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# Integrating Buprenorphine Treatment into Formerly “Drug-Free” Outpatient Programs: Staff Perspectives

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## BACKGROUND

- A significant proportion of opioid-dependent people who want and need buprenorphine have been unable to obtain treatment by private physicians because they either do not have medical insurance or they are unable to pay for it out-of-pocket.
- To reduce this disparity, some health departments now provide funding for buprenorphine treatment through formerly “drug-free” outpatient programs (BSAS, 2007).
  - ✓ It is unclear how the culture of these formerly “drug-free” clinics impacts critical aspects of buprenorphine treatment, such as dosing levels, encouragement by program staff towards detoxification, and staff responses to continued or even occasional drug use.
  - ✓ There are also limited data regarding the appropriate levels of counseling or the benefits of AA/NA attendance for buprenorphine treatment provided in outpatient programs.

## PURPOSE

To explore staff perspectives regarding integrating buprenorphine treatment into formerly “drug-free” outpatient programs.

## METHODS

### Participants:

- 15 staff members at 1 of 3 outpatient buprenorphine treatment programs in Baltimore City, Maryland.
  - ✓ All programs have been providing buprenorphine treatment since 2006.

### Procedures:

- Individual, semi-structured interviews were conducted at the programs by an experienced interviewer.
  - ✓ Interviews were conducted in May and June 2010.
- Interview duration ranged from 50 to 120 minutes.
- All interviews were digitally recorded, professionally transcribed, and checked for accuracy.

### Analysis:

- Grounded theory methodology was used for coding.
  - ✓ Inter-rater reliability was assessed for a sub-set (33%) of interviews.

## DESCRIPTION OF SAMPLE

*Program Staff (from 1 Community Health Center and 2 Counseling Centers)*

- *N* = 15
  - ✓ 3 Clinic Directors
  - ✓ 3 Physicians
  - ✓ 3 Nurses
  - ✓ 3 Clinical Coordinators
  - ✓ 3 Counselors
- 11 African Americans; 4 Caucasians
- Nearly all had a decade or more of experience working in the substance abuse treatment field
- Nearly all had previously worked in a “drug-free” treatment setting
- Only medical staff were part-time employees

## RESULTS

### 1. Counseling v. Medication: Providing a Therapeutic Effect

- Since many staff members had worked at the clinics prior to the adoption of buprenorphine treatment, they discussed some initial resistance and staff turn-over related to using pharmacotherapy, particularly among the counseling staff. Even among those who clearly advocated for the benefits of buprenorphine, all levels of staff indicated that the principle therapeutic element provided was the counseling. Buprenorphine was viewed as supportive and reinforcing, at best. Surprisingly, even some of the medical staff endorsed these types of views regarding buprenorphine. The following quote by one of the physicians illustrates this point:

*I tell the patients all the time, “I would love to believe that the medication makes me cure you.” I know that’s... , I don’t believe that’s the truth. I think the counseling is what does it.*

### 2. Patient Abstinence and AA/NA Participation

- Abstinence from all substances, not just opiates, was clearly conveyed as the staff members’ goal for patients. Negative results on urine tests were bench-marks of success and were required in order for patients to progress to different levels within the programs. AA/NA language permeated the interviews and AA/NA attendance was either strongly encouraged or required of patients in the programs, though it was considered to be a source of social support and positive peer modeling.

*When they first start, I mean we don’t require it, we strongly recommend it, particularly in the beginning. Because the goal is to move you away from here [treatment], you need to develop a support system outside of here. So the best way to introduce it initially is through the fellowship of NA or AA. So we do have meetings on site.*

- Staff either disregarded or minimized the over-arching negative stance of NA regarding pharmacotherapy, in general. Some staff members did warn patients about how others in NA may view buprenorphine, and told them to find a new group or go to an AA meetings if it was a problem.

### 3. Logistical Factors Associated with Outpatient Buprenorphine Treatment

- The majority of contact occurred between the patient and the counseling staff, who provided both Intensive Outpatient and Standard Outpatient levels of counseling. For this reason the counseling staff far outnumbered the medical staff at the clinics and the physicians at two of the clinics, as well as the nurses, worked only part-time. This meant that the other staff members felt they had a better understanding of what was happening with individual patients than did the physicians, and it created situations in which they were telling the physicians how to prescribe and when to discharge patients.

*I mean we’ve literally said, you know, a patient will see Dr. X and the nurse will look at the prescription and say, “You’re not getting this [medication increase]. Dr. X, you need to write this for such-and-such amount..”*

- Concerns regarding medication diversion led to the implementation of program practices and rules, including: pill recounts for patients with take-homes, denying take-homes or writing prescriptions for only a week’s dose, and not prescribing more than 16 milligrams of buprenorphine.
- In some instances during pill counts it was found that patients had more pills than they should have if they had been taking the medication as prescribed, indicating that they were modifying their buprenorphine regimen if they felt they could cut back without experiencing withdrawal.

## CONCLUSIONS

- Though the three outpatient clinics have integrated buprenorphine into their treatment, many vestiges of their former “drug-free” orientation were still present, including a propensity to refer patients to AA/NA.
  - ✓ The mixed message regarding pharmacotherapy that patients may be receiving from the clinic staff and others in AA/NA should be taken into account, and other ways of developing positive social networks should be considered.
- While buprenorphine was considered an effective medication for opiate-dependent patients, it was not believed to be responsible for patients’ recovery. All staff endorsed the idea that the real treatment that took place in their clinic was the counseling.
  - ✓ The larger study findings will compare outcomes for patients receiving different levels of counseling (IOP v. OP) and will carefully track the frequency of individual counseling and group sessions received by patients and how they relate to treatment retention, continued drug use, and DSM-IV criteria for opioid dependence.
- Programs exerted time and staff attention to reducing the likelihood that patients could divert their medication to others.
  - ✓ Prior research has found that diverted buprenorphine can sometimes serve as a bridge for people who are considering entering treatment (Mitchell et al., 2009). Treatment providers and policy makers should rationally examine this issue and develop alternative mechanisms for making buprenorphine available to out-of-treatment opioid users.
- Formerly “drug-free” outpatient programs show promise as settings for delivering buprenorphine, however the clinic culture is likely to impact service delivery. Its impact on outcomes is currently unknown.

## REFERENCES

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