HHS Public Access

Author manuscript

*Subst Abus*. Author manuscript; available in PMC 2016 March 22.

Published in final edited form as:

*Subst Abus*. 2016 ; 37(1): 70–75. doi:10.1080/08897077.2015.1088496.

# Optimizing psychosocial support during office-based buprenorphine treatment in primary care: patients' experiences and preferences

**Aaron D. Fox, MD, MS**[1,2], **Mariya Masyukova**[1], and **Chinazo O. Cunningham, MD, MS**[1,2]

[1]Albert Einstein College of Medicine, Bronx, NY 10461

[2]Montefiore Medical Center, Bronx, NY 10467

## Abstract

**Background—**Buprenorphine maintenance treatment is effective and has been successfully integrated into HIV and primary care settings. However, one key barrier to providers prescribing buprenorphine is their perception that they are unable to provide adequate counseling or psychosocial support to patients with opioid addiction. This qualitative study investigated supportive elements of office-based buprenorphine treatment that patients perceived to be most valuable.

**Methods—**We conducted five focus groups with 33 buprenorphine treatment-experienced participants. Focus groups were audio-recorded and transcribed. Iterative readings of transcripts and grounded theory analysis revealed common themes.

**Results—**Overall, participants perceived that buprenorphine treatment helped them to achieve their treatment goals and valued the flexibility, accessibility, and privacy of treatment. Participants identified *interpersonal* and *structural* elements of buprenorphine treatment that provided psychosocial support. Participants desired good physician-patient relationships, but also valued care delivery models that were patient-centered, created a safe place for self-disclosure, and utilized coordinated team-based care.

**Conclusions—**Participants derived psychosocial support from their prescribing physician, but were also open to collaborative or team-based models of care, as long as they were voluntary and confidential. Buprenorphine prescribing physicians without access to referral options for psychosocial counseling could focus on maintaining non-judgmental attitudes and shared decision making during patient encounters. Adding structure and psychosocial support to buprenorphine treatment through coordinated team-based care also seems to have great promise.

**Corresponding author**: Aaron Fox, MD, MS, Assistant Professor of Medicine, Albert Einstein College of Medicine, Montefiore Medical Center, 111 E. 210th Street, Bronx, NY 10467, Phone: 718-920-7173, adfox@montefiore.org.

**Contributions:**

All authors contributed to research conception, study design, and interpretation of results. AF and MM collected data and performed the analysis. AF and MM wrote the first draft and all authors contributed to subsequent revisions.

## INTRODUCTION

Opioid addiction has become a national public health crisis with opioid overdose deaths tripling over the past decade.[1] Buprenorphine maintenance treatment (BMT) is effective, reducing opioid abuse and HIV risk behaviors, and has been successfully integrated into HIV and primary care settings.[2-4] Despite the need for more treatment providers, many primary care physicians interested in providing buprenorphine treatment have been reluctant to do so.[5] One key barrier to providers prescribing buprenorphine is their perception that they are unable to provide adequate counseling or psychosocial support to patients with opioid addiction.[6-8]

Supportive components of opioid addiction treatment may be structural or interpersonal. Methadone maintenance treatment programs (MMTPs) have been the mainstay of opioid addiction treatment in the United States for decades and provide more structure than office-based buprenorphine treatment. Patients typically attend MMTPs six days a week, where directly observed doses of methadone are administered by a nurse, until they achieve stability.[9] For interpersonal support, many MMTPs also offer individual or group counseling, which may improve abstinence rates in comparison to pharmacotherapy alone.[10] The intensity and structure of MMTPs are likely important components of treatment; however, some patients perceive MMTPs to be inflexible and burdensome, which can provide another barrier to engagement in opioid addiction treatment.[11]

In the United States, regulations regarding office-based buprenorphine treatment allow for more flexibility in opioid addiction treatment in comparison to MMTPs. Although the requirements to prescribe buprenorphine are clear and well-defined, the requirement to provide psychosocial support is vague. Physicians must only certify that they have the capacity to refer patients for counseling or other non-pharmacologic therapies.[12] Thus, regulations allow for buprenorphine treatment to be tailored in a variety of ways to meet the needs of individuals with opioid addiction. Nonetheless, the ideal approach to structuring office-based buprenorphine treatment and providing psychosocial support are unknown.

With the goal of developing a model of buprenorphine treatment to provide enhanced psychosocial support, we investigated supportive elements of office-based buprenorphine treatment that patients perceived to be most valuable. Buprenorphine-treated patients have reported preferring office-based buprenorphine treatment to MMTPs due to flexibility and privacy,[13] but patients' perspectives on other supportive components of buprenorphine treatment have not been investigated. Findings could inform interventions seeking to better train buprenorphine treatment providers or adapt the structure of buprenorphine treatment models.

## METHODS

We conducted a qualitative study of individuals with opioid addiction and buprenorphine treatment experience in primary care. The study was approved by the institutional review board of the Albert Einstein College of Medicine.

## Setting

We conducted focus groups at a Federally-Qualified Health Center (FQHC), which houses an office-based buprenorphine treatment program in the Bronx, NY. The FQHC serves a low-income urban neighborhood that is 57% Hispanic and 39% Non-Hispanic Black.[14] Over 65% of patients have public insurance. The FQHC's buprenorphine treatment program, which includes 10 physicians (9 general internists and a psychiatrist) and a clinical pharmacist coordinator, has cared for more than 700 patients since 2006. Psychosocial needs are addressed by treating physicians, and social workers are available for mental health counseling for all FQHC patients. The program has been described in detail elsewhere.[15]

## Participants

Current or former buprenorphine treatment patients were recruited via advertisements at the FQHC, physician referral, and from a registry of FQHC patients who had indicated interest in participating in research about buprenorphine. The registry included patients of all FQHC physician prescribers, and one non-physician researcher (MM) made recruitment phone calls. Participants were: 1) adults (age ≥ 18); 2) had buprenorphine treatment experience in primary care (either at the FQHC or another site); and 3) fluent in English. All interested participants providing informed consent were included in focus groups. No participants withdrew consent or dropped out of the study.

## Data Collection

We conducted five focus groups of 3-11 participants (median 6 participants) in August 2014. Our team conducting focus groups included one male general internist from the FQHC with qualitative research experience, a female senior medical student with clinical experience participating in buprenorphine treatment, and a female MPH-trained research assistant. The team had prior experience working together clinically and conducting one other qualitative research study on buprenorphine treatment. At least two members of the team facilitated each focus group utilizing a semi-structured interview guide.

Focus groups were held in a private conference room at the FQHC. Participants were informed that their comments were confidential, would be used to improve models of buprenorphine treatment, and would not affect their care at the FQHC. Each participant completed a demographic survey prior to the focus group. No unique identifying information was collected (e.g. age was collected in categories of 5 years) and personal identifiers were censored in transcriptions. One researcher acted as group facilitator and the other researcher was present as observer and recorder. Focus groups were about one hour in length. All were audio recorded and transcribed verbatim. Data integrity was verified by cross-checking of transcripts. An incentive of cash ($10 for 1 focus group, which was increased to $20 for the remaining 4 groups to enhance recruitment), a public transit pass, and lunch were provided to each participant.

## Interview Guide

A semi-structured interview guide was developed for this study and included several domains: 1.) experiences with buprenorphine treatment provided by a primary care doctor; 2.) experiences with psychosocial support provided by therapeutic or peer support groups;

and 3.) differences between addiction treatment in individual and group encounters. Questions started open ended (e.g. “What has been your experience getting buprenorphine (Suboxone) treatment through your primary care doctor?”) with more specific probes to highlight key areas of interest. The sub-domains regarding treatment experience addressed: acceptability, *(*e.g. “What do you like about buprenorphine treatment with a doctor?”); utility, (e.g., “How has buprenorphine treatment with a doctor been helpful to your recovery?”); and innovation, (“What do you wish were different about your treatment with your doctor?”). The interview guide was reviewed by a group of addiction researchers with qualitative research experience prior to conducting data collection. Over the course of the study, several questions were dropped due to time constraints.

### Analysis

We used a Grounded Theory approach as described by Auerbach and Silverstein.[16] After reading the first several transcripts, the research team discussed “repeating ideas” within the transcripts, which were used for the coding list. Codes were determined by consensus, and then each member of the research team individually coded transcripts. Data were then organized into categories of increasing complexity. In an iterative process, “repeating ideas” were organized into “themes” by consensus. We then identified key “themes” related to supportive elements of buprenorphine treatment and developed a schematic diagram incorporating “theoretical constructs” that linked and explained these themes. Finally, we described a “theoretical narrative” regarding ways to enhance psychosocial support during office-based buprenorphine treatment.. We stopped conducting focus groups when few additional “repeating ideas” were detected in the source text indicating thematic saturation. This occurred after analysis of the fifth focus group. Subsequently, themes and the theoretical narrative were discussed with two focus group participants who gave feedback on the accuracy of findings.

## RESULTS

Of 33 participants, most were male (85%), middle-aged (median age range 50-54), and Hispanic (61%). Most reported past experience with group-based addiction counseling (64%).

Overall, participants perceived that buprenorphine treatment helped them to achieve treatment goals and valued the flexibility, accessibility, and privacy of treatment. Participants identified *interpersonal* and *structural* elements of buprenorphine treatment that provided psychosocial support. Nearly all participants recognized that in addition to the physical components of withdrawal or craving, treatment needed to address the psychological or “mental” component of addiction, which required that physicians have counseling skills. Patients desired good physician-patient relationships, but also valued care delivery models that were patient-centered, created a safe place for self-disclosure, and utilized coordinated team-based care. A more detailed discussion of these themes follows with quotes from participants that display typical attitudes.

## Interpersonal considerations

**Good physician-patient relationships—**Most participants had received buprenorphine treatment in primary care from an individual physician who provided prescriptions and brief counseling. Therefore, they stressed that their providers' knowledge, experience, and comfort with treating opioid addiction affected their own experience of buprenorphine treatment. Participants emphasized that physicians' attitudes should build trust, reduce stigma, and be accepting instead of confrontational.

For most participants, counseling was provided by their prescribing physician. The quality of physician-patient relationship influenced subsequent treatment engagement and perceived effectiveness. Good doctors were described as understanding, trustworthy, and knowledgeable, and ineffective providers were described as judgmental, stigmatizing, unavailable, and overly concerned about their own liability rather than the patient's well-being. One participant with a positive relationship with his physician explained the importance of building trust:

> There's that stigma when you tell somebody you're an addict…so you don't feel comfortable sharing that with everybody. Let's say, some doctors understand, they work with a lot of addicts, they understand addicts. But some don't. And they think that everyone's always trying to get over. You're always trying to find a way to get high…

Several participants emphasized that the physician-patient relationship needed to be two-sided where both parties trust each other. A trusting physician could hold patients accountable and help them to honestly disclose substance use, which was perceived as an essential step within treatment. One participant described this honesty:

> I gotta be open with my doctor just like she's gotta be open with me. We gotta be 50-50 on the same page, you know. I'm trying to find a way to stay clean with [buprenorphine]. And she's the only one who can help me with my treatment plan. That's why I say, it's a 50-50 thing with a patient and their doctor.

When their physicians were inflexible in decision making, participants feared that being honest with them would lead to discomfort, judgment, and being removed from the treatment program. Some participants cited prior experiences being denied treatment because of disclosure of substance use:

> Ideally, you want to be honest with your doctor all the time, because that should lead to the best result of treatment. But realistically speaking, the way the medical system is set up, the doctor is the gatekeeper to you and your medication. And if the doctor is strict with what they do and do not allow, and you fear that if you tell your doctor the truth, if you did cocaine one time let's say, and the doctor's gonna kick me off, then why would I want to reveal that to the doctor?

Participants also perceived that their physician should feel comfortable discussing psychosocial issues and needed a broad range of professional skills. One participant described how an effective physician needs counseling skills:

> I'm good with my doctor, you know. I could talk to her about anything that I'm going through. And she understands. She's not only my doctor, she's a friend. She's also a counselor as well, all in one. So I'm grateful.

Conversely, ineffective physicians were described as being either inexperienced or confrontational. One participant described how her doctor's inflexible attitude was a barrier to effective treatment:

> With this doctor here, all she came out and said was, I gotta put you on this, and you got to sign this, and you can't get high on this, and she never made me feel comfortable…So if you don't have that personal communication with your doctor, it's not gonna work no matter what they're giving you.

Participants also appreciated when their physician included them in development of a treatment plan by personalizing treatment goals, dosages of medications, and tapering schedules. One participant reported a positive experience in determining his/her maintenance dosage with his/her doctor:

> I was able to adjust the dosage as to what was personally best for me…He asked me how I felt, if I needed more or less, and we got to adjust it to what was exactly right for me, because people's bodies are different. So it works out good seeing a doctor.

Another participant's physician recommended a taper of the medication, which was acceptable to this participant because of good communication:

> I think what worked for me personally is he started me on a certain dose and kept me aware every time I came in to see him…He kept track of how the medication was pretty much holding me down throughout time. As time went on, he slowly weaned me down. And throughout that whole time as he was doing that, I didn't feel any difference. So that was the good part about having a doctor and keeping track of all that.

## Structural considerations

**Patient-centered models—**The structure of office-based buprenorphine treatment was also perceived to be important with participants desiring patient-centered care delivery models where treatment was voluntary, confidentiality was protected, and as mentioned above, physicians collaborated with their patients in developing a treatment plan.

A common sentiment was that forcing patients to specific treatment modalities, such as attending group counseling, would be ineffective and alienating. One participant felt that treatment was very different, "when you're forced to do something or when you volunteer to do something." This participant went on to emphasize the importance of internal motivation in seeking treatment:

> If I'm seeking the help, if I want the recovery, if I'm really deep into the buprenorphine, if I'm deep into the treatment, if I want to get clean, my participation in groups…I try to do it clean. I like groups, not the ones that I'm

> forced to, but the ones that I want to go to…When your heart is in something, I think it has better effect. I think you get better results.

Another aspect of patient-centered models was privacy or protection of confidentiality. Participants contrasted the anonymity of buprenorphine treatment with the stigma or shame of being seen at a MMTP where they perceived that privacy was not respected:

> With the methadone, they used to have people stand outside to get into the building. And if a family member came by, it was not anonymous at all. If you wanted to get inside, you had to stand on that line while people drive by, walk by. It was degrading. As far as me getting the [buprenorphine]…I've been wanting a drug like that for the longest.

**Having a safe place for self-disclosure—**Participants also desired care delivery models that created a safe place for self-disclosure of stigmatized behaviors, such as relapse to substance use. Participants explained that self-disclosure, or being able to speak openly about their experiences, kept them accountable to their treatment goals and helped them cope with painful experiences. Some participants worried about whether they would be judged or if their confidentiality would be protected, but they were willing to take these risks in individual or group-based treatment. When participants disclosed stigmatized behaviors, treatment models that emphasized peer support were also validating because other group members often had similar past experiences.

Having a safe place for self-disclosure – to a physician or a group of peers – was perceived as a therapeutic tool that was crucial to progress in treatment. One participant explained how disclosing or speaking about his/her problems helped him/her to deal with them:

> I gotta be open with everything. I can't hide, I can't sugarcoat it or… I'd tell [my doctor] everything, because there's something wrong with your body, you gotta be open as possible. I'm not afraid to throw anything out there. It's something that's gonna help me. The more I keep it in, the more imma go out there and get high.

Another participant explained that the act of articulating painful experiences could be therapeutic:

> You put it out there, you get it off your chest, it just makes you a better person.

Confidentiality was perceived to be important to create a safe space for self-disclosure. The privacy of office-based buprenorphine treatment and physicians' professionalism fostered this sense of safety. One participant compared disclosure during physician visits to disclosure in group-based treatment:

> In a group setting, they can't really express their real feelings, because then people take it outside, they see him on the street, they say oh look, he was this and that, but what's said in the group is supposed to stay in that group, and it doesn't always work that way. People don't express themselves as much in a group setting as they would individually with a doctor.

Despite the risk of breach of confidentiality, many other participants believed that peer support and feedback were essential components of treatment, because disclosure to groups of peers validated their feelings of shame or pain within recovery.

> Knowing that you're around people who are going through the same thing that you are, that we're all on buprenorphine and we're all trying to get our lives back together, that also helps a lot too. Just being able to vent, and be around other people that understand what you're going through, and not thinking that you're an alien, like you're the only person going through it.

**Collaborative or team-based care—**Some participants had received buprenorphine in treatment models that included an addiction counselor or peer groups, and these approaches were perceived to complement physician visits. Participants emphasized that coordination between treatment providers was necessary to help patients reach their treatment goals. Not all participants perceived that a behavioral counselor or therapeutic group was necessary, but most were open to additional supportive counseling if offered.

In some treatment models, medical and behavioral health providers played complementary roles. One participant appreciated having multiple providers:

> With my doctor, there's another counselor there and he asks me how I'm doing in the week. Do I have any problems…He works side to side, when I go to see the doctor for my [buprenorphine], I'm still getting counseling. So it's a little bit of everything.

Another participant, who also had multiple providers who collaborated to provide buprenorphine treatment, emphasized the importance of coordination among the treatment team:

> Everybody has to work together – the pharmacist, the therapist, the doctor – everybody has to work together in trying to find me treatment, and alleviate the problem that you're having.

Most participants also had positive experiences with past group-based counseling and believed that groups could be used as part of buprenorphine treatment to provide psychosocial support and treat the psychological dimension of addiction. A representative participant quote endorsing group-based treatment was:

> The group process would be a good idea to help with the mental part of addiction cause you could talk about it more… When you take your [buprenorphine], you go for an hour group…so we could learn somewhere how to combat the mental addiction.

Not all participants thought that additional psychosocial counseling or group treatment was necessary, but most recognized that it would be useful for some:

> I know everybody's different, and groups work for some people and maybe not for others. Not that they don't work for everybody - I think a support group is always good. I'm just fortunate…that I wasn't doing any groups when I was on

[buprenorphine] and I didn't need the group. I was just focusing on what I want to achieve.

## DISCUSSION

We assessed patient perspectives of office-based buprenorphine treatment and found that good physician-patient relationships, patient-centered treatment, opportunities for self-disclosure, and collaborative or team-based care were important supportive elements of buprenorphine treatment. Our data show that buprenorphine treatment provided by individual physicians or collaborative teams were both acceptable to individuals with opioid addiction. These findings suggest that efforts to expand office-based buprenorphine treatment should focus on training physicians to provide appropriate addiction counseling, while also expanding use of collaborative treatment models to provide psychosocial support.

Our study is one of the first to assess patient attitudes regarding buprenorphine treatment. A qualitative study, which compared patient attitudes about buprenorphine treatment to those about methadone treatment, emphasized patients' preference for the privacy and convenience of office-based buprenorphine treatment.[13] Another patient survey from Australia demonstrated satisfaction with buprenorphine treatment providers, but more than half of respondents reported that they did not have input into their treatment plan.[17] A patient satisfaction survey from the United States also demonstrated high levels of satisfaction with office-based buprenorphine treatment, but referral to Narcotics Anonymous and interactions with other patients were aspects of treatment that received the lowest satisfaction scores.[18] Our findings are mostly consistent with these, but also add meaningful data to the literature by specifying attributes of physicians (e.g., counseling skills and non-judgmental attitudes) and treatment models (e.g., voluntary and collaborative) that are perceived to be patient-centered and supportive. In regards to interactions with other patients, we found that therapeutic groups would be valued by some but not all patients. These findings can inform development of innovative buprenorphine treatment models.

Our findings can also inform efforts to improve physician interactions with buprenorphine patients. Physicians have reported lack of training in addiction treatment and referral options for psychosocial counseling as barriers to prescribing buprenorphine treatment. Our data suggest that physician attributes desired by patients, such as being understanding, knowledgeable, and trustworthy, are consistent with those routinely emphasized in primary care and psychiatry, not unique addiction treatment skills. However, the 8-hour buprenorphine certification training, could be complemented with quality improvement modules that emphasize non-judgmental and patient-centered care. Specifically, counseling skills, such as motivational interviewing, are increasingly being utilized to encourage behavior change in chronic medical conditions and could be included in modules.[19] Shared decision-making improves the quality of communication in difficult areas such as chronic pain management, and approaches have already been developed to train physicians in these skills.[20] Our group has effectively trained medical residents to provide buprenorphine treatment, and focusing on trainees may be one way to implement a robust educational intervention,[21] but many resources are available to support novice prescribers.[22]

Therefore, some of the fears that physicians report may be addressed with education and support.

In regards to buprenorphine care delivery models and psychosocial support, or structural considerations, our participants believed that requirements for additional counseling should be voluntary, but many also desired support that would not solely be provided by a physician. Group-based treatment was seen as helpful and created a safe space for participants to disclose stigmatized behaviors, which was seen as an important step in successful treatment. Several randomized controlled trials demonstrate that when intensive psychosocial counseling is routinely added to office-based buprenorphine treatment it does not improve treatment outcomes in comparison to medical management alone.[23-25] However, group-based counseling has not been evaluated, and for buprenorphine patients requiring high levels of support, alternative care delivery models such as combining treatment with group-based counseling, appear to be acceptable and may improve outcomes.

This study has several limitations. We did not collect data on participants' current opioid use, past use of heroin or opioid analgesics, and other clinical co-morbidities, which makes generalizability challenging. Recruitment was from low-income urban neighborhoods with high rates of heroin use, but other populations, such as suburban opioid analgesic users, may have different preferences for treatment. Our sample was recruited from a single FQHC. Though participants had received buprenorphine treatment from multiple prescribing physicians, shared attitudes or attributes among these physicians may also affect generalizability. Additionally, one focus group facilitator (ADF) was a buprenorphine provider at the FQHC, which may have influenced group responses. However, only one focus group included current or former patients of the provider (< 10% of total participants), and participants in each focus group were forthcoming about negative attributes of buprenorphine providers. Our interview guide specifically asked about group-based treatment models, but other treatment models offering structure and support may also be acceptable. Focus groups were only conducted in English.

Office-based buprenorphine treatment has created a feasible option for opioid addiction treatment, but additional work is necessary to develop patient-centered treatment models that can meet the diverse psychosocial needs of different patient populations. Our findings suggest that buprenorphine-treated patients can have powerful relationships with their physicians, but treatment models that provide additional psychosocial support are also perceived to be important for successful treatment. While the privacy and convenience of office-based buprenorphine treatment are highly valued, adding structure and psychosocial support through coordinated team-based care also seems to have great promise.

## Acknowledgements

This study was supported by NIH K23DA034541 (PI: Fox); NIH R34DA039041 (PI: Fox); K24DA036955 (PI: Cunningham); the Center for AIDS Research at the Albert Einstein College of Medicine and Montefiore Medical Center (NIH AI-51519); and NIH R25DA023021 (PI: Arnsten). These sources had no further role in study design; in the collection, analysis and interpretation of data; in the writing of the report; or in the decision to submit the report for publication. We also thank Jennifer Sanchez, MPH for assistance with facilitating focus groups, our participants, and the Qualitative Research Affinity Group of the Division of General Internal Medicine at Montefiore Medical Center/Albert Einstein College of Medicine.

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