

## Overview of Treating Opioid Addiction in an Office-Based Practice

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**Introduction:** Opioid abuse and dependence remains a serious and growing public health problem in the United States. For decades heroin has been a primary opioid of concern and it continues to be regularly abused. In 2005 there were an estimated 379,000 heroin users nationwide. (<http://www.whitehousedrugpolicy.gov/drugfact/heroin/index.html>).

But adding to America's opioid problem has been a surge in problems related to prescription opioids such as Oxycontin, Vicodin and Percocet, a surge that has occurred in tandem with their growing medical use as painkillers. As of 2005, about 1.8 million Americans were believed to have engaged in some type of "non-medical use" of oxycodone and hydrocodone prescription opioids. (<http://www.oas.samhsa.gov/2k7/pain/pain.htm>).

In 2002 alone there were 5528 deaths attributed to an overdose of prescriptions opioids, exceeding deaths caused by either heroin or cocaine (Merrill, 2002). According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), in 2001 emergency room visits related to prescription opioids for the first time exceeded those involving heroin.

There is substantial evidence that opioid dependence, whether it involves heroin or prescription drugs, can be successfully treated with methadone and a newer medicine called Buprenorphine. Both of these treatments work by blocking the effect of the abused opioid and eliminating suffering related to withdrawal. Medication-assisted treatment of opiate addiction has been shown to enhance social productivity and to decrease drug use, overdose deaths, criminal activity and the spread of infectious diseases, including HIV (Salsitz et al., 2000). Oral doses of a medication called Naltrexone, which block the effects of illicit opiates and ease withdrawal, have been used to treat addiction. Oral Naltrexone is not used very often in the US due to limited effectiveness and poor adherence, (Merrill et al., 2005), (Weinrich and Stuart, 2000) though a monthly injectable form of Naltrexone has recently been developed and shows some promise (Brands et al., 2002).

However, there is a gap between treatment effectiveness and treatment access. Since the 1970's, federal and state regulations have generally restricted methadone availability to specially licensed methadone clinics, effectively preventing most private physicians from offering methadone for addiction treatment. There are fewer regulatory inhibitions on prescribing Buprenorphine, but impediments remain and in practice its availability in mainstream medical care is limited.

Recently, many experts have considered whether more patients could get help if methadone treatment could be provided by physicians in a general "office-based" setting (as opposed to a special clinic) through what have come to be known as "methadone medical maintenance" programs. There is also interest in broadening access to office-based treatment with Buprenorphine.

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