

# The CBHSQ Report

Short Report

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## MEDICATION PRESCRIBING AND BEHAVIORAL TREATMENT FOR SUBSTANCE USE DISORDERS IN PHYSICIAN OFFICE SETTINGS

### AUTHORS

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### INTRODUCTION

More than 17 million persons aged 12 or older in the United States in 2013 (6.6 percent of the population) had alcohol use disorders (AUD), and about 2.4 million had opioid use disorders (OUD).<sup>1</sup> The current medications approved by the Food and Drug Administration (FDA) for the treatment of OUD are methadone, buprenorphine (Subutex®), buprenorphine/naloxone (Suboxone®), and oral as well as injectable naltrexone (Vivitrol®).<sup>2</sup> Some of these medications require physicians to apply for a waiver from the Drug Enforcement Agency in order to prescribe them outside of a narcotic treatment program (i.e., clinic). The medications approved for AUD are naltrexone oral (ReVia®, Depade®), naltrexone injectable (Vivitrol®), disulfiram (Antabuse®), acamprosate (Campral®).<sup>3</sup> Collectively these medications are referred to as substance use disorders (SUDs) medications in this report.

It has been reported that maintenance medication is underutilized in treatment for substance use disorders.<sup>4</sup> Although a combination of medication and behavioral treatment is recommended to treat these chronic disorders, medication and behavioral treatments such as counseling have traditionally been carried out in separate settings. Treatment for substance abuse has been provided in specialized facilities separate from mainstream medical practices. These specialized facilities tended to provide mostly behavioral treatment, with a smaller proportion providing medication treatment. This separation of the two forms of treatment has not provided optimal care for patients with substance use disorders (SUD).<sup>4</sup> Only recently have office-based practices begun to incorporate screening and referral services, and to a more limited degree medication.<sup>5</sup>



### In Brief

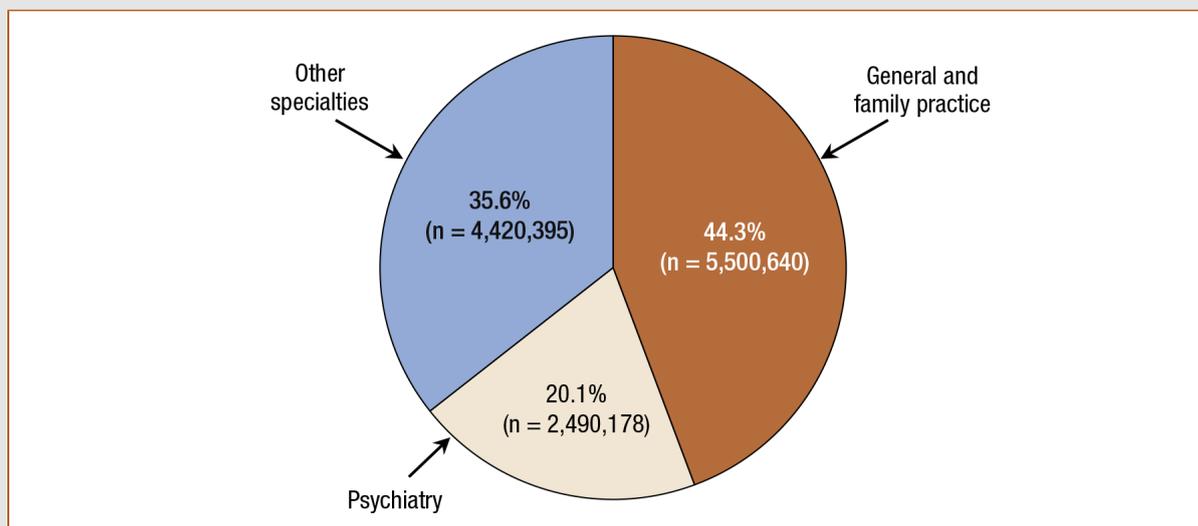
- About 3.4 million visits to physician offices in 2010 involved medication prescriptions to treat substance use disorders (SUD).
- About 44.3 percent of the prescriptions for AUD and OUD were made in these office visits by general and family practice physicians, and 20.1 percent were made by psychiatrists.
- Regardless of specialty, behavioral treatment for these substance use disorders (SUDs) was only provided in a minority of office visits (34.3 percent) during which SUD medications were prescribed.

Little is known about the degree to which SUD medication is prescribed by office-based physicians, the specialty of those who do prescribe, and the associated diagnoses. Likewise, information is scarce about the extent to which combined care involving medication and behavioral treatment for common types of SUD treatment is occurring. This report addresses these questions using data from the 2010 National Ambulatory Medical Care Survey (NAMCS), an annual survey from a sample of physicians who deliver care directly to patients in their offices.<sup>6</sup>

## PRESCRIPTIONS FOR ALCOHOL AND OPIOID USE DISORDERS AND SPECIALTY OF THE PROVIDER

Slightly more than 1 trillion visits were made in 2010 to physicians' offices, for a rate of 332.3 visits per 100 persons in the United States. Of these visits, about 757 million visits (about three-quarters of the total) involved prescribing new or continuing medications, with 0.5 percent (3.4 million) of these visits involving prescriptions for medications to treat SUD. With regard to the specialty of the prescribing physician, 44.3 percent of the prescriptions for SUD were given by general and family practice physicians, 20.1 percent were given by psychiatrists, and the remaining 35.6 percent were given by all other specialties combined (Figure 1). Approximately 32.5 percent of the prescriptions for SUD were written by the patient's primary care provider.

**Figure 1. Substance use disorder (SUD) prescriptions provided by office-based physicians, by medical specialty: 2010**



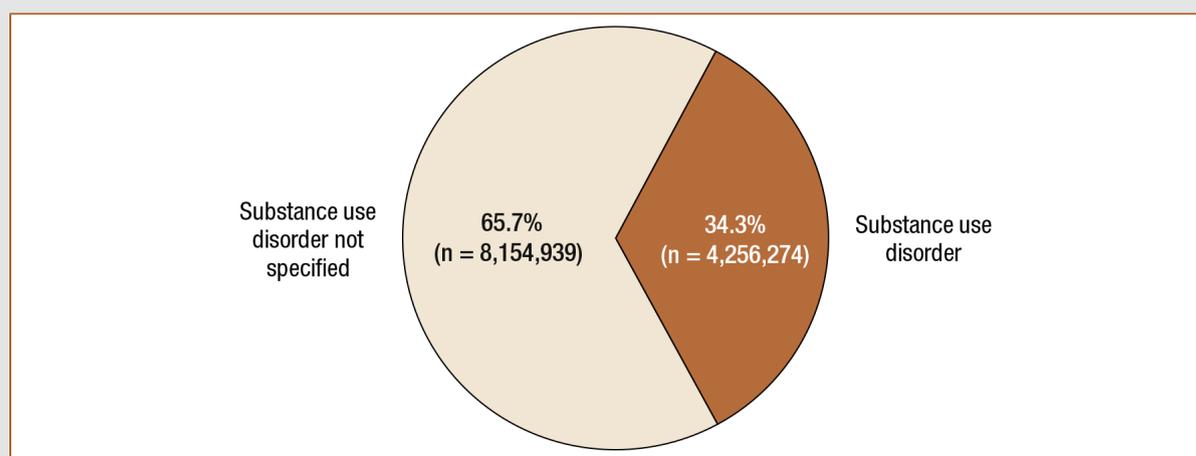
Note: Medications prescribed for opioid dependence included methadone, buprenorphine (Subutex<sup>®</sup>); and buprenorphine/naloxone (Suboxone<sup>®</sup>) and oral as well as injectable naltrexone (Vivitrol<sup>®</sup>).

Note: Medications prescribed for alcohol dependence included naltrexone oral (ReVia<sup>®</sup>, Depade<sup>®</sup>), naltrexone injectable (Vivitrol<sup>®</sup>), disulfiram (Antabuse<sup>®</sup>), and acamprosate (Campral<sup>®</sup>).

Source: National Ambulatory Medical Care Survey (NAMCS), National Center for Health Statistics, 2010.

This report examines whether the prescriptions given for the 3.4 million SUD-related visits were connected with an appropriate diagnosis requiring the prescriptions. Physicians who prescribe a medication to treat SUD would typically diagnose substance disorder (either AUD or OUD) for that visit. Of the medications prescribed for SUD, only 34.3 percent were associated with a substance use disorder diagnosis (Figure 2).

**Figure 2. Percentage and number of substance use disorder prescriptions provided by office-based physicians, by diagnosis: 2010**



Source: National Ambulatory Medical Care Survey (NAMCS), National Center for Health Statistics, 2010.

The proportion of office visits for substance abuse medications during which some form of behavioral treatment was also provided was examined in the 2010 NAMCS. The survey assessed provision of or referral to psychotherapy or other mental health counseling, as well as whether a mental health provider provided care. For all substance abuse medication visits, 34.3 percent of the visits also involved some form of behavioral treatment; approximately 27.1 percent of these included both receipt of psychotherapy and other mental health counseling.

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## DISCUSSION

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In this study general and family practice physicians were found to prescribe 44.3 percent of medications to treat SUD prescribed in physician office settings. The bulk of the prescribing of these medications is done by other medical specialties. Although this result suggests that these treatments are available in some office settings, we might have expected even greater accessibility to SUD medications in physician office settings. One barrier is that nationwide just 3% of primary care physicians have the required DEA waiver.<sup>7</sup> A third of the physicians in this study who prescribed medications for SUD were also the patient's primary care physician. While the efficacy of medications to treat SUD has been established, general and family practice physicians may be unfamiliar with these drugs, lack clear clinical guidelines for their use,<sup>8</sup> and/or may refer to self-help approaches. State-specific accrediting agencies with their own regulations and guidelines for medication-assisted treatment of OUD may also be restrictive. Continued education on clinical guidelines may promote increased prescribing of SUD medications along with integration of behavioral treatment.<sup>9</sup>

Several factors may explain why physicians who are prescribing SUD medications are not recording an SUD diagnosis. First, physicians may not always assign a diagnosis such as opioid dependence or alcohol abuse/dependence because of concerns related to patient resistance or denial of the condition, or potential workplace discrimination.<sup>10,11</sup> Second, some of these medications can be prescribed for conditions other than SUD. Finally, some physicians may not record diagnoses that were not connected to the primary reason for the visits, although they may still continue the SUD medication treatment prescribed previously.

Best practices for opiate and alcohol use disorders hold that along with medication, some form of behavioral treatment should be given, such as direct physician advice and counseling, and more involved interventions such as contingency management, community reinforcement approach plus vouchers, and 12-Step Facilitation therapy.<sup>12</sup> This report finds that only a minority of office visits for medications to treat SUD include provision of or referral to behavioral treatment. Although psychiatrists may be able to provide psychotherapy during a visit, other physician specialties may be unequipped to provide or even refer to behaviorally oriented services due to lack of training, experience or resources. Consequently, patients may not be receiving an optimal mix of both medication and behavioral treatment to address their substance abuse.

These results suggest that continued work is necessary to achieve further incorporation of behavioral and medical treatment of SUD into office-based care. Research on the barriers and facilitators of integration will help to us to understand the possible benefits of bringing substance abuse treatment into a more accessible setting.<sup>13</sup> Bringing medical and behavioral treatment together in physician offices can increase the accessibility and effectiveness of substance abuse treatment, as well as reduce health care costs associated with substance abuse.<sup>14,15,16</sup>

Guidance for medication assisted therapy protocols is provided in several documents available through <http://www.samhsa.gov>.

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## END NOTES

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## SUGGESTED CITATION

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## SUMMARY

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**Background:** More than 17 million persons aged 18 or older in the United States in 2013 (6.6 percent of the population) had alcohol use disorders (AUD), and about 2.4 million (2.9 percent of the population) had opioid use disorders (OUD). A variety of behavioral treatments for substance use disorder (SUD) are available, as well as several FDA-approved medications. This report examines the magnitude of integration of these treatments into office based practice by estimating new and continued prescribing of these medications and provision of mental health counseling. **Methods:** The data analyzed in this report came from the 2010 National Ambulatory Medical Care Survey (NAMCS). This survey provides information about pharmacologic and behavioral treatments for SUD provided by physicians in office-based settings. NAMCS is conducted on an annual basis from a sample of physicians who deliver care directly to patients. **Results:** About 4.3 million visits to physician offices in 2010 involved medication prescriptions to treat alcohol use disorder (AUD) (1.2 million visits) and opioid use disorder (OUD) (3.1 million visits). About 37.2 percent of the prescriptions for AUD and OUD were made in these office visits by general and family practice physicians, and 17.5 percent were made by psychiatrists. Behavioral treatment for SUDs was only provided in a minority of office visits (37.2 percent) during which SUD medications were prescribed. **Conclusions:** Continued work is necessary to achieve integration of behavioral and medical treatment of SUD into office-based care. Research on the barriers and facilitators of integration will help us to understand the possible benefits of bringing substance abuse treatment in to a more accessible setting.

**Key Words:** alcohol use disorders, opioid use disorders, medications, behavioral treatment, integration of care

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## KEYWORDS

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2010, Alcohol, Alcohol Abuse, Alcoholism, All US States Only, Client-Level Data, Integrated Care, Medication-Assisted Treatment, Nonmedical Use, Opiate or Opioid, People in Treatment as Audience, People with Alcohol Use or Abuse Problems as Audience, People with Alcohol Use or Abuse Problems as Population Group, People with Substance Use or Abuse Problems as Audience, People with Substance Use or Abuse Problems as Population Group, Population Data, Primary Care, Public Health Professionals, Public Officials, Short Report, Treatment

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The National Ambulatory Medical Care Survey (NAMCS) is a national survey sponsored by The National Center for Health Statistics, Center for Disease Control, and is designed to meet the need for objective, reliable information about the provision and use of ambulatory medical care services in the United States. Findings are based on a sample of visits to non-federal employed office-based physicians who are primarily engaged in direct patient care. The data for this report was collected in 2010.

The CBHSQ Report is prepared by The Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA, and by RTI International in Research Triangle Park, North Carolina. (RTI International is a trade name of Research Triangle Institute.)

Information on NAMCS is available online at <http://www.cdc.gov/nchs/ahcd.htm>

Other substance abuse reports:  
<http://www.samhsa.gov/data>



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