INTRODUCTION

This State Issue Brief has been prepared by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) primarily for distribution to State Alcohol and Other Drug (AOD) Agencies and their constituents through support from the National Institute on Drug Abuse (NIDA). This Brief is unique in that it is not intended to be a comprehensive review of the science around a topic but rather a compilation of selected findings in an area and an exploration of the implications for administrators of AOD treatment systems.
BACKGROUND

The current use of buprenorphine to help people addicted to opioids (e.g., heroin, Rx painkillers) can attribute its success to basic and applied research, begun 30 years ago, with findings showing that buprenorphine had low abuse potential, was well-tolerated in addicts, and produced a low level of physical dependence. Subsequent research and clinical trials supported by the National Institute on Drug Abuse verified the medication’s safety and efficacy in countering opiate addiction, and validated its use in office-based settings. In October 2002, the U.S. Food and Drug Administration (FDA) approved buprenorphine for use in the treatment of opioid addiction.

Buprenorphine is available as a treatment alternative to methadone for the treatment and/or detoxification of patients addicted to heroin and other opioids, including prescription pain medications. Buprenorphine’s unique effects and pharmacology make it an attractive, and clinically beneficial, treatment option. Buprenorphine is related to morphine, but is a partial agonist that functions on the same brain receptors as morphine, but does not produce the same high, dependence or withdrawal syndrome. It is long-lasting, less likely than morphine (or other full receptor agonists) to cause respiratory depression, and well-tolerated by patients. Its unique pharmacological properties also reduce its abuse potential, particularly when formulated with naloxone, a narcotic antagonist. Buprenorphine is the first medication to have been approved since passage of the Drug Addiction Treatment Act (DATA 2000; SAMHSA, 2005a) and brings narcotic addiction treatment more into the mainstream of medicine.

The DATA has dramatically changed the way opioid addiction can be treated in the U.S. It permits qualified physicians to obtain a waiver from the special registration requirements of the Controlled Substances Act (CSA) (DOJ, 2005) to prescribe buprenorphine, a Schedule III drug, in an office-based setting for the purpose of treating opioid addiction. Physicians who prescribe buprenorphine must meet State licensing and training requirements as specified in the Act. Until an August 2005 amendment, DATA imposed a limit of 30 buprenorphine treatment patients per physician at any given time. Unfortunately, that limit also applied to group practices without regard to the number of qualified physicians practicing within that group. In August 2005, the group limit was removed, however the 30 patient limit remains for each individual physician. The limit was originally established to minimize diversion and abuse but was not meant to restrict group practices and was seen as restrictive and a barrier to the broad utilization of buprenorphine. Under the current law, each DATA waived physician may treat 30 patients regardless of the nature of their practice setting,
exception being opioid treatment programs, which are not required to obtain a waiver or follow the thirty patient limit.

Before DATA 2000 was enacted and buprenorphine was approved, medication-assisted treatment of opioid addiction essentially occurred only in federally approved opioid treatment programs (OTPs) that administered methadone, a Schedule II drug, and levo-alpha-acetyl-methadol (LAAM) before it was discontinued by the manufacturer in April 2004. The State Methadone Authorities (SMAs), a component of the State alcohol and other drug (AOD) treatment and prevention systems oversee the OTPs, which are required to meet federal standards for certification and accreditation (SAMHSA, 2002). At the Federal level, the Center for Substance Abuse Treatment’s (CSAT) Division of Pharmacological Therapies, located within the Substance Abuse and Mental Health Services Administration (SAMHSA) manages the day-to-day regulatory oversight activities on the use of narcotic medications (methadone, LAAM, buprenorphine) approved by the FDA for addiction treatment including certification and accreditation. At this time, over 1,100 OTPs are certified and accredited which serve more than 280,000 patients annually. CSAT also grants waivers under the provisions of DATA to qualified physicians to prescribe buprenorphine.

Earlier, two separate pieces of legislation were passed that had the effect of prohibiting the use of narcotics to treat addiction and regulated the manufacturing and distribution of narcotics and other drugs. In 1914, The Harrison Narcotics Tax Act (Historical Documents, 2005) was intended to regulate the marketing and distribution of narcotics but produced an entirely different result after it was enacted. Before the Act was passed physicians could prescribe opioid medications to patients to treat narcotics addiction, but after it was passed the language of the Act was interpreted in a way that prohibited this practice. While the Act continued to permit physicians to prescribe opioids in the course of their professional practice, law enforcement and courts frequently viewed the provision of narcotic drugs to addicts as falling outside the definition of a physician’s professional practice since addiction was not considered a disease. Later in 1970, the Controlled Substance Act (CSA) (DOJ, 2005) was passed to consolidate laws regulating the manufacture and distribution of narcotics and other drugs, and categorize the drugs into five schedules based on the drugs’ medicinal value, harmfulness, and potential for abuse/addiction. Schedule I drugs have high abuse potential and are considered to have no currently accepted medical use, whereas Schedule II drugs have high abuse potential but have a currently accepted medical use. Schedule III-V drugs are considered to have lower abuse potential with Schedule V drugs having the lowest. Buprenorphine currently falls under Schedule III.

The use of buprenorphine in an office-based setting offers a new and promising treatment alternative to methadone clinics and other treatment modalities. It creates an opportunity to increase accessibility for the treatment of opioid abuse or addiction.
Currently, only one fifth of the estimated one million Americans who are addicted to heroin are receiving treatment (Schottenfeld et al., 2000); and the number is greater if other opioid addiction is taken into consideration. In urban areas methadone clinics often have long waiting lists, and in rural areas methadone clinics are scarce. The availability of buprenorphine and the ability of qualified physicians to prescribe it to clients in an office-based setting have the potential to dramatically change the treatment model for opioid addiction.

Opioid addicted patients are the primary beneficiaries of this new treatment option. Patients addicted to opioids, including opioid prescription pain medications, can now be treated with buprenorphine in an office-based setting, thus increasing convenience and accessibility of treatment options. Importantly, buprenorphine is not subject to the same “take home” restrictions that apply to methadone. The availability and implementation of new treatment options that take into consideration the best fit between the client’s needs and treatment approaches may lead to improved treatment outcomes.

This new treatment model will affect the State Alcohol and Other Drug (AOD) Agencies that administer the public treatment and prevention system that includes the OTPs. To examine how the availability and use of buprenorphine would affect the State AOD Agencies, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) developed an inquiry on States’ perceptions of the use of buprenorphine to treat opioid addiction. Information was sought on important issues and concerns surrounding the availability and use of buprenorphine related to State treatment capacity, outreach efforts, information dissemination, clinical practices, regulatory provisions, abuse and diversion potential, client-level data collection, planning, and third party reimbursement issues (NASADAD, 2004). A follow-up study designed to capture States’ experiences related to the use of buprenorphine is near completion (NASADAD, In Press). This study should offer new information on the use of buprenorphine in the public treatment system for the treatment of opioid addiction.
UNDERSTANDING BUPRENORPHINE – PHARMACOLOGY AND TREATMENT EFFECTIVENESS

There are two forms of buprenorphine approved for use in treating addiction to opioid drugs: Subutex and Suboxone. Subutex contains buprenorphine only, whereas Suboxone is a combination drug that contains both buprenorphine and naloxone. Both Subutex and Suboxone have the same clinical effects when administered sublingually but when suboxone is injected, the naloxone component, a synthetic opioid antagonist, will precipitate withdrawal in an opioid dependent individual (Johnson, Strain & Amass, 2003). Thus, Suboxone has a decreased potential for abuse. Both forms of sublingual buprenorphine are safe and effective but the combination drug has not been FDA approved yet for use in pregnant women (Harris et al., 2000).

In a recent article, Jones (2004) reviewed pharmacological issues associated with the use of buprenorphine and identified research findings on many relevant and important studies of safety, flexibility, treatment effectiveness, training, and research. Buprenorphine has many features that make it safe to use for the treatment of narcotic addiction. Since buprenorphine is a partial agonist, a plateau, or ceiling effect, occurs that reduces the euphoric effects of the drug. As the dose increases, the euphoric effect of the drug increases to a moderate level and then plateaus as the dose continues to increase (SAMHSA, 2005b). Thus, it is not likely that an individual will continue to increase the dose. It is associated with limited physical dependence and respiratory depression, and mild withdrawal symptoms (Fudala, Jaffe, Dax & Johnson, 1990; Jasinski, Pevnick, & Griffith, 1978). As noted earlier, negative effects from the naloxone component of Suboxone are minimal (Harris et al, 2000) when taken sublingually. There are few drug interactions with buprenorphine but when they do occur, buprenorphine's effects may be enhanced. In such cases the buprenorphine dose can be reduced to ensure appropriate clinical management (Jones, 2004). If buprenorphine is injected, interactions can occur with alcohol or benzodiazepines that can be fatal (Reynaud, Petit, Potard, & Courty, 1998a; Reynaud, Tracqui, Petit, Potard, & Courty, 1998b).

There is flexibility in the dosing regimen of buprenorphine for the treatment of opioid addiction. Buprenorphine can be administered daily, on alternate days, or even three times a week. Schottenfeld et. al. (2000) found that treatment was equally effective for daily versus three times a week dosing schedules. Both groups had similar outcomes in: the proportion of opioid-positive urine samples dropping over time; reported reductions in illicit drug use; showing up on time for treatment; retention in treatment; and attendance in counseling sessions (Zickler, 2001). An alternate day or three times a week dosing schedule provides not only
flexibility but also convenience, and it improves patient satisfaction and compliance (Amass, Bickel, Crean, Blake, & Higgins, 1998; Amass, Kamien, & Mikulich, 2001).

Buprenorphine has been shown to be effective in several studies on treatment of opioid addiction in office-based settings (O’Connor et al., 1998; O’Connor et al., 1997; Fudala et al., 2003). It is effective as a maintenance treatment, and for the management of withdrawal symptoms (CSAT, 2004). Studies have compared the effectiveness of buprenorphine to methadone, examined the effectiveness of using buprenorphine in office-based settings, and evaluated the effectiveness of buprenorphine with special populations (i.e. pregnant women, adolescents, and co-occurring). Barnett, Rodgers, & Bloch (2001) performed a meta-analysis of studies that compared fixed doses of buprenorphine to methadone and found that buprenorphine was more effective than methadone at 20-35 mg, but the effect was not as strong compared to a higher methadone dose of 50-90 mg for maintenance treatment.

Buprenorphine is also effective in the treatment of opioid addiction in special populations. Although methadone is currently approved in the U.S. for treating pregnant opioid addicted women and buprenorphine is not, case reports from other countries indicate that opioid addicted pregnant women who are administered buprenorphine experience normal pregnancies but more research is needed in this area (CSAT, 2004; Johnson et. al., 2001). In a prospective follow-up study (Gandhi et al., 2003) on 18-25 year old heroin users, clients were detoxified with buprenorphine over a three day period and followed up at 1, 3 and 6 month intervals. Results showed reduced frequency and intensity of drug use on various measures and it was suggested that this was an effective approach for youth who are not ready for abstinence or maintenance treatment. It should be noted that buprenorphine is not FDA-approved for youth under 16 years of age (Jones, 2004). For opioid addicted clients with co-occurring disorders (substance abuse and mental health disorders), it is necessary to assess these disorders before or at the initiation of buprenorphine treatment and refer clients to specialized treatment, as necessary, to improve treatment outcomes (CSAT, 2004).

THE USE OF BUPRENORPHINE – ISSUES AND IMPLICATIONS FOR STATE AOD SYSTEMS

There are a number of important issues surrounding the use and implementation of buprenorphine that have implications for State AOD Systems. Major issues include: diversion and abuse, physician location and availability, physician and staff training, treatment capacity, client level data, cost, and the need for additional research. These issues are highlighted and discussed below.
Diversion and Abuse

Diversion and abuse of buprenorphine are important issues that must be addressed and are of considerable interest and concern to the State AOD Directors. There have been reports of diversion and abuse of buprenorphine (without naloxone) in France (Obadia & Perrin, 2001) where buprenorphine has been used extensively since 1996 (Auriacombe, Franques, & Tignol, 2001). These reports are based on the buprenorphine only product; however, data is limited on the buprenorphine/naloxone product. States responded to a NASADAD inquiry on their perceptions of the potential threat for diversion and abuse of Subutex and Suboxone and indicated that Subutex posed a larger threat of abuse and diversion than Suboxone (NASADAD, 2004). One third of the States were concerned that Subutex would be a significant threat but only ten percent were concerned that Suboxone would be a threat.

According to a recent article by Foxhall (2005), Dr. Charles R. Schuster, Director of the Substance Abuse Division at Wayne State University's medical school found that 99% of diversion of buprenorphine involves individuals purchasing the drug on the street to assist in managing their addiction and not to get high. Patterns of diversion and abuse will become clearer over time as buprenorphine is prescribed more often and data are collected and analyzed from various sources (Cicero and Inciardi, 2005).

Not only is it important to develop procedures that will minimize the potential for diversion and abuse of buprenorphine, but it is also important to monitor incidents involving buprenorphine abuse. The Drug Abuse Warning Network (DAWN) monitors drug related emergency room visits and drug related deaths to track drug use and abuse in the U.S. (DAWN, 2005). Prescription opioid pain medications, heroin, and other illicit drugs are monitored. Buprenorphine was added to the list of drugs that are tracked by DAWN in 2004 and will be included in future data analyses and reports on trends of drug abuse.

Buprenorphine Physician Location and Availability

State AOD Directors need to have knowledge about qualified physicians who can prescribe buprenorphine for the treatment of opioid addiction. Access to this information allows States to conduct outreach activities and assists treatment counselors and other medical professionals to make appropriate referrals. SAMHSA (2005c) provides an On-Line Physician Locator that identifies qualified physicians (who have agreed to be listed) and their contact information by State. The locator is updated frequently. A recent query of that data base returned a total of 3,310 physicians and their contact information. Physicians are listed for the fifty States, the District of Columbia, and five U.S. territories. One State and two U.S. territories did not have a qualified physician listed. The table below shows how many qualified physicians are available in each State based on the recent query.
Table of States and the Number of “DATA Waived” Physicians per State (Dec. 2005)

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The majority of State AOD Directors plan to request identifying information for physicians who have opted out of listing their identifying information in the Buprenorphine Physician Locator. States are interested in having complete and accurate information on the availability of buprenorphine and the number and location of qualified physicians as they plan outreach activities and address related regulatory matters. The State Methadone Authorities (SMA’s) and other regulatory officials have access to this information (NASADAD, 2004) but five States (MI, MT, ND, SD, and WY) do not have SMA’s. SMA’s may access the information by contacting CSAT (Nicholas Reuter).

It should be noted that not all qualified physicians actually prescribe buprenorphine for the treatment of opioid addiction. In a study completed by Join Together, it was found that one third of the physicians listed in the SAMHSA Buprenorphine Physician Locator had not yet prescribed buprenorphine (Join Together, 2003). Some of the barriers to prescribing buprenorphine were noted in that study and included difficulty in finding the medicine in pharmacies, the 30 patient limit for individual and group physician practices, and the high cost of buprenorphine.

Physician and Staff Training
Under DATA 2000, in order to qualify for a waiver that will allow physicians to prescribe buprenorphine, they must satisfy specific training requirements. Physicians may be qualified if they have participated in
clinical trials research related to schedule III, IV, and V drugs for maintenance or detoxification, have acquired relevant training and experience in the treatment of opioid addiction, or completed at least 8 hours of specific training. The training may include instruction in the classroom, in seminars at meetings, and through electronic communication. Training is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, and other organizations (SAMHSA, 2005d). The training for physicians focuses on pharmacology of buprenorphine, side-effects and drug interactions, treatment goals, and dosing schedules for the treatment of opioid addiction (Lintzeris, Ritter, Dunlop, & Muhleisen, 2002). SAMHSA (2005e) provides a list of both physician and non-physician training events on their web site on buprenorphine (http://buprenorphine.samhsa.gov/training.html). In addition, the Buprenorphine Physician Clinical Support System (PCSS) is funded by SAMHSA and supports physicians in the field on a range of subjects in the delivery of buprenorphine in the U.S. More information may be found at www.pcssmentor.org.

The top buprenorphine related technical assistance needs identified by State AOD Directors was on training, education and the development of materials for treatment providers, private non-physician practitioners, and physicians. (NASADAD, 2004). States also identified four areas in which they thought their Addiction Technology Transfer Centers (ATTCs) could provide support: training, best practice guidelines, dissemination packets to increase awareness, and strategies and materials to aid in the development of partnerships with physicians. Thirty percent of States have already held discussions with their ATTCs on buprenorphine oriented training. A new on-line buprenorphine three hour course for counselors entitled, “Buprenorphine Treatment of Opioid Addiction – a Counselor’s Guide” is available through the Central East Addiction Technology Transfer Center (ATTC) (SAMHSA, 2005f). This course assists counselors in gaining knowledge on the use of buprenorphine in various settings, the safety and effectiveness of buprenorphine, and their role in partnering with physicians. In addition, a six hour classroom training course to increase awareness of buprenorphine and educate non-physicians on the use of buprenorphine for the treatment of opioid addiction was created through an ongoing collaboration between the National Institute on Drug Abuse (NIDA) and SAMHSA, called the Blending Initiative. More information on this course for multidisciplinary treatment professionals is available through the Mountain West ATTC (2004). The NIDA-SAMHSA Blending Initiative has also developed a training package titled: “Short-Term Opioid Withdrawal Using Buprenorphine” to instruct treatment providers about a unique, 13-day buprenorphine intervention for opioid dependent patients. This training package is now available through the ATTC National Office and can be found at http://www.nattc.org/aboutUs/blendingInitiative/products2.htm#bupdetox.
**Treatment Capacity**

State AOD Agencies expect to have the treatment capacity to handle the “counseling and other ancillary treatment services” needs associated with physician referrals of buprenorphine patients (NASADAD, 2004). Sixty-one per cent of States anticipated that they would have sufficient treatment capacity to meet that need. Forty-five per cent believed that referring physician needs will be met by private practitioners outside the State AOD Treatment System. When asked about the role of existing treatment program Medical Directors, AOD Agencies said they anticipated significant involvement from program Medical Directors and other qualified physicians affiliated with treatment programs. This expectation was highest for physicians with programs currently providing opioid replacement therapy. These results suggest new and expanded roles for existing treatment program Medical Directors or State AOD Agency Medical Directors.

**Client Level Data**

Approximately three quarters of State AOD Agencies indicated that they do not anticipate being able to capture client level data on patients receiving buprenorphine in an office-based setting in existing client level data systems, nor do they believe those data systems will be able to distinguish buprenorphine patients from other patients, and they do not plan to evaluate treatment outcomes for buprenorphine patients (NASADAD, 2004). At the national level, the Treatment Episode Data Set (TEDS) does not currently allow for the collection of data that would identify clients treated with buprenorphine. It would be beneficial to collect this information and to be able to track and monitor client use of buprenorphine in the public treatment system to develop a more complete understanding of the implications of this new treatment option on public treatment systems at both the State and national levels.

**Cost**

Although the cost of buprenorphine is less than some other recently approved medications and is estimated to be cost-effective for the treatment of opioid addiction (Barnett et al., 2001), the cost is still significantly higher than the cost of methadone (The Medical Letter, 2003). Many States do not anticipate a large number of referrals to the publicly funded treatment system from physicians prescribing buprenorphine. States expect that most buprenorphine clients will have private insurance or be able to pay “out of pocket” for services external to the public system (NASADAD, 2004). A slim majority of the States did indicate, however, that treatment with buprenorphine, and the cost of the medication, per se, would be covered under the State's Medicaid program.
State AOD Systems’ Response to the Availability of Buprenorphine, Constraints, and Future Federal Supportive Actions

The approval of buprenorphine for the treatment of opioid dependency combined with the availability of physicians qualified to treat clients in an office-based setting and make referrals for counseling and other ancillary services has the potential to form the basis of a new treatment model for opioid addiction. Clients can be identified from traditional sources and referred for treatment to the State AOD Treatment System and/or Opioid Treatment Programs (OTP) or to a qualified physician’s office and receive comprehensive, individualized treatment service.

Given that the primary locus of care would be a primary care setting, buprenorphine treatment could occur in relative isolation. While such isolation may bring with it certain benefits in terms of increased accessibility and convenience, it also carries the potential for negative consequences. Many “DATA Waived” physicians currently hold substance abuse specialty credentials and have extensive experience in meeting the diverse needs of narcotic addicts. Others, especially those located in rural settings, may be more likely to serve a broad spectrum of patients and have limited experience in treating substance use disorders in general and narcotic addiction in particular. This inexperience may result in a reluctance to actually provide medication assisted treatment to those who could benefit or to the provision of treatment services of inappropriately narrow scope. This creates both challenges and opportunities for State AOD Agencies which have a vested interest in ensuring that all recipients of treatment services receive care of the highest possible quality regardless of the locus of care.

Most States have already begun aggressive programs of outreach to “DATA Waived” physicians to provide them with expanded training and educational opportunities both directly and in partnership with other entities. To some extent this effort has been hampered by the lack of an ongoing mechanism to assess the evolving information needs of the prescribing physicians. States have also devoted significant efforts to the crafting and delivery of training on referral procedures and the benefits ensuring that buprenorphine patients receive comprehensive services beyond medication which can be provided through “traditional” treatment programs. Such services are often available through publicly funded providers at little or no additional cost to eligible patients. Most State AOD Agencies will adopt a supportive role in the provision of buprenorphine rather than a more direct one such as a purchaser of services. For that reason, information and communication become core issues.

On the communications side, NASADAD members have been very active. They have developed or collaborated on the development of protocols for the exchange of protected, confidential information between physicians, AOD providers, pharmacists, and other involved practitioners. In addition, they have
supported forums which have produced a variety of clinical guidelines and protocols along with their delivery through a variety of media. They are limited, however, in their ability to acquire necessary information to support new lines of communication.

At the present time States have virtually no ability to capture information on clients treated in a physician's office. Thus, any effort on the part of States to, for example, estimate their “treatment gap” would, of necessity, fail to consider the number or characteristics of clients receiving office-based treatment. States have also identified the fact that there is no existing feedback loop established which would permit the refinement and expansion of services and products developed to date to support the many aspects of office-based treatment. In the absence of activities that can be reasonably undertaken by the individual States to correct this deficiency, the States have identified a variety of information initiatives for the consideration of Federal agencies with a shared interest in advancing buprenorphine and office-based treatment. Feedback from the NASA DA D membership indicates that the following types of information initiatives were judged to be both desirable and important for the Federal government to undertake for dissemination to the States:

- Studies on changes in treatment access attributable to the availability of buprenorphine.
- Studies that would provide information on both short and long term treatment outcomes for patients receiving buprenorphine. Outcomes of interest include changes in the frequency and amount of drug use, changes in involvement in the criminal justice system, changes in employment status, and changes in stable living arrangements.
- Studies/mechanisms which would periodically inform States regarding the incidence and nature of buprenorphine abuse.
- Studies/mechanisms which would inform States regarding the incidence and nature of buprenorphine diversion.
- Mechanisms to ensure that States are informed of evolving modifications to evidence-based or consensus driven “best” practices for participating physicians and other involved practitioners/providers.

Additional Resources

To view many more references on buprenorphine, search under buprenorphine on the NIDA Web site at http://www.drugabuse.gov/ (NIDA, 2005).

For more information on buprenorphine links to additional resources, visit the SAMHSA Web site at http://buprenorphine.samhsa.gov/otherlinks.html (SAMHSA, 2005g).
REFERENCES


About the National Institute on Drug Abuse (NIDA)

The mission of the National Institute on Drug Abuse (NIDA) is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA addresses the most fundamental and essential questions about drug abuse—from detecting and responding to emerging drug abuse trends and understanding how drugs work in the brain and body to developing and testing new treatment and prevention approaches. The Institute also strives to rapidly and effectively disseminate research results to various stakeholders to improve prevention and treatment practices in real-world settings. NIDA is one of 27 Institutes and Centers that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the Federal government, charged with uncovering new knowledge that will lead to better health for everyone. NIDA/NIH is a component of the U.S. Department of Health and Human Services.

Visit the NIDA website at http://www.drugabuse.gov

About the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD)

NASADAD is a private not-for-profit educational, scientific, and informational organization that was established in Washington, D.C. in 1971 to represent Directors of State Alcohol and Drug Abuse Agencies. NASADAD’s basic purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State. NASADAD serves as a focal point for the examination of alcohol and other drug-related issues of common interest for both State and Federal Agencies.

Visit the NASADAD website at http://www.nasadad.org

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