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Human Services Committee

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BUPRENORPHINE

I. An evidence based best practice Buprenorphine (EVBP) when practiced correctly! It is one component of this EVBP.

   a. Criteria demands motivation for recovery, when not motivated or possibly ambivalent, we see misuse, abuse, adulteration and diversion.

   b. Suboxone works for people "who are sick and tired of the ravages of addiction" Dr. H. Westley Clark, former Director, SAMHSA.

II. Issue is that too often it is not being used in accordance with the principles of MAT.

III. Guidelines were at fault since prescribers were not mandated to refer to treatment and many prescribers believed the buprenorphine was the treatment.

IV. National Alliance of Advocates for Buprenorphine Treatment states:

   a. The Purpose of Buprenorphine Treatment

   "To suppress the debilitating symptoms of cravings and withdrawal, enabling the patient to engage in therapy, counseling and support, so they can implement positive long-term changes in their lives which develops into the new healthy patterns of behavior necessary to achieve sustained addiction remission."

Buprenorphine is only a small part of treatment.

The medication suppresses symptoms of cravings and withdrawal that might otherwise interfere with the reconditioning of the opioid exposed and dependent brain that allows positive changes in behavior and reflex reactions to stress and various environmental cues to craving. Buprenorphine allows the brain's neuroplasticity to develop new patterns and pathways while allowing old ones to disappear by suppressing cravings and withdrawal that may otherwise interfere, **but it is the deliberate self-reconditioning process which is the actual recovery.**

V. Diversion and abuse (patients who are not motivated).

a. As a SAMHSA Trainer on topic "Buprenorphine for the Non-Medical Professional" I have been told many stories and case studies by attendees regarding diversion and abuse of Buprenorphine by their patients.

b. Many addicts have "hijacked Bup so that instead of using it to manage their recovery they use it to manage their addiction." This is a direct quote from an ASAM and Buprenorphine-waivered physician who attended my training.

c. While presenting to State Correctional Prison Wardens in Maryland, I was informed that Buprenorphine is "the #1 drug behind the walls" rivaling K2 and often used concurrently with K2.

d. Many patients are polysubstance abusers. Therefor we see Drug to Drug Interactions (DDIs) drugs.com lists #601 total with, #178 major, #417 moderate, #6 minor.

e. I have been told of patients who sell or give doses to others who have not been prescribed buprenorphine, to often generate income to purchase their desired street opioid of abuse.

f. Additionally, there is a "black market" for buprenorphine to be used to self-prescribe and administer in attempt to stop opioid abuse.

g. There are popular resources with millions of subscribers designed for SUD persons such as Bluelight.org, Reddit, and erowid.org forums that provide directions for "self-management" (Doug Johnson, "The Wire"). Studies show contributors to discussion boards trust each other more than pharmacists and prescribing physicians. For those not familiar, Bluelight or Erowid are the "how to" regarding psychoactive drugs of abuse. Buprenorphine is in a group with Imodium and Kratom.

h. Naloxone was added to buprenorphine to deter abuse. However, this effect only occurs when used IV. When other routes of administration are used such as: snorting, smoking, etc., there is none or minimal withdrawal effects to work as a deterrent. Additionally, there are proven methods of extraction to remove the naloxone which are described on various websites and in scientific studies.

i. The film which was alleged to decrease adulteration has proven to be a dosage form more prone to abuse and transporting than the other routes of administration.

VI. Difficulty stopping & Psychological Dependence.

a. Take life-long? If so when does brain repair itself?