Buprenorphine Diversion in the Treatment of Opioid Use Disorder

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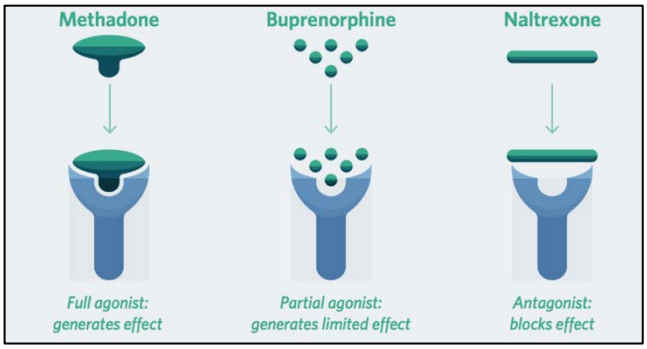
The gold standard medical treatment for substance use disorder (SUD) involving opioids is medications for opioid use disorder (MOUD), which provides pharmacological treatment of addiction supported by behavioral therapy.[1-6] The three medications approved for the treatment of opioid use disorder (OUD) in the United States include methadone, buprenorphine/Suboxone, ® and naltrexone/Vivitrol. ®



Accessing MOUD in the United States

Despite the effectiveness of this treatment, less than 1% of prisons or jails provide any form of MOUD, and even fewer provide all three FDA-approved medications.[7] In 2017, only 15% of OUD patients received MOUD as part of their treatment within the United States.[8] Those facilities that *do* provide MOUD disproportionately provide long-acting injectable naltrexone as the only option, despite research demonstrating that it is not as effective as methadone or buprenorphine in improving treatment outcomes.[9-11] Research indicates that the use of MOUD within treatment systems is *lower* in states with *higher* opioid mortality, especially in areas with high poverty and rates of heroin and fentanyl availability.[8] The cost of implementation, stigma, and misconceptions about effectiveness of MOUD drive its limited use within incarceration systems and treatment facilities.[12,13] In particular, fear of diversion—the use of buprenorphine *without a prescription*--- presents a significant concern to law enforcement agencies. However, recent research indicates that diversion of buprenorphine is associated with a reduction in overdose deaths.

Diversion

Those who use nonprescribed buprenorphine often do so to bridge the gap in treatment services.[14] The majority of individuals who use nonprescribed buprenorphine do so not to "get high," but to stop withdrawal symptoms or to self-detox[14-19] Indeed, most non-prescribed buprenorphine use (diversion) occurs as people with OUD want to enter treatment but experience barriers in doing so, such as limited access to a prescribing physician or lack of health insurance.[20] For instance, research shows that many prescribers indicate they would terminate a patient's care and access to MOUD if diversion is suspected, which contributes to the issue of limited access to care.[21] Table 1 highlights reasons for non-prescribed use of buprenorphine among participants in four studies.[14-15,20,22]

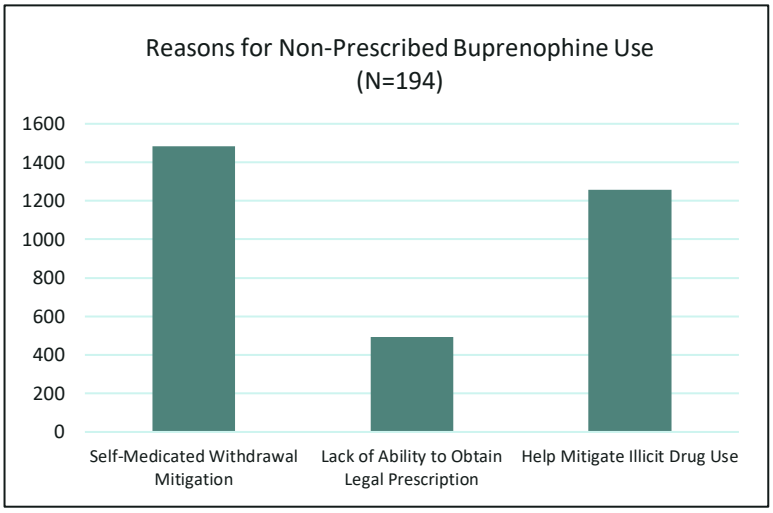


Table 1: Commons reasons for use of non-prescribed buprenorphine

A recent study from Ohio found an association between the use of non-prescribed buprenorphine and a *decreased* risk of overdose.[15] This study shows that the more often nonprescribed buprenorphine is used by those with OUD and, the *less* fentanyl or heroin is used, resulting in a lower risk of overdose.[15] As such, the use of nonprescribed buprenorphine by those with OUD is directly related to the decision *not* to purchase or use heroin.

Non-prescribed buprenorphine use is also associated with OUD treatment initiation and retention. Those with a history of using nonprescribed buprenorphine are often have an increased willingness to enter formal treatment because of "perceived effectiveness of the medication, cost of obtaining prescription buprenorphine compared to purchasing non-prescribed medication, and convenience of obtaining medication via daily-dosing compared to non-prescribed buprenorphine."[23] In conclusion, in most cases, the use of diverted medications, such as buprenorphine, is a bridge to treatment, not a way to "get high." Indeed, most individuals who use diverted buprenorphine do so because they want to enter recovery.[14-20]

Conclusions

MOUD is currently the most effective treatment for OUD. As shown, limited access to MOUD often results in use of non-prescribed buprenorphine to self-treat and manage withdrawal symptoms. Despite continued stigma and fear surrounding use of diverted buprenorphine, research indicates that use of non-prescribed buprenorphine contributes to a reduction in overdose deaths as well as an increase in treatment success and retention. It is recommended that treatment agencies and correctional facilities offer all three forms of MOUD to clients in order to provide the best possible care while also working to reduce barriers related to accessing this care.

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