Report to

The Maine Association of Substance Abuse Programs (MASAP)

Focus Groups with Counselors and Clinical Supervisors on the Use Of Medications in Drug and Alcohol Addiction Treatment

Prepared by

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Section I. PROJECT BACKGROUND, OBJECTIVES AND METHODOLOGY

BACKGROUND AND METHODOLOGY

- Working on contract to MASAP Pan Atlantic SMS Group, a Maine based marketing research and consulting practice, conducted a series of five focus groups in Bangor, Caribou, Augusta, Brunswick, and Waterville between Monday the 5th and Friday the 9th of February 2007.

  Groups were conducted principally with counselors from the local drug and alcohol treatment centers, on site, at their organizations' offices.

- One of the five groups was conducted at the offices of MASAP with clinical supervisors from several of the treatment centers.

- For the most part those who participated are counseling clients on drug and alcohol addiction issues though a small number are also simultaneously counseling on mental health issues. However, the focus of each session was solely devoted to drug and alcohol addiction issues. The Brunswick group also included 2 administrative staff and a resident psychiatrist.

- Groups had a good mix of male and female participants and age/career experience levels. A total of 54 people attended the five groups.

  Attendance was as follows:

Bangor	Caribou	Augusta	Brunswick	Waterville
10*	12	14	11*	7*

  *In each of these groups a clinical supervisor participated who also attended the Augusta (clinical supervisors group) focus group.

- In the case of the Bangor focus group, which was held at the Acadia Hospital facility, the primary focus of those participating, is the treatment of opiate and not alcohol addiction.

- Participants in each group were recruited by a clinical supervisor in each agency (Acadia Hospital in Bangor, Aroostook Mental Health Center in Caribou, Midcoast Hospital in Brunswick and Health Reach/ Maine

General Hospital in Waterville). The Augusta (clinical supervisors) group was recruited by MASAP.

- A copy of the discussion outline which was used to conduct the groups and which was pre-approved by MASAP is attached in Appendix A.

- Verbatim comments from each group will be identified by the first letter of the town/city in which the group was conducted: Bangor=B, Caribou=C, Augusta=A, Brunswick=BR, and Waterville=W.

- All five groups were moderated by Patrick O. Murphy, President of Pan Atlantic SMS Group.

OBJECTIVES

The principal objectives of the project are to evaluate:

1. Participants' beliefs and attitudes as they pertain to the use of medications in the treatment of addictions.

2. Participant knowledge levels and experience with various addictions treatment medications.

3. Key barriers to their (counselors) recommending greater use of medication in the treatment of addictions.

4. Participants' recommendations on actions which could be taken to reduce barriers to the use of medication in the treatment of addictions.

Notes

1. There is a risk in attempting to predict the attitudes and opinions on addiction treatment issues of all counselors statewide based solely on the information gathered from these five focus groups. The size of the participant sample does not allow Pan Atlantic SMS Group to quantitatively project overall perceptions, attitudes or the likely behaviors of the overall population of addiction counselors in Maine in relation to the use of medications. However, they are extremely helpful in exploring the qualitative viewpoints of participants in an in depth analytical fashion.

2. The reporting format which follows reports on differences in opinion, by group where applicable. Secondly, perceived barriers and recommended actions to reduce those barriers are reported out separately for each group.

SECTION II. SUMMARY AND RECOMMENDATIONS

- In all groups, participants cited an ever-increasing caseload of opiate addicted clients in Maine. The majority of these newly addicted patients tend to be younger – teens through early 30's. Participants also said that their alcohol addiction clients tend to be older and in many cases male.

- Key challenges facing counselors include:

  - ✓ Increasing client case loads especially due to perceived increases in opiate addiction, including in rural areas of Maine.

  - ✓ Lack of integration in the provision of services between counselors and external providers e.g. physicians, mental health service providers etc.

  - ✓ Lack of financial resources to deal with the increasing level of opiate addiction in the population.

  - ✓ The increasing challenge of treating clients who need both mental healthcare and addiction treatment.

Beliefs and Attitudes

- In general, participants feel that attitudes have changed and will continue to change with increasing acceptance of the use of medications in the treatment of addictions.

- That said, many said that acceptance of the use of medications lagged well behind acceptance of the use of antidepressants in mental health treatment.

- For the most part, however, participants expect that acceptance (both societal and in the addiction treatment community) will increase over the next decade.

- **However, some cautioned that acceptance of medication in this treatment setting would be slower since society views addiction in the context of a moral choice whereas mental health is perceived to be an inherited condition.**

- The majority of participants view addiction to be a psycho/emotional/spiritual/ medical condition as opposed to being solely a medical condition.

- When asked if addiction is treatable via the use of medications many participants pointed out that the use of medications in treatment is but one component of the treatment regimen – counseling, case management, etc. Thus, medications are viewed in some but not all cases as a useful adjunct to other interventions.

- With the exception of some counselors, principally in the Caribou and Waterville focus groups, the majority of participants feel that medications can be successful (when used in conjunction with counseling, and other therapies) in the treatment of both alcohol and opiate addictions.

- However, they feel that success may be limited to a fraction of the population – the success level depends on factors such as the client's determination to go into remission, the support structures which are in place etc.

- In general, the younger counselors and the clinical supervisor participants tended to be more supportive of the use of medications in addiction treatment.

- For the most part (with the exception of some, in the Caribou groups – 5 of 12) participants agreed that their organization's philosophy on the use of medications is consistent with their own.

Medications

- There was pretty good top of mind awareness of the range of medications used in both alcohol and drug addiction treatment settings. These were principally cited as being:

Alcohol	Opiates
✓ Campral	✓ Methadone
✓ Antabuse	✓ Suboxone
✓ Naltrexone	✓ Subutex
✓ Vivitrol	✓ Naltrexone (as a blocker)

- However, levels of specific knowledge on each of these medications varied considerably. In general, participants in the clinical supervisors group (Augusta) were more knowledgeable and indeed overall more supportive of the use of medications in addiction treatment.

- Additionally, counselors appeared to be somewhat more supportive of the use of medications (though not necessarily methadone) for the treatment of opiate versus alcohol addiction.

- Again, though experience with and knowledge levels of Campral, Antabuse and Naltrexone varied, there appeared to be some reluctance on behalf of counselors to recommend the use of these three medications (especially in the Caribou and Waterville groups) because of a perception that these medications can cause severe side effects such as nausea, diarrhea, etc.

  Another worry cited was the potential for troubling side effects when the patient is taking other medications e.g. antidepressants or anxiety drugs.

- Vivitrol a newer drug (for alcohol addiction treatment) was cited as being a very expensive medication, which a lot of clients cannot afford.

- In the case of the two principal opiate addiction drug therapies, there appeared to be (with the exception of the Acadia Hospital group, which operates a methadone clinic) much greater support for the use of Suboxone.

- Attitudes to the use of methadone were more mixed. In part, these were tempered by several factors including:

- ✓ Lack of knowledge or indeed belief in the effectiveness of methadone treatment (except in the Bangor and Augusta focus groups).

- ✓ A perception that societal attitudes to methadone treatment are very negative due to negative media coverage, etc.

- ✓ A perception that many methadone patients do not ever wean themselves off the opiate addiction – as such, some participants view it as a maintenance only situation and not a long-term situation.

- ✓ A perception that for profit methadone clinics provide no or very low levels of counseling to their patients.

- ✓ A perception that for profit methadone clinics do not have an incentive to 'cure' patients (wean them off methadone)

- On the positive side, some participants say that methadone is a very low cost treatment method especially for an addicted population, which in many cases has very little financial resources.

- A strong majority of participants appeared to be supportive of the use of Suboxone medication for treatment of opiate addiction.

  This attitude appears to be influenced by the perceived evidence to date (although Suboxone is a relatively new drug) that Suboxone is effective and that it has a no major side effects.

- Participants in general described their level of knowledge of the biology of addiction in the 7 range (scale of 1-10 1 – low, 10 = high).

- On the issue of their knowledge level of the biology of medications used in addiction treatment, they averaged a 6 (out of 10). Some participants – especially younger counselors cited their need for more education in this arena.

BARRIERS

- When asked to list the principal barriers to their recommending the use of medication in alcohol and drug addiction treatment, counselors tended to cite external barriers in addition to some of their own.

- The principal barriers cited are:

  1. **Beliefs / Attitudes** – some counselors (especially in the Waterville and Caribou groups) do not believe that addiction treatment medications are effective.

     In particular, they cite lack of supportive evidence in the case of the alcohol addiction medications (as discussed earlier).

  2. **Resistance to methadone treatment –**

     Secondly, many counselors do not have in depth familiarity with methadone treatment or view it unfavorably for the reasons cited earlier in this report.

     With the exception of participants in the Bangor group and most of the clinical supervisors (Augusta group), there appears to be a lack of knowledge of and a lack of support for methadone treatment.

  3. **Side Effects** – Concern regarding the negative side effects of some of these medications (especially the alcohol addiction medications) is seen to be a strong barrier. This is especially so in cases where there is not a strong support system in place.

  4. **Clients abandoning therapy when they get medications –**

     Though the use of Suboxone is well regarded, there is concern that some patients will abandon other interventions because they may view it as the wonder drug and thus feel that they no longer need counseling etc.

  5. **Counselor Education** – It appears that there is the need for more counselor education (especially for younger/less-experienced counselors) on the use, impacts, effectiveness, and biology of all of these medications.

6. **Concerns regarding the impacts of abuse of medications –**

   Counselors cited dealing with a high-risk population who in some cases are mixing the use of alcohol and drugs (legal and illegal). Thus, they feel that recommending the use of medication for addiction treatment can be very risky in some situations.

7. **Access to medications** – Maine has a limited number of addiction specialists. Additionally, many physicians are not willing to treat any sizeable number of addicted patients (often very low income) or prescribe addiction medications

   In the case of Suboxone, there are still a limited number of physicians who have taken the required 8-hour training session and who can thus prescribe this medication.

8. **Transportation / babysitting** – in the case of many rural patients lack of, transportation and babysitting services are a major impediment to their accessing services at a treatment clinic on a regular basis.

9. **Cost** – a significant portion of the impacted population is either not insured or is low income. MaineCare will not cover much of the cost of medications, some of which are very expensive.

10. **Need for a more fully integrated treatment model** – Some counselors fear that patients will drop out of the treatment program if they get access to medications. Thus, there is a need for a much better integration of services between the various service providers (counselors, psychiatrists, doctors, etc.) so as to ensure that counselors are more in the picture and thus can feel comfortable recommending medications.

11. **Lack of support at the societal and public policy development levels** – There is a major need for better public education on the whole issue of addiction so as to (1) reduce the stigma associated with addictions/addiction treatment (2) strengthen support structures for those undergoing treatment.

RECOMMENDATIONS

1. **Better Provider Education is needed**

   Though a minority of participants are not supportive of the use of medications in addiction treatment, the majority and their sponsoring organizations are.

   However, there would appear to be a real need to provide education to counselors on issues including:

   - ✓ Addiction treatment principles.
   - ✓ The use and applicability of each medication.
   - ✓ Impact of specific medications.
   - ✓ Medical and other side effects.
   - ✓ Clinical evidence on each medication.
   - ✓ The biology of each medication etc. to the counselor and physician population at large.

   This might be accomplished through statewide seminars or individual on-site seminars using an appropriate panel of experts.

2. **Public Education**

   There appears to be a real need to mount a strong public awareness campaign to educate the general public (and patient support groups, families, etc.) on the positive impacts of the use of medication in addiction treatment in conjunction with other therapies. A sustained campaign will assist in reducing the societal stigma associated with addiction and increase acceptance of the use of medication in treatment.

   Any such campaign will also need to deal head on with negative perceptions of methadone treatment.

3. **Develop an Integrated Treatment Model**

   So as to increase the chances for success in the treatment process and to increase counselor support for the use of medications in addiction treatment, there is a need to develop an integrated service provider program model, which is used uniformly in Maine. Many counselors feel that the medical (prescribing) community is difficult to access for

information on specific cases and thus a more integrated treatment structure would be invaluable for client treatment and case management.

4. **Fee Structure Modifications** (unbundling of payments)

   Clinical counselors (Augusta group) recommended that the structure for (state) payment of services to methadone clinics be unbundled so that the counseling services element could be paid separately to other treatment centers. This issue should be examined in more detail.

5. **Physician Shortage**

   The lack of a sufficient population of physicians in Maine, especially in more rural areas, who are trained in addiction treatment or are licensed to prescribe drugs such as Suboxone was cited as a real issue. This situation should be looked at with a view to finding remedies.

6. **Funding**

   In general, it was felt that there is a severe lack of funding for treatment services and funds to cover the costs of medications for what is in many cases a very low income addicted population.

7. **Transportation / Babysitting**

   In order for the not insignificant population of rural patients to have access to treatment better transportation and babysitting services, need to be put in place.

8. **Partnerships**

   A better level of partnership should be developed with Maine hospitals and physicians (via MHA, MMA, etc.) so as to get their buy-in in a variety of areas – training, establishing a better model of service provider treatment integration, treatment of more addicted patients, etc.

   In this context, the issue of providing incentives to physicians who partner with substance abuse treatment programs should also be looked at.

SECTION III. KEY FINDINGS

- In all groups, participants cited an ever-increasing caseload of opiate addicted clients in Maine. The majority of these newly addicted patients tend to be younger – teens through early 30's. Participants also said that their alcohol addiction clients tend to be older and in many cases male.

III.1 Challenges

- **Key challenges facing counselors include:**
  - ✓ Increasing client case loads especially due to perceived increases in opiate addiction, including in rural areas of Maine.
  - ✓ Lack of integration in the provision of services between counselors and external providers e.g. physicians, mental health service providers etc.
  - ✓ Lack of financial resources to deal with the increasing level of opiate addiction in the population.
  - ✓ The increasing challenge of treating clients who need both mental healthcare and addiction treatment.
  - ✓ The fact that the client base for alcohol addiction treatment is getting older.
  - ✓ Engaging the client base in counseling.

"More and more of our treatment is for drugs. As recently as three years ago opiate addiction was very low – now it's at crisis level." – B

"To engage our clients in treatment is a challenge – often they are here involuntarily through the court system." – C

"The system is so fragmented in Maine – the primary doctor is in one place, mental health treatment is there and addiction treatment is somewhere else." – BR

"There's a lot more Oxycontin out there and a lot more younger teens and early 20's that we are seeing." – W

"We just don't have enough of services – there used to be more 28 day programs." – BR

- It should be noted that though participants in all groups cited an ever increasing workload for treatment of opiate addiction, that both the Caribou and Waterville groups also appeared to have significant alcohol addiction caseloads.

- Participants in the Bangor group are very much involved in opiate addiction treatment, while their counterparts in Brunswick cited an increasing opiate addiction treatment caseload.

III.2 Beliefs and Attitudes

Early on, participants were asked to fill out a form, which elicited their viewpoints on the use of medications in the treatment of addiction. This was done prior to more in-depth discussion of these issues. The chart, which follows, outlines tallies from all five groups on their beliefs and attitudes. Tallies for individual groups are contained in Appendix B.

Belief/Attitudinal Statements – Overall (5 Group Tallies)

Please mark whether you agree or disagree (somewhat or strongly) with each of these statements.

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
• The use of medication allows patients to better control drinking addiction.	6	10	30	5
• The use of medication allows patients to better control drug addiction.	2	11	21	18
• The use of medication is not consistent with my treatment philosophy.	16	15	6	4
• The use of medication is not consistent with my organization's treatment philosophy.	33	15	3	0
• I do not know enough about it to recommend the use of medication.	22	14	6	3
• There is insufficient evidence regarding its (medications) efficacy.	19	14	13	5
• I do not support it because there is inconsistent patient compliance.	20	19	10	2
• I believe it works as an adjunct with counseling.	0	2	13	36
• I do not support it because the local AA is opposed to the use of medications for addiction treatment.	37	13	0	0
• I do not recommend its use it because it costs too much.	26	15	9	0

- **Overall, a good majority of participants support the use of medication in the treatment of alcohol and opiate addictions.**

- However, it should be noted that in general, those who support it appear to do so with certain caveats – (1) it only works in conjunction with counseling, (2) a client must be prepared to engage and be determined to become whole again (3) there needs to be a strong client support network in place.

> "I've seen it work and so I believe in it but it works with the counseling piece." – B

> It's another tool – we've seen some great results with Campral here." – BR

> "It can work for some people but they must be ready to quit." – B

> "It helps some people – I like to think of it as another crutch."

> "It has its place – it works sometimes." – W

> "It works – if there was an effective medication for cocaine, we would use it." – B

> "Just because there is inconsistent patient compliance, doesn't mean we should not recommend it." – BR

> "I know it's difficult to get off Suboxone but it's better than trying to get off the drug cold turkey." – BR

> "I've seen dramatic results but the client must be prepared to look at their life and move on." – B

- However, while support levels for the use of medication in addiction treatment were strong in the Bangor and Brunswick groups and very strong in the clinical supervisors group in Augusta, participants in both the Caribou and Waterville groups were split in their attitudes on the issue.

- In these two latter groups, there was a noticeable difference in the attitudes of the older more experienced counselors and their younger, less experienced colleagues, with the older counselors being less receptive or supportive in general.

- In the clinical supervisors group there was almost universal support for the concept.

Those who are not supportive (of the use of medications in addiction treatment) are principally not so because:

1. They are not convinced that it works (at least in a high percentage of cases).

2. They believe that there is not a high enough level of compliance by clients or that clients abuse the medication in many cases by taking their banned substances or alcohol in conjunction with the medications.

3. They are concerned about the medical side effects of these medications.

4. Some believe that the medications are simply replacing the use of one drug with another.

5. They have not seen enough clinical evidence to support the thesis that medications work.

> "Generally the use of medications is not the way to go but I bet there are some cases where it may work." – W

> "There can be big side effects when they use Antabuse (for alcohol addiction treatment)." – W

> “There just is not consistent patient compliance (for me to recommend it).” – C

> “With Suboxone, people who have good support seem to be doing well with it but those who don’t have the support, do not do well.” – W

> “There are significant side effects to all these drugs.” – BR

> “I have a real concern if it’s strictly alcohol dependency. I don’t believe they (clients) should go on medications for at least a year – they should get therapy first.” – W

> “I go back and forth on this issue. Some alcohol patients do fine without it but for some it works.” – W

- Based on the responses provided (see tally sheets), it appears that most counselors and clinical supervisors believe that their respective organizations support the use of medications where appropriate.

- Unlike participants in the three other focus groups, a majority of the Caribou and Waterville participants said they agree with the statement “there is insufficient evidence regarding the efficacy of medications as used for the treatment of addiction.”

- Interestingly most participants agree with the statement:

> “I believe it (use of medications) works as an adjunct with counseling.”

Methadone

- With the exception of the Bangor group (Acadia Hospital has a large Methadone treatment program) and the clinical supervisors group, the majority of participants in the other three groups and in particular those in the Caribou and Bangor groups are not supportive of the use of Methadone in treatment principally because:

- ✓ They do not believe it (methadone treatment) works long term.
- ✓ They feel that most of the methadone clinics in Maine are offering low or in some cases zero levels of counseling to clients and as a result, they do not feel this treatment can be effective.
- ✓ They think that the for profit methadone clinics in Maine do not have any financial incentive to wean clients off methadone.
- ✓ They feel that it is not effective because much of the client base (which they regard as high risk) may be using it in conjunction with other banned substances and or alcohol and as such, it poses a real health threat.

"It's the same thing as heroin." – C

"My experience in this area is that its not a good thing at all – where there's a clinic, there's more drugs and you need better treatment (counseling etc.) with the methadone." – W

"It could be the way it's done in the state – there is no therapy and for us the biggest thing is the therapy." – BR

"They (clients) go on and on with it. They are using it 3 years into recovery." – C

"Methadone has its place – it has been successful for some people but historically, it has not been successful." – W

"I have not seen people weaned off it – that was my experience in Bangor." – BR

"Methadone clinics have to provide counseling but the counseling leaves a bit to be desired, but MaineCare will not pay for them to come to us." – W

“Methadone may help with opiates but they (clients) may also be using alcohol, cocaine, etc.” – BR

- Attitudes relating to methadone treatment were decidedly different in the Bangor group and also to a large extent in the clinical supervisors group. Those who are supportive believe that the use of methadone has been a success, that it stabilizes the patient, and that it keeps patients in the treatment environment often long enough for them to begin to engage in therapy.

“Based on the harm reduction model we work on, it’s been very effective.” – B

“Has it been successful? – You can bet on it – we have 700 clients and more who want to come in the program.” – B

“It keeps them in the treatment environment and many will engage at some point.”

- The majority of participants view addiction to be a psycho/emotional/ spiritual/ medical condition as opposed to being solely a medical condition.

“It’s not a medical only problem – its biological/psychological/social/ medical/spiritual.” – B

“Yes it’s a disease but there’s so much more to it.” – B

“There’s a medical component but also a behavioral component which is even greater than the medical piece.” – C

- When asked if addiction is treatable via the use of medication many participants pointed out that the use of medications in treatment is but one component of the treatment regimen – counseling, case management, etc. are other key components. However, a majority feel that the use of medications is a useful adjunct to counseling and case management in addiction treatment.

"It's being used more and more in substance abuse." – B

"Yes it's treatable – the use of medications will bring you to the point of stability with withdrawal." – B

"If they (clients) want to change then it works." – C

"The effectiveness with meds is far better than without, research says for opiates." – B

"Only to a certain point – there is no yes or no answer to this question." – B

- In general, participants feel that attitudes have changed and will continue to change with respect to increasing acceptance of the use of medication in the treatment of addictions.

- However, some pointed out that the process of attitudinal change on this issue is a slow one and in particular, that attitudes in more rural areas are much slower to change.

- **The principal reasons cited why attitudinal change in this area is slower are that society views addiction as a moral failure and that the stigma associated with it is usually greater than that for mental health.**

"Addiction is still seen as a personal fault – a moral weakness. It carries more stigma than mental illness." – W

"Drug use carries a big stigma but mental health attitudes have changed there is more acceptance." – BR

"Substance abuse is viewed as a moral problem." – B

"It's societal – society is now more accustomed to accept the use of medications for mental health." – W

"In rural communities there is a different attitude – they are in denial – it's not happening in my community." – B

- When asked to comment on the thesis that the use of medications in addiction treatment is simply replacing the use of one drug with another, the majority of participants did not agree with this statement. **However, even some of those who disagreed with this statement were inclined to agree with it as pertains to methadone treatment.**

"With Methadone, I think no but not with Suboxone". – BR

"I embrace the use of new medications but then we forget other things (counseling etc.)." – BR

"This is an uninformed view point, I disagree." – B

- That said, many said that acceptance of the use of medications in addiction treatment lags well behind acceptance of the use of antidepressants in mental health treatment.

- For the most part, however, participants expect that acceptance (both societal and in the addiction treatment community) will increase over the next decade.

- **However, some cautioned that acceptance of medications in this treatment setting would be slower since society views addiction in the context of a moral choice whereas mental health is perceived to be an inherited condition.**

III.3 Medications

- There was pretty good top of mind awareness of the range of medications used in both alcohol and drug addiction treatment settings. These were principally cited as being:

Alcohol	Opiates
✓ Campral	✓ Methadone
✓ Antabuse	✓ Suboxone
✓ Naltrexone	✓ Subutex
✓ Vivitrol	✓ Naltrexone (as a blocker)

- However, levels of specific knowledge on each of these medications varied considerably. In general, participants in the clinical supervisors group (Augusta) were more knowledgeable and indeed overall more supportive of the use of these medications in addiction treatment.

- However, counselors appeared to be somewhat more supportive of the use of medications (though not necessarily methadone) for the treatment of opiate addictions than for the treatment of alcohol addiction.

- Again, though experience with and knowledge levels of Campral, Antabuse and Naltrexone varied, there appeared to be some reluctance on behalf of counselors to recommend the use of these three medications (especially in the Caribou and Waterville groups) because of a perception that these medications can induce severe side effects such as nausea, diarrhea, etc.

  Another worry cited was the potential for troubling side effects when the patient is taking other medications e.g. antidepressants or anxiety drugs.

- Vivitrol a newer drug (for alcohol addiction treatment) was cited as being a very expensive medication, which most clients cannot afford. ($600 per once off 30 day injectable dose)

- In the case of the two principal opiate addiction drug therapies, there appeared to be (with the exception of the Acadia Hospital group, which

operates a methadone clinic) much greater support for the use of Suboxone.

"Naltrexone – I've seen it used with mixed results – it can cause nausea, it's not as effective as promoted to be." – BR

"Campral (for alcohol treatment) it's fairly new – 3 years – there's just not enough evidence yet on how effective it is." – W

"When I think of the alcohol medications, Antabuse is the most effective if people comply and can tolerate the side effects." – BR

"With methadone there is potential weigh gain, nausea, sweating, etc." – B

"Yes with methadone there are side effects, however, the other option is death – it's worth the trade off." – B

"Naltrexone – it will make you very sick if you drink alcohol – that's the reason it's effective (in the first place)." – BR

- A strong majority of participants appeared to be supportive of the use of Suboxone medication for the treatment of opiate addiction.

  This attitude appears to be influenced by the perceived evidence to date (although Suboxone is a relatively new drug) that Suboxone is effective and that it has a no major side effects.

"Suboxone is great for opiate treatment." – W

"The Suboxone model is different than the methadone factory model. Physicians can only prescribe it for up to 100 patients." – BR

"Suboxone works for some of our clients but others just do not have enough support programs." – W

- Participants in general described their level of knowledge of the biology of addiction in the 7+ range (scale of 1-10, 1 = low, 10 = high).

- On the issue of their knowledge level of the biology of medications used in addiction treatment, they averaged a 6+ (on a 1-10 scale, 1 = low, 10 = high). Some participants – especially younger counselors cited their need for more education in this arena.

	Bangor	Caribou	Augusta	Brunswick	Waterville	Overall
• How would you describe your knowledge level of the biology of addiction?	6.78	7.33	7.71	6.6	8.17	7.3
• Tell me about your level of knowledge regarding the biology of medications used in this arena. Where is your knowledge level?	7.22	5.33	6.14	5.2	7.67	6.3

"The biology of the medications – it's complex – people's biology can be so different." – C

"On the biology of the medication s, I know a bit, yet there's so much I don't k now." - B

III.4 Barriers to the Use of Medication in Addiction Treatment

- Though there was much common thought in all five groups on the key perceived barriers, this report outlines the key barriers cited in each focus group with a summary of the common themes at the conclusion of this section. Illustrative quotes are also provided from each focus group.

  It should also be noted that participants in each group individually listed their key perceived barriers on pads prior to group discussion.

Bangor

- Demand – there are not enough available resources for treatment (space and demand limitations).
- The difficulty of recruiting addiction treatment physicians to the Bangor area.
- Geography – rural patients have transportation problems – can't get to treatment facilities.
- Cost (Suboxone is not a generic drug and thus is expensive).
- Community - the social stigma of using medications for addiction treatment.
- The risky lifestyles of many patients (will mix medication with drugs/alcohol).
- Concern re other drugs being used often impedes the likelihood of counselors recommending medications.
- There is not enough insurance or state coverage for the cost of drugs.
- Negative attitudes among policy decision makers towards the use of medications for drug treatment addiction – need to educate them.
- Lack of support systems for patients.

> "The need far outstrips the resources we have a long waiting list for the methadone clinic." – B

"Cost is a major issue – any meds that have not gone generic are cost prohibitive." – B

"There is often a lack of family support for methadone treatment." – B

"For women patients, daycare (lack of) is a real problem." – B

"It's hard to get physicians for this service – not all physicians want to do it." – B

"We need community education so as to reverse the social stigma and the negative family support." – B

"Risky lifestyles are a problem – it they are on other drugs or alcohol." – B

Caribou

- Some counselors in this group do not support the use of medication in addiction treatment or only in a very limited number of cases.
- Counselors feel that they need more information on the impacts/success of medication in the treatment scenario before recommending them.
- They feel that many clients abuse medications – thus they are less willing to recommend their use.
- There is a lack of interaction/coordination between those involved in the treatment regimen e.g. doctors, etc. this makes counselors less likely to recommend the use of medications.
- The impacts of medications on clients is not predictable. Thus in some cases, counselors have a reluctance to recommend medications.
- Belief that some drugs e.g. methadone may simply be replacing another drug addiction. In general, this group has a negative attitude to methadone treatment.
- Negative community attitudes toward the use of medications are a barrier.

"I'm not at all convinced that clients are really committed to sobriety and recovery." – C

"There is a lack of checks and balances in place within the whole treatment community – it's a mess." – C

"I think the doctors are just too giving with prescription drugs." – C

"I'm not sure about meds – they will only work on one of the symptoms of addiction and you really need to treat the whole persons." – C

"There's a lack of consistency of knowledge on medications across the board." – C

Augusta

- Access to medications - many physicians are not willing to prescribe and Maine has only a small number of addiction specialists.
- Cost – Medicare only pays for the prescription but not the visit - or lack of insurance for costly medications.
- Since many counselors fear that if patients get meds they will drop out of treatment programs – thus we need a more fully integrated treatment model.
- Community misinformation/stigma associated with opiates replacement therapies is a barrier.
- Alcohol medications – the data on efficacy is not as conclusive – the jury is still out!
- Age resistance (older patients don't always want meds).
- Public policy – resistance/lack of education of the general public on this while issue results in creating a barrier.
- Transportation > 20 mile – less access- less treatment.

- Availability of trained primary care physicians to prescribe (especially Suboxone).

- There is a lack of PCP's willing to treat this client population often because it is low income.

Brunswick

- There is a lack of qualified professionals who are trained to prescribe (Suboxone).

- There is a need for much better integration of service providers, in this arena.

- Cost – no health insurance, MaineCare is limited and drug costs are too high for most.

- Lack of client buy in and family objections to the use of meds.

- Clients often want the meds but not the therapy – thus counselors in many cases are not supportive of the use of meds.

- There is not enough long-term evidence on the impacts/success of Campral and Vivitrol (for alcohol addiction treatment).

- Potential medical complications arising from the use of meds makes counselors more cautious.

- Societal stigma and lack of public education.

- A perception that methadone clients are sometimes over medicated makes these counselors less supportive of methadone treatment.

> "Sometimes patients will just get the meds as a quick solution and then do no therapy." – BR

> "There is a real stigma to the use of medications (for addiction treatment) in society." – BR

"Cost is a real issue – it's (meds) too expensive, there's no funding or often health insurance." – BR

"Family members objections to the use of medications is a barrier." – BR

"There's not enough long term evidence that they (meds) work." – BR

"Doctors don't feel confident and are not educated on addictions plus there's a lack of qualified doctors to prescribe and consult with." – BR

Waterville

- Some counselors do not support the use of medication or only in a limited set of cases.
- There is not enough appropriate assessment in first place – thus it (use of meds) is not the always the way to go.
- Client abuse of drugs – a concern in prescribing the use of meds.
- Failure to address the secondary alcohol/drug use issue.
- Some clients are becoming emotionally dependent on the replacement meds.
- Lack of counseling – especially in methadone clinics & doctors offices makes counselors wary to recommend meds.
- Negative side effects of meds – anxiety, etc.
- Lack of short-term (28-day) residual programs (insurance won't cover).
- Doctor restrictions on # of drug abuse patients they will take on and a lack of trained PCP's.
- Clients misrepresenting their situations to the physician to get meds.
- MaineCare preauthorization requirements.

- Transportation issues (visits to clinics are difficult for rural patients).

- MaineCare preauthorization requirements make it difficult.

- Lack of community support for use of meds in addiction treatment and the social stigma associated with it.

> "There's a problem with getting in to see a doctor who will prescribe – doctors have waiting lists." – W

> "Cost is an issue – MaineCare patients need a preauthorization first." – W

> "There's not enough facilities in the state to meet the demands of this population." – W

Summary of Barriers

1. **Beliefs / Attitudes** – some counselors (especially in the Waterville and Caribou groups) do not believe that addiction treatment medications are effective.

   In particular, they cite lack of supportive evidence in the case of the alcohol addiction medications.

2. **Resistance to methadone treatment** –

   Secondly, many counselors do not have an in depth familiarity with methadone treatment or they view it unfavorably for the reasons cited earlier in this report.

   With the exception of participants in the Bangor group and some of the clinical supervisors (Augusta group), there appears to be a lack of knowledge of and in many cases a lack of support for methadone treatment.

3. **Side Effects** – Concern regarding the negative side effects of taking some of these medications (especially the alcohol addiction medications) is seen to be a strong barrier. This is especially so in cases where there is not a strong support system in place.

4. **Clients abandoning therapy when they get medications** – Though the use of Suboxone as a treatment medication is well regarded, there is concern that some patients will abandon other interventions because they may view it as the wonder drug and thus feel that they no longer need counseling etc.

5. **Counselor Education** – It appears that there is the need for more counselor education (especially for the younger/less-experienced counselors) on the use, impacts, effectiveness, and biology of all of these medications.

6. **Concerns regarding the impact of abuse of medications** – Counselors cited dealing with a high-risk population who in some cases are mixing the use of alcohol and drugs (legal and illegal). Thus, they feel that recommending the use of medication for addiction treatment can be very risky in some situations.

7. **Access to medications/prescriptions** – Maine has a limited number of addiction specialists. Additionally, many physicians are not willing to treat any sizeable number of addicted patients (often very low income) or prescribe addiction medications

   In the case of Suboxone, there are still a limited number of physicians who have taken the required 8-hour training session and who can thus prescribe this medication.

8. **Transportation / babysitting** – in the case of many rural patients, lack of transportation and babysitting services are a major impediment to their accessing services at a treatment clinic on a regular basis.

9. **Cost** - a significant portion of the impacted population is either not insured or is low income. MaineCare will not cover much of the cost of medications, some of which are very expensive.

10. **Need for a more fully integrated treatment model** – Some counselors fear that patients will drop out of the treatment program if they get access to medications. Thus, there is a need for much better integration between the various service providers (counselors, psychiatrists, doctors, etc.) so as to ensure that counselors feel comfortable recommending medications.

11. **Lack of support at the societal and public policy development levels** There is a major need for better public education on the whole issue of addiction so as to (1) reduce the stigma associated with addictions /addiction treatment using medications in conjunction with therapy (2) strengthen support structures for those undergoing treatment.

III.5 How to Reduce the Barriers to the Use of Medications in Addiction Treatment

Bangor

- Provide more funding for treatment using medications.
- Provide more effective education at all levels – society, family, policy makers, physicians, law enforcement, etc.
- Need for more nonprofit (methadone) clinics in Maine.
- Target teens using the family intervention model.
- Look at the overall issue (cure).
- Create community awareness of the positive effects of methadone treatment.
- Provide funding for rural patient transportation.
- Shift (public funding) dollars from corrections to treatment.

> "Societal education is needed – start with the policy makers, physicians, etc." – B

> "There is no more important group to be on board than physicians – right now they are not on board." – B

> "We need to target teens using the family intervention model." – B

> "We need to create awareness of the positive effects of methadone." – B

Caribou

- Education on meds should not come from drug companies. ”It needs to be independent.”
- Provide more funding for programs and specifically – prevention programs.
- Increase awareness / education in the community and of doctors on addiction and treatment issues.
- Provide more structure in the treatment community, doctors, counselors, psychologists etc. – develop a better-integrated treatment model.

“There’s a need to fund our progress better.” – C

“Community education – improve on their knowledge of the use of medications.” – C

“There has to be more structure and support – otherwise patients are back on the street.” – C

“Everyone including all service providers need to be better educated.” – C

“Number 1 – it’s begins with funding – social programs are continually being cut.” – C

“Place structured regulations on the distribution of medications and ensure that all providers stick to the same regulations.” – C

Augusta

- Dismantle the bundled fee structure for methadone maintenance.
- Provide more training on the use of meds for directors and counselors.
- Hospital medical directors (get them more involved).

- Develop a simplified process for provision of services in treatment settings and simplify the licensing process.

- Conduct a TV ad campaign to educate the public on this issue (addiction and meds. treatment).

- Educate the medical professionals – get the primary care doctors more involved.

- Adopt a creative approach to the funding of transportation and childcare.

- OSA (or surrogates) should provide publications for the general public on the use of meds and also influence the legislative process to secure better funding of meds for addiction treatment.

- Eliminate financial barriers to meds treatment (high costs of Suboxone etc.).

- Provide incentives to physician practices who partner with substance abuse centers.

- Change the reimbursement structure for methadone maintenance to allow for counseling support in other agencies (unbundling).

- Advocate for more funding for treatment.

- Ensure greater partnership on the issue with the Maine Hospital Association.

- Develop a simplified process for provision of services in treatment settings and simplify the licensing process.

Brunswick

- Ensure less fragmentation of services (mental health, addiction treatment and general health).

- Educate physicians on addiction treatment – “they should have mandatory training.“

- Ensure adequate counseling of patients along with the use of meds.

- Increase specific assessment and ensure better communications between the various providers (integration).
- Educate counseling staff at clinics on addiction treatment principles.
- Provide more public funding for treatment addiction and meds. cost.
- Provide funding for patient transportation and childcare.
- Educate the general public better on this issue (addiction and meds treatment).
- Train more PCP's on medications (especially Suboxone).
- Get MaineCare to pay it's bills more promptly.
- Regulate methadone treatment so the non-profit sector is more involved.
- Ensure transport availability for rural patients.

> "Physicians should have mandatory training on addiction treatment." – BR

> "There needs to be better integration of services – if we had it all under one roof, we would have better case management." – BR

> "Methadone treatment needs to regulated differently – in a not for profit treatment manner." – BR

> "The public needs to be educated so as to change people's perceptions of these drugs." – BR

> "Deal with the stigmas." – BR

> "There needs to be better communication between doctors and other providers – docs don't return phone calls, at best you can hope to talk to a nurse." – BR

> "There is a lack of MaineCare coverage – more is needed." – BR

Waterville

- Educate physicians on addiction treatment – (also if they can prescribe they should have mandatory training in addiction).
- MaineCare coverage is an issue.
- Improve communications between PCP's and provider organizations.
- Effect better integration of services between providers.
- Regulate methadone treatment in a not for profit manner (and thus change negative public perceptions).
- Educate the general public on addiction and treatment issues.
- Provide funding for transportation and childcare (rural patients).
- Allocate funding to pay for the meds of patients who have no insurance coverage.

> "Educate the politicians on the funding needs for social services in general." – W

> "There needs to be increased assessment for clients who will be on medications." – W

> "Take the patients off the meds if they don't follow the treatment regimen." – W