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Using medication-assisted treatment for substance use disorders: Evidence of barriers and facilitators of implementation

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ABSTRACT

The use of medications to treat substance use disorders (SUDs) has emerged as a potentially central part of the treatment armamentarium. In this paper we present data from several recent US national surveys showing that despite the clinical promise of these medications, there has been limited adoption of pharmacotherapies in the treatment of SUDs. The data reveal variable patterns of use of disulfiram, buprenorphine, tablet naltrexone, acamprosate and injectable naltrexone. After examining the environmental and institutional context for the adoption of pharmacotherapies, the specific organizational facilitators and barriers of medication adoption are considered. The paper concludes with a discussion of the minimal clinical and administrative guidance available to enhance adoption, the lack of client and consumer knowledge of medications that puts a brake on their adoption and availability, and the difficulties that must be surmounted in bringing new medications to market.

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1. Introduction

The use of medications to treat substance use disorders (SUDs) has emerged as a potentially central part of the treatment armamentarium. While disulfiram and methadone have relatively long histories, over the past decade medications with what might be called greater sophistication of action have become prominent. Given the intensity of concern in the U.S. with "the drug problem" and its management, it would be expected that new treatments (e.g., buprenorphine, acamprosate, and injectable naltrexone) would be greeted with enthusiasm accompanied by rapid diffusion and adoption. In the case of these new medications, that has yet to happen. It is the objective of this paper to investigate potential explanations for this limited adoption in specialty treatment programs.

In this paper we explore "policy and procedure gaps" in the diffusion, adoption, and implementation of medications, the category of evidence-based practices (EBPs) that is indeed the most revolutionary and most challenging to traditional practice. We present data from several nationally representative surveys as well as from treatment programs attached to a clinical trials network specifically designed to promote innovation adoption. These data demonstrate the limited adoption of pharmacotherapies in the treatment of SUDs. After considering these data, we use the explanation of these patterns to highlight several macroscopic processes that could be applicable in understanding the use of EBPs SUD treatment organizations generally.

1.1. The policy emphasis on evidence-based practices

Few issues in substance abuse treatment have more prominence than the perceived urgency of adopting and implementing EBPs. Within a broader mission based on a declared universal need for enhancing the quality of treatment for SUDs, EBPs now represent the panacea for the ambiguous and ambivalent attitudes toward substance abuse treatment within the broader medical care community. Compared to other policy issues raised in the recent past, such as service integration to accommodate the dually diagnosed or the enhancement of treatment staff credentials, there is remarkable consensus among field leadership about the marked importance of SUD treatment programs' openness to adopting particular innovations (Hanson, Leshner & Tai, 2002; McCarty, Gustafson, Capoccia & Cotter, 2009; National Quality Forum, 2007; National Institute on Drug Abuse, 2000).

There has, however, been a tendency to frame this issue along a single dimension: achievement of the goal of enhancing treatment quality through innovation is defined by greater degrees of adoption behavior by treatment organizations. Thus, some policies have used simple reporting of adoption behavior as the criterion for conformity to new standards of innovativeness. Experience is demonstrating, however, that it is a major mistake to place all EBPs in one generic category, and/or to regard multiple adoptions as some kind of measure of treatment quality. Further, attention has not yet been

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given to long-term implementation and the extent to which implementation actually follows from adoption.

While there is yet to be an accepted typology categorizing EBPs relevant to SUDs treatment, there can be no doubt that they are not identical in their contingencies for implementation within treatment organizations. Specifically, the requirements for organizational change embedded in the design of EBPs vary widely, with some implementations flowing quickly and easily and others potentially causing major disruption of an organization's treatment delivery. Outside the category of medications, an apt example may be the relative investments required by motivational interviewing versus contingency management. Further, important innovations such as electronic health records may require extensive reorganization. Some innovations affect patients directly, while others are implemented with absolutely no direct effect on patient care.

The common dichotomy between psychosocial and pharmacological innovations actually captures little, as the "psychosocial" category needs to be broken into subcategories of innovations involving treatment delivery, treatment management, and organizational management. Further, perhaps as a means to facilitate acceptance, there is widespread consensus that the successful implementation of pharmacological treatments requires not only concomitant psychosocial interventions, but also requires multiple psychosocial considerations in assuring long-term treatment success associated with such treatments. Curiously, recent empirical evidence regarding the effectiveness of buprenorphine protocols are ambiguous about this assumption. As compared to shorter counseling, longer counseling sessions for buprenorphine-maintained patients were not associated with improved outcomes (Fiellin et al., 2006). This was not consistent with an earlier trial that found greater attendance at CBT counseling sessions was associated with better outcomes (Montoya et al., 2004).

1.2. Pharmacotherapy and the mainstreaming of the treatment of SUDs

Given the high level of institutionalization of 12-step practices in alcoholism treatment and traditional "drug-free" SUDs treatment (Milne, Blum & Roman, 2000; White, 1998), the use of pharmacotherapy introduces what might be seen as a totally new paradigm, providing biochemical aid in the reduction of craving for substances in the case of several of the medications. The consequences of introducing pharmacotherapy in SUD treatment on a widespread basis may have sweeping implications that are not yet well understood. Doubtless the introduction of such treatment and its possible movement to primacy is a dramatic paradigm shift, moving SUD treatment much closer to "mainstream" medical practice. A basic implication centers on the staffing requirements for effective implementation, and the manner of balance between medication-based treatments and physicians and nurses, the treatment organization, and the more-or-less organized systems of SUD treatment that presently exist at the level of the state or territory, linked to the single state "authority" in each of these geographic settings.

Together with the emphasis on EBPs, SUDs field leadership continues to heavily stress the critical importance of integration of the identification and some level of treatment of SUDs into primary care. Thus, the use of medications may be seen as a "second point of entry" into both primary care medicine as well as specialties of medicine such as pediatrics and obstetrics that parallel emerging addiction medicine. The first point of entry, currently being pursued vigorously, is Screening, Brief Intervention and Referral to Treatment (SBIRT) in which physicians are urged to take on roles in screening for SUDs, followed by different levels of possible intervention (O'Connor, Nyquist, & McLellan 2011).

To the extent that these efforts to engage primary care are successful, the use of pharmacotherapies to treat patients with SUDs who present in primary care offers a modality of treatment that is consistent with emphases of training in the larger arena of medical practice. Such an introduction has been "forced" by Federal regulations through the significant limitation of the use of buprenorphine to specially trained physicians in individual practices. While the enrollment in credentialing for buprenorphine administration has been substantial and appears very promising, the success of this effort remains to be rigorously evaluated. Of considerable significance is that the use of pharmacotherapy in SUDs treatment is supportive of the chronic disease/brain disease model of SUDs based in neurochemistry and possible altering of structural configurations in the brain. Acceptance of such a model within medical education and practice is probably critical to the effective mainstreaming of SUDs treatment into medical care.

The introduction of broad pharmacotherapeutic opportunities may offer several significant advantages to therapeutic regimens. First, there can be little doubt that the overall quality of treatment will be enhanced with the addition of treatment alternatives. Persons who have been unresponsive to psychosocial regimens may be assisted by medications, leading to positive treatment outcomes not otherwise possible. In a related fashion, candidates for treatment who are resistant to the limited alternatives of psychosocial regimens (and who may refuse to enter or re-enter treatment) may be attracted to treatments centered heavily on medications. Further, the potential availability of medication-based treatments through either primary or specialty care physicians may attract a part of the potential patient population currently unwilling to access SUD treatment (Sullivan, Chawarski, O'Connor, Schottenfeld, & Fiellin, 2005).

As stated earlier, it would be expected that these promising features of pharmacotherapies would facilitate enthusiastic adoption and implementation. Such an outcome is not supported by survey data collected from large samples of SUD treatment organizations in the US. In this paper, we present longitudinal data on adoption of medications from these samples and integrate findings from our body of research about barriers and facilitators to adoption.

2. Methods

Data for this study are taken from the National Treatment Center Study (NTCS), a family of national studies of substance abuse treatment programs in the United States. This study includes data from three separate NTCS samples. The first study includes two waves of onsite data collected between 2002–2004 and 2007–2008 via face-to-face interviews with administrators and/or clinical directors of a nationally representative sample of privately funded treatment programs. Private sector treatment programs were defined as programs that receive at least 50% of their annual operating revenues from commercial insurance, patient fees, and income sources other than block grant funding such as government grants or contracts. Medicaid and Medicare were not regarded as "block" funding because these reimbursements are received by programs on an individual patient basis. See Abraham and Roman (2010) for study details.

The second study includes two waves of data collected from a nationally representative sample of publicly funded treatment programs. Programs were defined as publicly funded if they received at least 50% of their annual operating revenues from government grants and contracts, including block grant funds and criminal justice contracts. The first wave of data was collected via face-to-face interviews with administrators and/or clinical directors of public treatment programs between 2002 and 2004. The second wave of data (2009–2010) was collected via mailed surveys and telephone interviews with the administrator/clinical directors of the programs as part of a separately funded study. See Knudsen et al. (under review) for more details.

For both studies, treatment programs were selected via a two-stage random sampling design (Knudsen, Ducharme, & Roman, 2007). To be eligible for both the private and public studies, programs were required to offer alcohol and drug treatment at a level of intensity at least equivalent to American Society of Addiction Medicine (ASAM)

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