

A Tool for Buprenorphine Care

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(A series of monthly newsletters containing information on Buprenorphine)

NIDA/SAMHSA Blending Initiative

The National Institute on Drug Abuse (NIDA) and Substance Abuse and Mental Health Services Administration (SAMHSA) have worked together to reduce the delay between publication of research results and change in treatment by creating blending “products”, or clinical education packages that facilitate quicker adoption of new interventions. So far, the following products have been created:

- Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals
- Short-Term Opioid Withdrawal Using Buprenorphine Treatment Planning
- M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful
- Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA:STEP)
- Promoting Awareness of Motivational Incentives (PAMI)

Find out more at www.drugabuse.gov/blending/

Confronting Diversion

Diversion, defined by the Drug Enforcement Administration, is the use of prescription drugs for recreational purposes. The term comes from the "diverting" of the drugs from their original purposes. The problem of diversion of prescription opioid medications (often used for pain) is an enormous problem in the United States. Buprenorphine, intended for use for treatment of opioid dependence, can also be diverted. However, the diversion is often not for use as a recreational drug (to get "high"), but as a patient-directed treatment for other opioid dependent patients who are not engaged in health care treatment for their opioid dependence.

Practitioners should be aware of the possibility of diversion of buprenorphine. But should all cases of diversion be treated equally? Consider this vignette, submitted by a practitioner in New Mexico:

A 54-year old veteran lives in a rural area and has been on buprenorphine maintenance for 2 years. The veteran is married with grandchildren and has never had a positive toxicology screen, early refill, or other aberrant behavior since he was induced. At his monthly visit he appears to be withdrawing and admits he has only been taking 12 mg instead of the 16 mg he has been stabilized on. When the clinician asks why, he says he has been giving some of his buprenorphine to another Vietnam veteran who has also been addicted to heroin since the war and is trying to detox. The patient is made aware that such sharing of buprenorphine—however well-intentioned—is not appropriate or safe, and it could jeopardize his own prescription. The clinician suggests that the veteran help his friend get into treatment, and he does.

Updates in Research

1. Sullivan MA, Garawi F, Bisaga A, Comer SD, Carpenter K, Raby WN, Anen SJ, Brooks AC, Jiang H, Akerele E, Nunes EV. **Management of relapse in naltrexone maintenance for heroin dependence.** Drug Alcohol Depend. 2007 Dec 1;91(2-3):289-92. Epub 2007 Aug 2.
2. Chawarski MC, Fiellin DA, O'Connor PG, Bernard M, Schottenfeld RS. **Utility of sweat patch testing for drug use monitoring in outpatient treatment for opiate dependence.** J Subst Abuse Treat. 2007 Dec;33(4):411-5. Epub 2007 May 23.

Tip of the Month

There have been reported deaths associated with co-occurring administration of buprenorphine and benzodiazepines. However, these deaths were often linked to abuse of high-potency, high-dose benzodiazepines (including injection) and the mono-product of buprenorphine (Subutex) which was injected. Practitioners have been cautioned about this interaction during their certification training. However, if the patient is on or requires a regular dose of benzodiazepines and does not have abuse or abuse potential for benzodiazepines, co-administration of benzodiazepine and buprenorphine is generally safe. Using the combination buprenorphine/naloxone (Suboxone) in all situations (except for the indication of pregnancy where Subutex is preferred) also reduces abuse potential of injectable abuse buprenorphine.