Implementing buprenorphine treatment at a clinic without a dedicated onsite addictions team

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Framing question

How do we balance a harm reduction and trauma informed approach to addiction treatment for people experiencing homelessness, while trying to follow treatment guidelines and minimize diversion?

Overview/goals

1. Discuss some cases
2. Identify common challenges
3. Discuss strategies/solutions

Focus on settings where there is no addiction program on-site.

Poll of the room

Who is here with us today?

Where do you work?

Case JJ

50yo man with poorly controlled HIV infection, cocaine use disorder, opioid use disorder who has been out of care for years. Has been through many drug treatment programs in the past without any lasting success. He is currently living in a tent in a small encampment about 1 mile from clinic. He is insistent on restarting HIV medication because he feels he is getting too sick and weak. He also asks for suboxone. He can't do outpatient treatment groups due to fear of losing his belongings while he is at groups. He isn't willing to do inpatient treatment because he has to "get his things in order."

Do you treat him with suboxone? If so, what strategies could you use to maximize chances for success?

Do you offer him HIV treatment?

Case JJ continued

You decide to offer him HIV medication and suboxone in weekly increments, and he agrees to return each Wednesday to see the nurse. Within a couple months his HIV viral load is undetectable and remains there. His urine drug screens show positive but low buprenorphine and norbuprenorphine levels, intermittent morphine and fentanyl, and consistent cocaine. He still doesn't want to engage in a drug treatment program, states "I just need to stop using, I've cut way back. I'm working on it doc." You try asking him to bring in his suboxone wrappers and he brings in inconsistent numbers each week.

What would you do next?

Case EB

27yo woman with hepatitis C, depression, and opioid use disorder. She uses alcohol and benzodiazepines intermittently. She sometimes stays at friends houses within a couple miles of clinic, sometimes stays in a tent, and sometimes with her mom, a 30 minute drive from clinic. She has access to a car, but no drivers license. There are no treatment programs near her mom's house, but she can get to the clinic in about 2 hours if she gets a ride with her brother to his work then takes public transit. She is late/misses visits frequently. After 2 months of treatment, her urine has shown illicit drugs in every sample. She cannot enter drug treatment because she has no photo ID.

How would you manage her? What resources are avilable to her?

Case FJ

42yo woman with uncontrolled, advanced HIV infection, Hepatitis C, cocaine use disorder and opioid use disorder. She starts on suboxone with visits every 1-2 weeks. She reports she goes to NA a few times each week and lives “here and there” or with her parents. She frequently misses appointments then comes in within a few days. She is open to starting HIV medication, but isn’t consistent with it. She agrees to enter a drug treatment program and is escorted by outreach to 2 different programs, leaving each within a couple weeks. She would like you to prescribe suboxone.

Ideas for how to manage her? How can different team members help?

Case RR

35yo woman with a 10 history of IV methamphetamine and heroin use as well as heavy alcohol use who lives in an encampment down by the beautiful Russian River. She presents asking for inpatient treatment to “get away from it all.” She has medicaid coverage, but there are no centers within a 1 hour drive that can offer inpatient treatment that accept medicaid. After hearing this, she asks you to prescribe suboxone.

What do you do? How do you support this woman?

Case RW

RW 28yo man with hepatitis C and opioid use disorder. He has been on suboxone in the past with some brief success, not interested in methadone. He is requesting suboxone from you and his recovery plan includes taking care of his mom's beach house (3 hours away) and returning every few weeks for a visit. You decide to give it a try with 1-2 weeks of medication at a time. His first 3 urines all show morphine, fentanyl, cocaine and low levels of buprenorphine, he arrives late to appointments and is intermittently rude to office staff. You encourage him to enter a drug treatment program and he declines, says the suboxone is working, he just needs more time.

What would you do in this situation?

Cases from the audience

Challenges

No photo ID

No recovery-oriented housing while in outpatient treatment

No health insurance to cover medical or behavioral treatment

No inpatient treatment options that take medicaid

No transportation to treatment (or even to your office)

Unwillingness to accept referral to formal treatment program, focus on wanting suboxone

Ongoing use of opioids or other illicit substances or alcohol

Questions

- How do you link to other community resources/programs?
- Who are the members of your care team? How does the team communicate?
- Does anyone not have any nearby treatment resources?
- **How do we balance a harm reduction and trauma informed approach while trying to follow treatment guidelines and minimize diversion?**

HCH Clinicians network adapted clinical guidelines

“Prior experiences of treatment received by homeless people with addiction disorders may have been largely negative. Harm reduction therapy attempts to offset negative expectations by repeatedly expressing welcoming affect, making affirming statements, and offering a respectful and collaborative relationship.”

“Recognize that flexibility is key to beginning a therapeutic relationship.”

“... dosing should always be contingent on demonstrable, functional benefits to the patient. If the patient is not benefiting from a medication, it should not be prescribed.”

“Work with difficult behaviors rather than prohibiting them. Practice radical inclusion of all clients…”

“Balance overall benefits of continuing MAT with potential harms.”

“Most aspects of addiction treatment are more difficult without stable housing. Substance use declines when people become housed.”

HCH Clinicians network adapted clinical guidelines

“Housing should be a component of any treatment strategy to manage opioid use disorder.”

NIDA *Principles of drug addiction treatment*

> “Detoxification alone does not address the psychological, social, and behavioral problems associated with addiction and therefore does not typically produce lasting behavioral changes necessary for recovery. assessment and referral to drug addiction treatment.”

https://www.drugabuse.gov/sites/default/files/podat_1.pdf

Resources

NHCHC policy brief on MAT, May, 2016.

SAMHSA TIP 40: clinical guidelines for the use of buprenorphine in the treatment of addiction.

NHCHC adapted clinical guidelines, opioid use disorder, March, 2014.

Alford et al, 2007, Treating Homeless Opioid Dependent Patients with Buprenorphine in an Office-Based Setting

- Similar outcomes for housed vs. homeless patients
- Daily office visits for the first 2 weeks

Resources

NHCHC policy brief on MAT, May, 2016. https://www.nhchc.org/wp-content/uploads/2016/05/policy-brief-buprenorphine-in-the-hch-community-final.pdf

NHCHC adapted clinical guidelines, opioid use disorder, March, 2014. http://www.nhchc.org/wp-content/uploads/2014/03/hch-opioid-use-disorders_adapting-your-practice-final-to-post.pdf

Alford et al, 2007, Treating Homeless Opioid Dependent Patients with Buprenorphine in an Office-Based Setting, Society of general internal medicine;22:171-176.

SAMHSA TIP 40, clinical guidelines for the use of buprenorphine in the