The Opioid Epidemic: An Opportunity for Expanding Role of Physicians in the Treatment of Addiction

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Adams Professor of General Medicine
Chief, General Internal Medicine
Yale University School of Medicine

The Foundation for Community Health
May 25, 2016
The Opioid Epidemic: An Opportunity for Expanding Role of Physicians in the Treatment of Addiction

- Epidemiology of addiction in the United States
- Treatment of Opioid Addiction
  - The “Twin Epidemics”
  - Methadone Maintenance
- Role of Primary Care Physicians
  - Screening, brief intervention
  - Office-based buprenorphine
- Role of Physicians in the Treatment of Addiction
  - Primary care and other physicians
  - Addiction specialists
Epidemiology of Addiction in the US: Overall costs and prevalence of drug use

- > $500 Billion in annual economic costs in US.
- 2013 National Survey on Drug Use and Health (NSDUH): >12 years old, past 30 days:
  - heroin use increased 79% since 2007
  - prescription opioid abuse epidemic continues to increase since it began in ≈2000
  - overall 9.2% use illicit drugs
- For the first time opioid overdose deaths now exceed those from car accidents annually.
- Drug use is even more prevalent in patients seen in clinics, EDs, hospitals and other medical settings.
## Epidemiology of Alcohol Use: General population & medical settings

<table>
<thead>
<tr>
<th>Category</th>
<th>General Population†</th>
<th>General Medical Practice‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abstainers/Light</td>
<td>40%</td>
<td>----</td>
</tr>
<tr>
<td>2. Moderate Drinkers</td>
<td>35%</td>
<td>----</td>
</tr>
<tr>
<td>3. At Risk*</td>
<td>20%</td>
<td>20-35%*</td>
</tr>
<tr>
<td>4. Alcohol Abuse*</td>
<td>5%</td>
<td>5-10%*</td>
</tr>
<tr>
<td>5. Alcohol Dependence*</td>
<td></td>
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</tbody>
</table>

† National Longitudinal Alcohol Epidemiology Study 1992, National Comorbidity Study, 1992
‡ Wallace; BMJ 1988;297:663-8, Flemming JAMA 1997;277:1039-45
* Require treatment/intervention
Drug Overdoses in Perspective

DRUG OVERDOSES KILL MORE THAN CARS, GUNS, AND FALLING.

- Falling: 28,360 deaths
- Guns: 32,351 deaths
- Traffic accidents: 33,692 deaths
- Drug overdoses: 41,340 deaths

The Addiction Tsunami in the U.S
The Addiction Epidemic: Driving Health Policy in 2015
• “There continues to be a large ‘treatment gap’ in this country. In 2011...
  – 21.6 million Americans (8.4%) needed specialized treatment for addiction
  – 2.3 million people or only 11% those in need received treatment.”

[NIDA Drug Facts, December 2012]

• Physicians should play a much larger role in help to filling this treatment gap!
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Methadone Maintenance: First Clinical Trial

A Medical Treatment for Diacetylmorphine (Heroin) Addiction

A Clinical Trial With Methadone Hydrochloride

Vincent P. Dole, MD, and Marie Nyswander, MD

A group of 22 patients, previously addicted to diacetylmorphine (heroin), have been stabilized with oral methadone hydrochloride. This medication appears to have two useful effects: (1) relief of narcotic hunger, and (2) induction of sufficient tolerance to block the euphoric effect of an average illegal dose of diacetylmorphine. With this medication, and a comprehensive program of rehabilitation, patients have shown marked improvement; they have returned to school, obtained jobs, and have become reconciled with their families. Medical and psychometric tests have disclosed no signs of toxicity, apart from constipation. This treatment requires careful medical supervision and many social services. In our opinion, both the medication and the supporting program are essential.

ough review of evidence available in 1957, concluded that “The advisability of establishing clinics or some equivalent system to dispense opiates to addicts cannot be settled on the basis of objective facts. Any position taken is necessarily based in part on opinion, and on this question opinions are divided.” With respect to previous trials of maintenance treatment, the Council found that “Assessment of the operations of the narcotic dispensaries between 1919 and 1923 is difficult because of the paucity of published material. Much of the small amount of data that is available is not sufficiently objective to be of great value in formulating any clear-cut opinion of the purpose of the clinics, the way in which they operated, or the results attained.” No new studies bearing on the question of maintenance treatment have appeared in the
Research Findings: Methadone Maintenance is Highly Effective

• **Decreases:** heroin and other drug use
  HIV and hepatitis B/C infection
  crime & social dysfunction

• **Improves:** obstetric and birth outcomes
  overall survival

• **Limitations:** restrictions = limited access
  few programs
  patient acceptance

• **New Treatment Options Needed!**

“Twin Epidemics” fueled my research on new treatment approaches

• **Late 1980s:** HIV in Injection Drug Users

• **Early 2000s:** Prescription Opioid Abuse

These issues in discussing a comprehensive approach to the medical and psychosocial needs of this population.

**Screening for and Diagnosis of Substance Abuse**

Despite the high prevalence of substance abuse documented in various groups of patients, it often goes unrecognized by physicians, in part because of inadequate teaching in medical school and residency training. Careful screening for substance abuse is particu-
Opioid Use in America: The Physician’s Role

- Hydrocodone is the most prescribed drug in the US\(^1\)
- 259 million opioid prescriptions in 2012\(^2\)
- Number of opioid prescriptions dispensed quadrupled since 1991\(^3\)

\(^3\) SDI Vector One: National (VONA) 9-30-10 Hydrocodone & Oxycodone 1991-2009
Trends: Opioid Sales, Deaths, and Treatment Admissions

What Physicians (and Governors) should NOT do: Ban Methadone
One Vermont Governor Got it Right
The Opioid Epidemic: An Opportunity for Expanding Role of Physicians in the Treatment of Addiction

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  - Office-based buprenorphine
- Role of Addiction Specialists
  - History of the development of addiction as a specialty
  - Addiction Medicine as a new subspecialty
2009 COCHRANE REVIEW: “Brief Intervention” for heavy drinkers in Primary Care

- **Office based “Brief Intervention” (advice):**
  - Nondependent heavy drinkers
  - “feedback & advice” concerning heavy drinking provided by a general physician
  - 5-10 minutes, within a routine office visit, 1-2x

- 24 randomized trials, N: >7000, ≈20-30 drinks/w
- decreased mean consumption by up to 9 drinks/w, benefit most clear in men

- **Conclusion:** “Overall brief interventions in primary care lowers alcohol consumption.”
Naltrexone Works in Alcohol Dependent Patients in Primary Care

<table>
<thead>
<tr>
<th></th>
<th>CBT (n=97)</th>
<th>PC (n=93)</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td><strong>Primary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responder (n, %)</td>
<td>77 (79.4%)</td>
<td>74 (79.6%)</td>
<td>ns</td>
</tr>
<tr>
<td>Percentage of days abstinent</td>
<td>79.9 ± 31.4</td>
<td>77.9 ± 30.9</td>
<td>ns</td>
</tr>
<tr>
<td><strong>Secondary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinks per drinking day</td>
<td>3.3 ± 5.6</td>
<td>3.3 ± 4.7</td>
<td>ns</td>
</tr>
<tr>
<td>No relapse to heavy drinking</td>
<td>60 (61.9%)</td>
<td>52 (55.9%)</td>
<td>ns</td>
</tr>
<tr>
<td>Continuous Abstinence (n, %)</td>
<td>43 (44.3%)</td>
<td>31 (33.3%)</td>
<td>ns</td>
</tr>
<tr>
<td>GGT end point change from baseline (mean ± SD)</td>
<td>-43.1 ± 75.3</td>
<td>-37.9 ± 65.7</td>
<td>ns</td>
</tr>
<tr>
<td>OCDS total score Therapy (mean ± SD)</td>
<td>8.0 ± 5.4</td>
<td>8.2 ± 5.8</td>
<td>ns</td>
</tr>
</tbody>
</table>

Arch Intl Med 2003, 163:1695-1704
New Treatment Options Beyond Methadone: Office-based Treatment in Primary Care

• **Office Based Treatment in Primary Care:**
  – coordinate substance abuse treatment and primary care “under one roof”
  – *approach addiction like other chronic diseases*
  – engage patients in less stigmatizing medical settings that are widely available

• **Our Research Goal:**
  – develop new treatments that can engage office based *primary care physicians* in the treatment of addiction
Human Immunodeficiency Virus Infection in Intravenous Drug Users: A Model for Primary Care*


PURPOSE: The seroconversion rate among patients with HIV infection is estimated to be as high as 30% per year. The economic and social impact of HIV infection may be even greater in intravenous drug users (IVDUs) than in other high-risk groups. Therefore, an effective treatment for IVDUs is critical. The Central Medical Unit at the Yale University School of Medicine has developed a comprehensive model for the treatment of HIV-infected patients. This model may provide a cost-effective alternative to primary care for this population.

PATIENTS: The Central Medical Unit serves patients who are IV drug users or have contact with IV drug users. The patient population is predominantly male, and the median age is 35 years. The patient population is approximately 80% of the general population of New Haven, Connecticut.

RESULTS: Since the inception of the program, 1,000 patients have been seen. Of these patients, 64% were newly diagnosed with HIV infection. The median length of time patients were followed was 12 months. The patients were treated for a variety of conditions, including antiretroviral therapy, opportunistic infections, and substance abuse.

Outpatient Opioid Detoxification: Treatment Outcome

### Table 4

<table>
<thead>
<tr>
<th>Treatment Outcome: Ambulatory Opioid Detoxification</th>
<th>Success (%)</th>
<th>Failure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine ((n = 57))</td>
<td>24 (42%)</td>
<td>33</td>
<td>57</td>
</tr>
<tr>
<td>Clonidine/naltrexone ((n = 68))</td>
<td>64 (94%)</td>
<td>4</td>
<td>68</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>88 (70%)</strong></td>
<td><strong>37</strong></td>
<td><strong>125</strong></td>
</tr>
</tbody>
</table>

\(\chi^2 = 40.26, \ p < 0.001.\)

Buprenorphine: A New Treatment for Opioid Addiction

I. Full opiate agonist: Methadone

II. Partial opiate agonist: Buprenorphine

III. Opiate antagonist: Naltrexone
Outpatient Opioid Detoxification: A New Approach - Buprenorphine

Three Methods of Opioid Detoxification in a Primary Care Setting

A Randomized Trial

Patrick G. O'Connor, MD, MPH; Kathleen M. Carroll, PhD; Julia M. Shi, MD; Richard S. Schottenfeld, MD; Thomas R. Kosten, MD; and Bruce J. Rounsaville, MD

Background: Opioid detoxification in a primary care setting followed by ongoing substance abuse treatment may be appropriate for selected opioid-dependent patients.

Figure. Mean scores for withdrawal symptoms by detoxification day. No data were collected on days 6 and 7 (asterisk). Complete data on symptoms are available for 92% of visits (91% in the clonidine group, 90% in the combined clonidine and naltrexone group, and 94% in the buprenorphine group).

“The Quick Fix” – Ultra-rapid Detox...Under Anesthesia

Get drug-free. Stay drug-free.

Learn the facts about the very few rapid detox facilities throughout the country.
“Detox” under Anesthesia:
No more effective, more dangerous & expensive

Rapid and Ultrarapid Opioid Detoxification Techniques

Patrick G. O’Connor, MD, MPH; Thomas R. Kosten, MD

Objective.—To review the scientific literature on the effectiveness of rapid opioid detoxification (RD) (opioid withdrawal precipitated by naloxone hydrochloride or naltrexone) and ultrarapid opioid detoxification (URD) (opioid withdrawal precipitated by naloxone or naltrexone under anesthesia or heavy sedation) techniques.

Data Sources.—The MEDLINE database was searched from 1966 through 1997 using the indexing terms naloxone, naltrexone, substance dependence, and substance withdrawal syndrome. Additional data sources included bibliographies of papers identified on MEDLINE and bibliographies in textbooks on substance abuse.

Nonopioid approaches to opioid detoxification, such as clonidine hydrochloride, have been developed over the past several years.6,7 In addition, a rapid opioid detoxification (RD) technique has been developed, which is designed to shorten detoxification by precipitating withdrawal through the administration of opioid antagonists such as naloxone hydrochloride or naltrexone.8,9 This an-

JAMA. 1998;279:229-234
To the Editor (unpublished): “...Dr. O’Connor...is he really a “doctor”?...clearly he knows nothing about medicine, not to mention what’s best for my desperate opiate addicts...he should be tarred, feathered, and thrown out of the profession!”

(Medical Director of a major Ultrarapid Detox. Clinic)
Office Based Opioid Detoxification: Limitations & Need for a Different Approach

- Outpatient Opioid Detoxification Limitations:
  - short term “detox” highly successful...
  - but long term outcomes poor

- “Detoxification” vs. “Maintenance”:
  - detoxification: short term - from drug using to drug free
  - maintenance: long term opioid Rx (e.g.: MMP)

- Office Based Maintenance Treatment?
  - methadone: not possible due to federal restrictions
  - buprenorphine?
    - improved safety profile vs methadone
    - effective as methadone in specialized programs
    - effective in office based settings???
Primary Care Buprenorphine Maintenance: First Randomized Clinical Trial

A Randomized Trial of Buprenorphine Maintenance for Heroin Dependence in a Primary Care Clinic for Substance Users versus a Methadone Clinic

Patrick G. O’Connor, MD, MPH, Alison H. Oliveto, PhD, Julia M. Shi, MD, Elisa G. Trifileman, MD, Kathleen M. Carroll, PhD, Thomas R. Kosten, MD, Bruce J. Rounsaville, MD, Juliania A. Pakes, Richard S. Schottenfeld, MD

PURPOSE: Buprenorphine is an alternative to methadone for the maintenance treatment of heroine dependence and may be effective on a thrice weekly basis. Our objective was to evaluate the effect of thrice weekly buprenorphine maintenance for the treatment of heroin dependence in a primary care clinic on retention in treatment and illicit opioid use.

SUBJECTS AND METHODS: Opioid-dependent patients were randomly assigned to receive thrice weekly buprenorphine maintenance in a primary care clinic that was affiliated with a drug treatment program (n = 23) or in a traditional drug treatment program (n = 23) in a 12-week clinical trial. Primary outcomes were retention in treatment and urine toxicology for

RESULTS: Retention during the 12-week study was higher in the primary care setting (78%, 18 of 23) than in the drug treatment setting (52%, 12 of 23; P = 0.06). Patients admitted to primary care had lower rates of opioid use based on overall urine toxicology (63% versus 85%, P <0.01) and were more likely to achieve 3 or more consecutive weeks of abstinence (43% versus 13%, P = 0.02). Cocaine use was similar in both settings.

CONCLUSIONS: Buprenorphine maintenance is an effective treatment for heroin dependence in a primary care setting.

Primary Care Buprenorphine vs Methadone Maintenance Program (MMP)

Figure 1. Proportions of patients remaining in treatment protocol by study group.

Office Based Medical Management vs MMP: Patient Satisfaction

- Satisfied with the tx received
- Who felt the quality of care was excellent
- Would like to receive medication in a MD office

*JAMA*, October 10, 2001 – Vol. 286, No. 14
Office Based Medical Management vs MMP: Physician Satisfaction

- Patients who providers were satisfied with treating
- Patients with whom providers described having a good to excellent rapport

JAMA, October 10, 2001 – Vol. 286, No. 14
Research to Policy:
President Clinton signs DATA 2000 into law
Drug Addiction Treatment Act (DATA) of 2000

• Amended 1970 CSA: allow office based treatment of opioid dependence.

• Physicians may “qualify” for DEA approval by:
  – Board Certification (Addiction Psychiatry, Addiction Medicine), or
  – Training: 8 hour course, classroom or online.

• But only DEA Schedule III-V drugs can be used & none were available in 2000...until:

• **2002: Buprenorphine/naloxone was FDA-approved (Schedule III) for opioid maintenance and detoxification.**
Counseling plus Buprenorphine–Naloxone Maintenance Therapy for Opioid Dependence

David A. Fiellin, M.D., Michael V. Pantalon, Ph.D., Marek C. Chawarski, Ph.D., Brent A. Moore, Ph.D., Lynn E. Sullivan, M.D., Patrick G. O’Connor, M.D., M.P.H., and Richard S. Schottenfeld, M.D.

BACKGROUND
The optimal level of counseling and frequency of attendance for medication distribution has not been established for the primary care, office-based buprenorphine–naloxone treatment of opioid dependence.

*NEJM*, July 27, 2006 – Vol. 355, No. 4
Primary Care Buprenorphine: Intensity of Counseling “Standard” v “Enhanced” Medical Management


NEJM 2006:355,4
Intensity of Counseling: Does adding “Cognitive Behavioral Therapy” (CBT) help?

Figure 3: Study completion among opioid-dependent patients receiving buprenorphine/naloxone in primary care. Study completion was defined as not meeting the criteria for protective transfer, not missing medication for more than 7 days, or not missing 3 or more physician management sessions.

American J Med, 2013; 126, 74.e11-74.e17
Primary Care Buprenorphine: Long Term Outcomes (2-5 years)

TABLE 2. Outcomes among opioid-dependent patients receiving long-term buprenorphine/naloxone maintenance in primary care

<table>
<thead>
<tr>
<th>Primary outcomes</th>
<th>N = 53</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of opioid-negative urine specimens, n/N</td>
<td>91% (1005/1106)</td>
</tr>
<tr>
<td>Secondary outcomes</td>
<td></td>
</tr>
<tr>
<td>Percentage of cocaine-negative urine specimens, n/N</td>
<td>96% (1062/1106)</td>
</tr>
<tr>
<td>Dose of buprenorphine/naloxone, mean, SD</td>
<td>17.0 (4.2)</td>
</tr>
<tr>
<td>Treatment satisfaction score, mean (range)</td>
<td>86.3 (69–93)</td>
</tr>
<tr>
<td>Serum AST, mean (range)</td>
<td>29.6 (9–169)</td>
</tr>
<tr>
<td>Serum ALT, mean (range)</td>
<td>22.6 (4 – 119)</td>
</tr>
</tbody>
</table>

*Am J Addict, 2008; 17:116-120*
Primary Care Buprenorphine: More Effective in Prescription Opioid Abuse?

![Graph showing percentage of opioid-negative patients for Heroin only, Heroin & Prescription, and Prescription only.

*American J Med, 2013; 126, 74.e11-74.e17*
Primary Care-Based Buprenorphine Taper vs Maintenance Therapy for Prescription Opioid Dependence: A Randomized Clinical Trial

David A. Fiellin, MD; Richard S. Schottenfeld, MD; Christopher J. Cutter, PhD; Brent A. Moore, PhD; Declan T. Barry, PhD; Patrick G. O’Connor, MD, MPH

**Importance** Prescription opioid dependence is increasing and creates a significant public health burden, but primary care physicians lack evidence-based guidelines to decide between tapering doses followed by discontinuation of buprenorphine hydrochloride and naloxone hydrochloride therapy (hereinafter referred to as buprenorphine therapy) or ongoing maintenance therapy.

**Objective** To determine the efficacy of buprenorphine taper vs ongoing maintenance therapy in primary care-based treatment for prescription opioid dependence.

**Design, Setting, and Participants** We conducted a 14-week randomized clinical trial that enrolled 113 patients with prescription opioid dependence from February 17, 2009, through February 1, 2013, in a single primary care site.
Primary Care Buprenorphine: Prescription Drug Abuse – “Detox” Taper vs Maintenance?

Figure 2. Treatment Retention and Mean Buprenorphine Dosage for Patients With Prescription Opioid Dependence

- **Maintenance condition**
- **Taper condition**

<table>
<thead>
<tr>
<th>Time in Study, wk</th>
<th>Treatment Retention, % of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maintenance condition</td>
</tr>
<tr>
<td></td>
<td>Taper condition</td>
</tr>
</tbody>
</table>

Mean buprenorphine dosage, mg/d

- **Maintenance condition**
  - 14.9 15.1 15.2 15.3 15.3 16.0 15.9 16.2 16.2 16.6 16.8 16.2 16.1 15.8 14.6
- **Taper condition**
  - 15.6 15.6 15.4 15.3 14.2 9.7 5.7 3.1 0.6 0.2 0 0 0 0 0 0


Yale School of Medicine, Section of General Internal Medicine
Impact of Office-based Treatment: Methadone and Buprenorphine Treated Patients - 2001

- Methadone: 250,000
- Buprenorphine: 0
Research to Policy:
Impact of Office-based Treatment - 2012

- Methadone: 270,000
- Buprenorphine: 400,000
Physician Specialty and Buprenorphine Prescribing in the US, 2012 (N = 27,000 MDs)
Opioid Overdose Response: Community Naloxone Distribution

- Easily administered treatment for opioid overdose
- First community distribution program: 1996
- CDC MMWR: As of June 2014, 26,463 reversals reported
- But...then what?
New Frontiers: Buprenorphine in Emergency Department Patients

Original Investigation

Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D’Onofrio, MD, MS; Patrick G. O’Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD;
Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

JAMA. 2015;313(16):1636-1644
3 Treatments Randomly Assigned

- Referral to Treatment (n=104)
- Brief Intervention & Facilitated Referral (n=111)
- Brief Intervention, Buprenorphine, & Primary Care (n=114)

ED-Initiated Buprenorphine: 30-Day Outcomes

![Graph showing treatment engagement and past week illicit opioid use](image)

- Treatment Engagement
  - Referral
  - Brief Intervention + Referral
  - Bup + PC
  - P < 0.001

- Past Week Illicit Opioid Use
  - SRT
  - SBIF Bi+Re
  - SBIF Bup+PC

- JAMA 2015; 313: 1636-1644

Yale School of Medicine, Section of General Internal Medicine
Prescription opioid use may be starting to trend down, but...there’s more work to do.
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Evidence-based Addiction Prevention and Treatment: Primary Care and Other “Generalist” Physicians

- Office based treatment of opioid dependence ✔
- Screening ✔
- Brief Intervention ✔
- Referral to Treatment ✔
- Office-based treatment of alcohol dependence ✔
Integrating Addiction Medicine Into Graduate Medical Education in Primary Care: The Time Has Come

Patrick G. O’Connor, MD, MPH; Julie G. Nyquist, PhD; and A. Thomas McLellan, PhD

Substance use disorders create an enormous burden of medical, behavioral, and social problems and pose a major and costly public health challenge. Despite the high prevalence of substance use and its consequences, physicians often do not recognize these conditions and, as a result, provide inadequate patient care. At the center of this failure is insufficient training for physicians about substance use disorders.

To address this deficit, the Betty Ford Institute convened a meeting of experts who developed the following 5 recommendations focused on improving training in substance abuse in primary care residency programs in internal medicine and family medicine: 1) integrating substance abuse competencies into training, 2) assigning substance abuse teaching the same priority as teaching about other chronic diseases, 3) enhancing faculty development, 4) creating addiction medicine divisions or programs in academic medical centers, and 5) making substance abuse screening and management routine care in new models of primary care practice. This enhanced primary care residency training should represent a major step forward in improving patient care.

For author affiliations, see end of text.

• **Addiction Psychiatry:**
  – American Board of Psychiatry and Neurology
  – BE/BC Psychiatrists
  – ABMS recognized in 1991
  – 46 fellowship programs
  – more specialists needed to address treatment gap
Addiction Medicine

The Birth of a New Discipline

Patrick G. O'Connor, MD, MPH
Department of Internal Medicine, Yale University School of Medicine, New Haven, Connecticut.

Robert J. Sokol, MD
Department of Obstetrics and Gynecology, Wayne State University School of Medicine, Detroit, Michigan.

Gail D'Onofrio, MD, MS
Department of Emergency Medicine, Yale University School of Medicine, New Haven, Connecticut.

Substance use is highly prevalent, a substantial cause of morbidity and mortality and accounts for over $500 billion in economic costs in the United States annually. The 2012 National Survey on Drug Use and Health (NSDUH), which surveyed Americans 12 years or older, reported that 32% binge drink and nearly 7% reported heavy drinking over the past 30 days. In addition, 9% of those surveyed reported illicit drug use during the past 30 days, and heroin use increased by 79% since 2007. Opioid overdoses are on the rise, now exceeding deaths from motor vehicle crashes. Similarly, the global impact on disability and mortality of substance use and the phenomenon of addiction that often follows is enormous.

Individuals with specific substance use disorders and addiction interact frequently with the health care system, offering opportunities to intervene. The evidence base of research supporting the effectiveness of prevention and treatment of addiction is growing. For example, randomized clinical trials have demonstrated the priority. Like other chronic diseases, there is a role for both primary care physicians and referral to specialists when their expertise is needed.

Addiction specialists can play a critical role in addressing the treatment gap for substance use disorders and improving patient care. For example, primary care physicians may be reluctant to screen for substance use because of uncertainty about what to do once a patient is identified. The availability of addiction specialists can give confidence to primary care physicians that they can access expert consultation and follow up, when needed, such as with complex withdrawal or repeated relapse. In addition, specialists can help to decrease practice variation and ensure evidence-based care. The availability of addiction specialists who are broadly integrated into the medical community can also provide a bridge to substance abuse treatment programs, which many physicians are either unfamiliar with or reluctant to use. Once assessed by an addiction specialist, program re-
The American Board of Addiction Medicine (ABAM)

- Established as an “Independent” medical board in 2007, 1st exam in 2008
- Primary Goal: ABMS recognition
- Multidisciplinary subspecialty & Board of Directors:
  - Emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, preventive medicine, psychiatry, surgery
- Current status: following the 2015 board exam
  - 3900 ABAM diplomats
  - 39 Addiction Medicine fellowship programs
Yale professor co-chairs White House symposium on addiction medicine

By Ziba Kashef

September 21, 2015

Dr. Patrick O’Connor co-chaired the landmark White House symposium on the role of medicine in addiction prevention and treatment. (Photo courtesy of the White House Office of National Drug Control Policy)

U.S. Surgeon General Dr. Vivek Murthy and Dr. Patrick O’Connor (Photo courtesy of the White House Office of National Drug Control Policy)
Translation of the science of prevention and treatment into medical practice.

Engaging leaders in medicine to further integrate content on addiction medicine into their physician training requirements.

Developing fellowship programs for physicians to build a trained addiction medicine workforce.

Creating a lasting structure for collaboration between addiction medicine and federal partners.

Included leadership of:

– The White House & The American Board of Addiction Medicine
– Federal Agencies: NIH, CDC, Surgeon General, health care agencies
– Leaders in Medicine: medical schools, certifying agencies and boards, major healthcare providers
– Policy makers
Addiction Medicine: A New Subspecialty!

ABMS Officially Recognizes Addiction Medicine as a Subspecialty

On March 14, 2016

American Board of Preventive Medicine Sponsored the Application Allowing Physicians Certified by ABMS Member Boards to Apply for the New Certificate

The American Board of Medical Specialties (ABMS) officially recognized Addiction Medicine as a subspecialty at its October 2015 Board Meeting in Dallas, Texas. The American Board of Preventive Medicine (ABPM), a Member Board of ABMS, sponsored the application for the subspecialty to allow physicians certified by any of the 24 ABMS Member Boards to apply for the new certificate.
The Enigma of Stigma: Addiction
Summary: The Roles Of Physicians in Treating Addiction

– There is a substantial addiction “treatment gap” & physicians should play expanded role in treatment.

– Office based treatment for opioid use disorder with buprenorphine is highly effective.

– Brief interventions and naltrexone are effective for heavy drinking and alcohol use disorder in primary care.

– Interested physicians should consider becoming addiction specialists.

– Fight the stigma associated with this common chronic disease.
Thank You!
The Opioid Epidemic: An Opportunity for Expanding Role of Physicians in the Treatment of Addiction

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The Foundation for Community Health
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