The Evolution of Buprenorphine Care

From: The Next Stage of Buprenorphine Care for Opioid Use Disorder

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LOCATION OF BUPRENORPHINE INDUCTION

Previous Approach

- A medical setting is needed for safe and effective buprenorphine induction.

New Findings and Recommendations

- Home induction is safe and effective.

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COMBINING BUPRENORPHINE WITH A BENZODIAZEPINE

Previous Approach

- Benzodiazepines and buprenorphine are a toxic
- combination.

New Findings and Recommendations

- Withholding buprenorphine because of benzodiazepine use could result in harm from untreated opioid addiction that outweighs the risks of concomitant use of these medications.

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RELAPSE DURING BUPRENORPHINE TREATMENT

Previous Approach

- Patients who experience relapse have failed buprenorphine treatment.

New Findings and Recommendations

- Patients who experience relapse should be provided additional support and resources rather than cessation of buprenorphine treatment.

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REQUIREMENTS FOR COUNSELING

Previous Approach

- Traditional counseling is needed to benefit from buprenorphine treatment.

New Findings and Recommendations

- Traditional counseling is not necessary for successful outcomes in buprenorphine treatment.

USES OF DRUG TESTING

Previous Approach

- Drug testing indicates which patients are unsuccessful and should be removed from buprenorphine treatment.

New Findings and Recommendations

- Drug testing is a tool for supporting recovery rather than a method of punishment.

USE OF OTHER SUBSTANCES

Previous Approach

- Patients who use other substances are not appropriate candidates for buprenorphine treatment.

New Findings and Recommendations

- Buprenorphine does not have a direct effect on other substance use, and this use should generally not influence care for OUD.

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DURATION OF TREATMENT

Previous Approach

- Buprenorphine treatment can readily be discontinued.

New Findings and Recommendations

- Patients should receive buprenorphine as long as it provides benefit.

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Case 1

- 32 yom new patient
- History of OUD, in past on methadone, left and didn't use for 3 years, now "dibbing and dabbing" is getting hard to control – he doesn't want to spend all his money and he doesn't want his partner to find out.
- "I want to use heroin on the weekends but buprenorphine during the week"
- Otherwise reports occasional alcohol use

- What should you do? What are the potential risks and benefits?

A. Refuse to treat and suggest referrals
B. Treat after a discussion of risks and benefits
C. Wish you hadn't asked him about his treatment goals

Case 1 Outcome

- Patient began to report less and less heroin use as he preferred to use money on nephews instead of heroin.
- Finally decided to stop heroin – then left partner who he realized was controlling and abusive

Case 2

- My second patient in 2005
- 49 yom, HIV positive for 20 years, not in care; had been non-progressor but now CD4 is dropping; on parole, marginally housed
- Never able to manage methadone maintenance despite using for 30+ years
- Currently shooting cocaine with heroin and fond of blackberry brandy
- I am asked by a leader in harm reduction to offer him buprenorphine – patient has both used and helped build harm reduction services since 1992

- What do you do?

A. Refuse sadly; this patient obviously needs a much higher level of care
B. Offer him buprenorphine contingent on counseling
C. Offer him buprenorphine and see where it goes

Case 2 Outcome

- Housed
- Undetectable viral load
- Following up on cardiovascular health as well
- But afraid to carry bupe in his pockets due to law enforcement.
- Recently away from home for 2 nights, used heroin and had a nonfatal overdose
- Doing fine now

He started buprenorphine openly so a community was there to help his adherence. Flexibility of scheduling kept him in care

Questions

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