED APPROACHES

Alcohol

The prevalence of alcohol use disorder in the US population is increasing and has been termed a public health crisis. Certain groups, such as women, older adults, racial/ethnic minorities, and the socioeconomically disadvantaged, are particularly affected.[5] For decades, primary care settings have been considered important sites for the delivery of care to people with alcohol use and related disorders.[6] However,

Table 1
Pharmacotherapy options for alcohol use disorder and opioid use disorder

Generic Name	Usual Daily Dose
FDA approved for alcohol use disorder	
Acamprosate	666 mg orally 3 times daily
Disulfiram	250–500 mg orally daily
Naltrexone	50 mg orally daily
Extended-release Naltrexone	380 mg intramuscularly every 4 wk
Not FDA approved for alcohol use disorder	
Gabapentin	300–600 mg orally 3 times daily
Topiramate	100 mg orally twice daily
FDA approved for opioid use disorder	
Buprenorphine (with and without naloxone)	2–24 mg sublingually daily
Methadone	60–80 mg orally daily
Naltrexone	50 mg orally daily
Extended-release Naltrexone	380 mg intramuscularly every 4 wk

Abbreviation: FDA, US Food and Drug Administration.

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