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Subject area: Nursing

Education Level: Maters Program

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Title: Discussion 8

Instructions: as we more fully appreciate the magnitude of the opioid epidemic, there are calls for primary care providers to provide medication-assisted therapy. since 2000, the drug addiction treatment act (data) has enabled physicians, pas, and nps who work outside of treatment centers to complete specific training which then allows them to prescribe buprenorphine/buprenorphine naloxone for opioid use disorders. recent calls have asserted that primary care providers are well-suited to provide this type of therapy and expand the availability of treatment. in contrast, concerns have been raised that opiate addiction is beyond the scope of primary care practice. as a future prescriber, what is your position on this issue? should primary care providers with specific training be able to prescribe medication-assisted treatment for opiate use disorder? you must declare a position either for or against the assertion. while you may concede the validity of specific counter-arguments, you cannot take the non-committal position of "both sides have validity". as a psych apn, would you be comfortable with primary care providers prescribing mat if they had additional training? as an fnp, would you be comfortable prescribing mat after additional training or is that best left to specialists? you do not have to use additional sources this week if desired.

The Availability and Treatment Opioid Misuse

Name

Institutional Affiliation

Course

Tutor

Date

The Availability and Treatment Opioid Misuse

Over the last 20 years, opioid misuse and addiction in the United States have risen frequently. In 2009, roughly 5.3 million people used opioid medicinal products non-medically, 200 000 used heroin and about 9.6% used it in the following months. The available affordability and availability of healthcare services, including drug use disorders, was disparate in marginalized groups (Substance et al., 2016). Primary care professionals are also urged to distinguish between acceptable opioid usage for the treatment of pain and misuse and addiction. Race and ethnic minority groups are more likely than specialized mental health environments to benefit from primary medical care. Recent clinical developments enable patients with advanced treatment to be treated in primary care settings for opioid dependence and addiction (Levy et al., 2017). The 2000 Drug Addiction Treatment Act allows competent practitioners with readily accessible short term expertise in an office environment to treat opioid-dependent clients with buprenorphine and to allow primary care physicians active collaborators in diagnosing and treating opioid disorders.

Business-related opioid replacements are successful methadone and buprenorphine for maintaining or detoxifying opioid addicts. However, the availability of methadone has been restricted by stringent laws and by the stigmatization of opioid toxicity and treatment. A successful alternative has been the opioid partial agonist-antagonist buprenorphine/naloxone combination (Substance et al., 2016). There are far-reaching effects of mental disorders and use of substances (especially opioid and addiction). In 2001, estimated society losses totaled $8.6 billion in prescription drug misuse. The annual costs for direct healthcare among commercially assured clients during 1998-2002 were around $16,000 per person, compared to $1800 per person for opioid abusers. 4 People who use prescription medications miss more than twice as many days as non-users per month (Levy et al., 2017).

Currently in 1 out of 3 patients with opioid care are be used inadequately. These patients also have difficult personality characteristics and can be seen as "manipulative, medication-seeking and incompatible." However, opioid analgesia's tolerance usually increases over time, such that the need to increase the dose does not necessarily imply substance abuse. Overall, the buprenorphine side effect profile is milder than methadone. Colored glands, constipation, and sexual dysfunction also cause methadone (Substance et al., 2016). A research comparing sexual dysfunction with methadone or buprenorphine in male patients who rely on heroin has shown that less buprenorphine patients have documented loss of sexual fancy or desire, loss of moving erection, premature ejaculation and angulation loss of the penis. A solely drug-assisted treatment strategy is rarely, if ever, enough. The combination of treatment with addiction in primary care for patients seems to increase the results of treatment (Levy et al., 2017). Along with specialist drug therapy, buprenorphine/naloxone treatment is less successful. Further improved recuperation are broader psychosocial interventions. Recovery-oriented care systems are self-driven recovery approaches that draw on the sum of the services to sustain recovery in a group.

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References

Substance, A., Mental, H. S. A. U., & Office of the Surgeon General (US. (2016). Facing addiction in America: The surgeon general's report on alcohol, drugs, and health.

Levy, S., Seale, J. P., Osborne, V. A., Kraemer, K. L., Alford, D. P., Baxter, J., ... & Gordon, A. J. (2017). The Surgeon General's Facing Addiction report: An historic document for health care.