RECONCEIVING BUPRENORPHINE AS AN OVERDOSE PROPHYLAXIS

What if people who use drugs could be empowered to prevent their own overdose? Buprenorphine could do just that. Prescribed primarily as part of a cessation treatment program, the pharmacological properties of Buprenorphine mean it can act as an overdose prophylaxis — preventing overdose.

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Buprenorphine: Aspirin of Overdose?

Rhode Island's recent move to decriminalize Buprenorphine possession without a prescription is a step in the right direction. By making the drug more widely available to people who use drugs, even those not ready to stop, they are given agency over their lives. This could help people not only reach treatment outcomes but to help people live long enough for them to engage in those treatment options in the first place.

Last year, 384 Rhode Islanders lost their lives to unintentional overdose. This happened despite a record-setting year for Narcan distribution and harm reduction connections. We can do better. If even a quarter of those who died had taken a daily opioid overdose prevention medication, like Buprenorphine, nearly one hundred more Rhode Islanders would be alive today. If it was more commonly used, thousands more would be protected from avoidable death.

In 2020, many of these Rhode Islanders died alone — before EMS arrived — from a massive fentanyl overdose.

80% of these deaths happened in the victim's own home — not in public, where bystanders could have helped.

73% of accidental overdose deaths (with any drug) involved fentanyl. This is up from 35% in 2014. Fentanyl is 50-100 times more potent than morphine. Dealers often add it to increase the high and addictive power of their supply – even non-opioids. Which is why...

70% of cocaine-related overdoses (for example) involved fentanyl. Many accidental overdose deaths are among folks who did not identify as opioid users but used non-opioids laced with fentanyl .

Rhode Island Vigil to remember the hundreds of lives lost to overdose in 2020. *Providence Journal*, January 2021

We can't uninvent addiction. We can't ctrl-Z on fentanyl. We **can** help people use safely, if they choose to use. This is called harm reduction. Harm reduction can be achieved through:

- Distribution and use of fentanyl test strips.
- Using with others.
- Access to clean supplies.
- Decriminalization.
- Pathways to treatment without clean tox screens. Living "drug-free" is accepted as a choice, not a requirement.

Harm reduction keeps people alive, safe, and with their dignity intact. But harm reduction asks a lot of the user when they are at their most vulnerable.

"Never use alone."

"Always have Narcan."

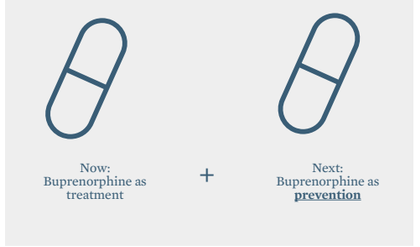
"Everything has fentanyl in it now — find a test strip and make sure you take time to test your drugs."

"Get the drugs out of your system, test 'clean', then start treatment."

A lot of this advice is to help us survive if we overdose. But what if we didn't have to wait for an overdose to happen? What if we could prevent an overdose before it started?

We want to expand on the progress that Rhode Island has made by recently decriminalizing possession of Buprenorphine without a prescription. We combine it with what we know about the pharmacological properties of Buprenorphine to reconceive it — not only as an effective treatment medication for people who are looking to stop using illicit full agonist drugs — **but as an overdose prophylaxis (prevention).** This could be a helpful intervention to help people not only reach treatment outcomes but to help people live long enough for them to engage in those treatment options by avoiding overdose.

As a matter of state law in Vermont and Rhode Island, you cannot arrest a person for possession of Buprenorphine if they do not have a prescription. This is signaling that we are in an intense crisis, and that this is a powerful useful medicine. It's saying to people if you're not getting a prescription from a doctor for treatment but you have your hands on Buprenorphine and it works for you in a way that you understand works for you as a person who uses drugs — we accept that. It's valuable, you are most likely doing this as a from of self treatment or to get yourself through a dangerous situation. We want to make that the norm not the exception.

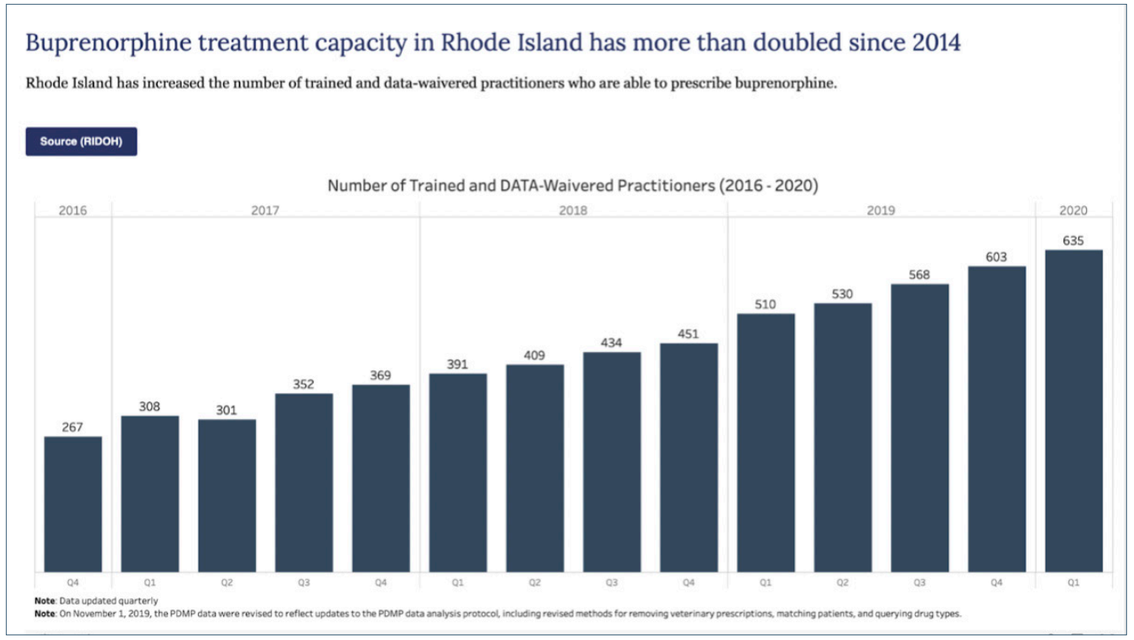


This belt-and-suspenders model isn't new. We already rely on good choices in the moment and daily medication for lots of other outcomes we care about:

- Healthy diet, exercise, stress reduction & Statins to control cholesterol
- Condoms & birth control
- Daily habits to ease depressive symptoms & daily antidepressants
- Behaviors that build recovery capital & Buprenorphine, methadone or naltrexone

We know Buprenorphine works and is safe:

- Gold standard for sustained recovery (along with all MAT)
- Nearly zero percent chance of a Buprenorphine overdose: Buprenorphine has a ceiling effect that blocks an overdose
- Broad acceptance and capacity



People who are in unstable housing or unstable employment situations, people who lost their dealer and don't trust what they are getting supplied with, or people who are not ready for formal treatment, can take Buprenorphine to prevent an overdose. **RI is uniquely positioned to experiment with this idea.**

However, there are major barriers in our current environment to expand the use of Buprenorphine:

- **Harder to get than it should be**
- **Racialized** (prescribed in predominantly white zip codes)
- **Bias, fear, and discrimination** (some say we're substituting one addiction with another)
- **Safety issues** (when combining certain drugs, break through ceiling effect can lead to overdose)
- **Fear it will cause increased risk-taking** ("we're just helping people prolong their addiction"

This kind of thinking has gotten us to 95,000 people dying in the first place. We can overcome these barriers. Our recommendations:

- Partner with addiction medicine and harm reduction professionals to develop a protocol for a safe, supported pilot.
- Issue a standing order prescription for those who could most benefit.
- Fund the pilot: Partner with innovative private funders and insurance companies to ensure broad coverage.
  - Recommendation of locations:
  - Treatment Clinics
  - Harm Reduction Clinics
  - Public Health Officials
  - Insurance Companies + Private Funders

There are real, valid concerns about the path forward and we ignore them at our peril. We need to develop honest, safe, risk-explicit answers to these types of questions so the pilot prioritizes safety, dignity, and transparency.

But what if?

- What if Buprenorphine gets diverted and is misused, overused, a drain on the system?
- What if people use it to seek a higher high and still overdose?
- What if the Buprenorphine becomes part of the contaminated supply and is laced with fentanyl?
- What if we just see more drug use?
- What if people reject the idea because it prevents the high they seek?
- What if people reject the idea because it's a medication, it's racialized, and folks of color don't feel supported?
- What if this doesn't work — how do we pull back?
- How do we prevent further harm?

...And many more.

The path forward is rocky, winding, and clouded But with courage and curiosity, we can honor these questions together and build a coalition of the brave.

Discussion and Insights:

- The system is already shifting towards Buprenorphine as prevention in addition to treatment (Genoa trials, syringe exchange in Vermont, etc.) but the language hasn't kept up. Let's call it what it is, rather than, "I'm here for treatment...wink wink."
- Buprenorphine is still being distributed through medical environments where we know stigma exists, we need to get Buprenorphine distributed beyond purely medical environments.
- Buprenorphine should be seen as the front end and naloxone as the back end.