

Why it's easier to be prescribed an opioid painkiller than the treatment for opioid addiction

May 31 2016, by Jeffrey Hom And Krisda H. Chaiyachati, University Of Pennsylvania



Credit: AI-generated image ([disclaimer](#))

Prescription opioid abuse and its downstream effects have reached epidemic proportions in the United States. On May 26, the Food and Drug Administration (FDA) moved a step closer to providing help to

those addicted to opioids by approving a new implant containing buprenorphine, an opioid replacement that can reduce the [cravings](#) of addiction.

Still, thousands of people who could benefit from the drug may not have access to it. If the implantable form is regulated in the same way as its oral counterpart – and there is no reason to believe it will not be – only certain doctors will be allowed to prescribe the drug.

While little training is required for doctors to prescribe opioids for pain, onerous restrictions are placed on physicians who wish to and currently do prescribe oral [buprenorphine](#). These restrictions exist because buprenorphine does have the potential to be misused. Yet the restrictions placed on it far exceed those on prescription opioid painkillers, for which the potential for abuse is high.

As physicians and health policy scholars, we see a disconnect. Why make it harder to receive treatment than to receive a dangerous drug in the first place?

Escalating problem, little oversight

In 2012 alone, over [259 million prescriptions](#) for opioid painkillers were written – at least one prescription for every adult in the country. [Deaths due to opioid overdose have surged](#), surpassing deaths due to motor vehicle accidents. In 2014 alone, more than 47,000 people died from opioid overdoses.

Despite alarming statistics and the significant attention focused on the epidemic, a hidden regulatory imbalance exists between two types of opioids – those prescribed for pain and those prescribed to treat opioid addiction.

As physicians, we need to obtain only a license from the Drug Enforcement Agency (DEA) in order to prescribe opioid painkillers. Maintaining it requires a licensing fee every three years, but there is no mandatory training on how to safely prescribe these medications and no requirements to monitor patients who receive them. There is, in short, little oversight.

Possible treatment, heavy oversight

In contrast, heavy regulations restrict those providers wishing to treat addiction by prescribing buprenorphine, the mainstay of medication-assisted treatment for opioid addiction outside of methadone clinics. Although [buprenorphine was approved by the FDA in 2002](#), it remains underused, [far below](#) the levels needed to meet the growing number of individuals requiring treatment.



Credit: AI-generated image ([disclaimer](#))

Rates of buprenorphine use are low not because physicians are unaware of it or believe it to be ineffective. It's largely because obtaining and maintaining the right to prescribe it are [onerous](#) for treating an already challenging population.

Physicians must first complete buprenorphine-specific training and receive a waiver from the DEA. Once certified, they must maintain strict logs pertaining to treatment. They are allowed to treat no more than 100 patients with buprenorphine at a time.

Not just a physician problem

Recently, [we wrote about the challenges and proposed solutions](#) for how policymakers and physician leadership should approach this asymmetry between the accessibility of opioids for treatment and pain. One important component missing from our piece, however, was the other imbalance faced by nurse practitioners (NPs) and physician assistants (PAs).

These two professions have received clinical education and training that is similar to that of physicians, and [practice autonomously](#) in many parts of the country. They can prescribe opioids for pain. However, regardless of their interest in treating addiction, they are not allowed to prescribe buprenorphine. This is particularly problematic because these "physician extenders" provide a significant proportion of health care in [rural areas](#), which are often hit hardest by the epidemic.

While the number of opioids prescribed by NPs and PAs is [small relative to those prescribed by physicians](#), it nonetheless creates a further

imbalance whereby these providers can contribute to the problem but not the solution. [Federal legislation](#) has been proposed to rectify this and expand buprenorphine waivers to eligible NPs and PAs, a measure that has been approved by a U.S. Senate committee.

Also recognizing the need to address the epidemic in a more balanced manner, the U.S. House recently passed 18 bills related to opioids in an effort to address the epidemic. Congress will now try to reconcile these with a comprehensive Senate bill passed earlier in the year. These measures have bipartisan support, but how much funding will be appropriated to them remains to be seen.

This discussion is timely. Despite [recent evidence](#) that the number of prescriptions written for opioid painkillers is declining, an encouraging sign, deaths due to overdoses continue to rise. Efforts to curtail prescribing patterns may prevent more individuals from becoming addicted, but they will do little to help those who already are.

Implantable buprenorphine may be an important advance in treatment for this addiction, but limitations will likely exist in addition to the regulation of providers. Cost and coverage may be barriers. The placement and removal of an implant are surgical procedures that will require adequate training and additional expenses.

There's already a simpler and better way to get buprenorphine to people who need it. Let's start by easing the path for providers to prescribe [opioids](#) for pain, including NPs and PAs, to help treat those with addiction.

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