I first developed the following process during my own personal opiate detox while using subutex. At the time I chose sub therapy I had no available advice that was based on actual experience using the medication. I chose to track my personal results through the process and have since worked with countless people on this forum for years using this system successfully exactly as written here. There have been many success stories since. The following plan works the same for using suboxone, subutex or the subutex generic buprenorphine.

I am only sharing my personal experience with what has worked repeatedly on this forum. I am not a doctor and recommend seeking advice from the professional of your choice in all matters that concern you. Drs need to be aware that approximately 15% of all patients taking suboxone react adversely to the naloxone in suboxone and should be placed on subutex rather than suboxone. They will have a much more pleasant experience in this program using subutex.

Sub therapy is rapidly becoming the gold standard for treating opiate addiction. The main problem we see on the forum is the typical sub therapy plan prescribed in the professional medical community is a one-size-fits-all method for treating all patients. Everyone is a little different in reality so it doesn't work best treating everyone exactly the same way. All too often too much medication is prescribed initially and for far too long of a time resulting in horror stories for many patients. In reality most patients need very little buprenorphine for it to be the most effective.

Patients do best when treated symptomatically. Drs are being advised to prescribe entirely too much medication for whatever reasons according to the success we've experienced sharing among ourselves. There are always some exceptions as with any medication, but the exceptions are few and far between. When over-medicated many of these patients under drs' care show up on this forum addicted (for years in many instances) to a medication they were told would aid them in their efforts to end their opiate dependency

Please review this post in detail before asking questions about sub therapy. Many of the most commonly asked questions are addressed here for your convenience.

INDUCTION

The induction is one of the most critical parts of sub therapy. If a person is not inducted properly

they often experience ongoing physical and emotional problems throughout the entire sub therapy process. The standard method that many sub drs use of administering anywhere from 16mg to as high as 32mg or more during induction consistently proves to NOT be in the patient's best interest. These doses inevitably lead to a patient with a physical dependency to the very medication that was supposed to help free them from their dependency.

The purpose of the induction is simply to stabilize the patient ending their w/d symptoms. We find this happens most effectively when the patient is inducted in dosing increments where the patient stabilizes at the "lowest effective dose". We suggest using an initial 1mg - 2mg dose for those with long term >>>>>> addictions and long term methadone addictions .(Using 1mg or 2mg is determined by the patient's using history.) For those with a history of using RX pain medications be it in pill form, fentanyl patches, etc I suggest starting the induction with a dose of .5mg and wait for two hours. This allows the patient enough time to ensure they are receiving maximum benefit from the medication prior to taking each additional increment while stabilizing. After the first two hour period we can add another .5mg if needed but we often find that adding .25mg doses every additional 90 minutes or so will allow the patient to stabilize at doses less than 3mg. This has become the average with most everyone we induct using this protocol. We seldom find it necessary to induct ANYONE at more than 6mg, including those with long-term IV abuse histories. Subs are very powerful and effective when used properly. We have people who have inducted at less than 2mg and we are typically successful with inductions totaling 2-4mg. The people who do best historically are those who begin this therapy at the lowest effective dose. This can only be achieved with an induction process administering minimal amounts of medication at each increment.

The induction process should last for a period of 4-5 days. The first day is when the patient is initially stabilized. On the second day the induction dose is split into two equal doses as this will help with making tapering easier later in the process. At the end of either three or four days we find that the dose used to stabilize the patient can be reduced by 25% on the following day and this becomes the lowest effective dose. Doing all of this takes 4-5 days depending on the individual. This is where the patient's dose remains until they begin to taper down the dose.

Allowing 4-5 days provides ample time to adjust the induction dose as may be required to maintain the stability of the patient. Those patients who don't stabilize properly have problems throughout their therapy. That is always the case. The amount used to stabilize doesn't seem to be as important as using the aforementioned process by which the induction is done up to a point as previously mentioned.

It is imperative the patient be in a state of moderately severe to severe w/d at the time of induction. Otherwise it's likely the patient will experience precipitated w/d. In short they end up deathly sick. This is another primary reason for beginning with the smallest amount of medication initially to make sure the patient will react desirably. The time required to reach severe w/d after stopping different drugs (pills vs methadone vs street drugs) varies some but the ABSOLUTE best guide is the COWS worksheet which most drs use some form of anyway. COWS (clinical opioid withdrawal scale) Go to http://www.drugs.com/resources/opioi...wal-record.pdf for the worksheet. If you make sure you're at a 26 or above accumulatively on the worksheet then you will normally do well with induction if the aforementioned dosing procedure is adhered to. The score of 26 on the COWS worksheet is a minimum. This is a non-negotiable factor that not all drs follow hence they administer large doses of medication attempting to cover up the precipitated w/d.

If a patient finds themselves in precipitated w/d for whatever reason the best thing to do is stop taking the subs immediately and redo the induction as outlined above. Wait until the sickness from precipitated w/d has ended and make sure you have reached the 26 again on the COWS worksheet before taking anything else. DO NOT attempt to take additional suboxone or subutex to cover up the precipitated w/d. You are asking for a hospital stay should you pursue this course of action.

USING SUB TO GET PAST THE OPIATE DETOX

I always suggest some type of support /recovery program for maintaining sobriety. Even those who don't participate in NA, AA, or Celebrate Recovery usually rely on church, family, or a combination of all the above for a solid system of support. Most of us who have survived our dependency and maintain a reasonable amount of clean time will agree it's almost impossible to do this on our own and stay clean forever. Staying clean of course is the ultimate goal behind my reasoning for sub use. Subs are just a tool to help us get clean. The people who end up STAYING clean would likely have done it with or without the subs. They are just a tool to assist us.

I agree with the medical community that a solid recovery program is nearly imperative with sub therapy as once the sub therapy ends you are on your own. Sub is an opiate. That's why it's called opiate replacement therapy. So when we stop the subs our long term chances for staying clean are so much increased if we are involved in a quality program of recovery whatever that program might be for you.

It takes only a matter of about a week, a little while longer with methadone, but the point being it only takes a short time and the original opiate detox is basically past. We are no longer in real need of a medication used to get us past the detox. So this is where we begin to taper down.

There are ongoing arguments regarding how long one should remain on sub that are based on our using history. The success we have seen to date shows best results are overwhelmingly on the side of using sub short term. We have started to taper in as little as four days and hardly ever over one week following induction. People are being inducted and tapering down to nothing in a matter of about eight weeks average. There are no horror stories from anyone using sub therapy on our forum who use it the way we have suggested from day one.Some allowances have to be made sometimes for those who come to the forum for help following poor previous guidance on using subs properly or following abuse of subs.

None of this means that some people won't do well using sub as a maintenance medication. I just don't personally promote long term sub use. It's certainly a better option than breaking the law to obtain drugs. But the purpose of this plan is for helping people free themselves from opiate dependency.

TAPERING

I began tapering down until I reached .5mg. (Some people find it necessary to taper down to a little less such as .25mg or less.) It's quite basic reducing to a very low dose following the Standard Taper Plan that follows. That can be accomplished by a formula. But getting to 0mg can be a little more of a challenge especially for those who come to this forum having been on sub elsewhere for a long time or have experienced some other type of extenuating circumstance.

Standard Taper Plan

The standard taper I used and promote is that if you will reduce by 25% of the total daily dose and maintain that dose for a period of four full days while experiencing minimal to no w/d

symptoms it's safe to reduce again by another 25% and expect the same results. If you experience any overwhelming w/d symptoms during the four day period you can take a .25 mg sliver (depending on your existing dose) and the w/d symptoms usually dissipate immediately. If you require slivers to remain stable at any level you should start over the next day trying to put four days together again. This allows for the long half life of buprenorphine which can be up to 72 hours for most people.

After I reached .5mg I began a process of skipping days. I would take a dose one day, then skip one day. Then dose again, and then skip two days. Then dose again, and then skip three days. Then dose again, and then skip four days. After four days clean I was finished. The half life has had time to catch up with itself.

We have found some people, for whatever reason, tend to stress out and suffer anxiety when it comes time to skip days. If that is your experience you can continue the standard 25% taper every four days all the way down to zero in lieu of skipping days if that makes you feel better. Again we are all a little different. The idea is to be successful and the skipping days is not written in stone. That is what worked for me and has worked for most others following this taper plan. But if you need to taper down to nothing instead of skipping days that is certainly a viable and acceptable option.

The reason for sometimes feeling w/d symptoms is the long half life of buprenorphine, the main drug that is in sub and the generic now available. To be very simple it can take days before we experience the w/d symptoms from sub. So this is why we wait for four days to allow for the half life which can easily be up to 72 hours depending on some variables. When we make it four days without symptoms we should be fine reducing again.

It's not uncommon to have some minor side effects from sub as with almost any medication. There can be some depression, sleep problems, anxiety. So we suggest not taking the sub close to bedtime, get some mild to moderate exercise depending on your physical condition, there are things to do that will help lots of things. But stick with the same principles all the way down as far as you are comfortable. We are here to help at that point.

Robert_325

http://www.mc.uky.edu/equip-4-pcps/documents/section9/Clinical_Opiate_Withdrawal_Scale_68.pdf