UNMH Addiction and Substance Abuse Program(ASAP), The Opioid Crisis and Outpatient Treatment

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Disclosures

None

Learning Objectives

- 1) Understand the disease model of addiction
  - Discuss medication management options
- 2) Understand how addictions are approached and treated clinically at UNM ASAP
- 3) Understand the importance of treating concurrent mental health disorders simultaneously alongside addiction

Substance Use Disorders as a Chronic Disease

" The concept of addiction as a disease of the brain challenges deeply ingrained values about *self-determination and personal responsibility*."
Volkow et al

Substance Use Disorders as a Chronic Disease

DISEASE MODEL

- Change to structure and function the leads to dysfunction or death
- Treatment addresses these changes, attempts to prevent further changes or reverse changes to improve functioning
- The disease has been impacted by non-modifiable influences
- Intervention is crucial to remission and successful treatment

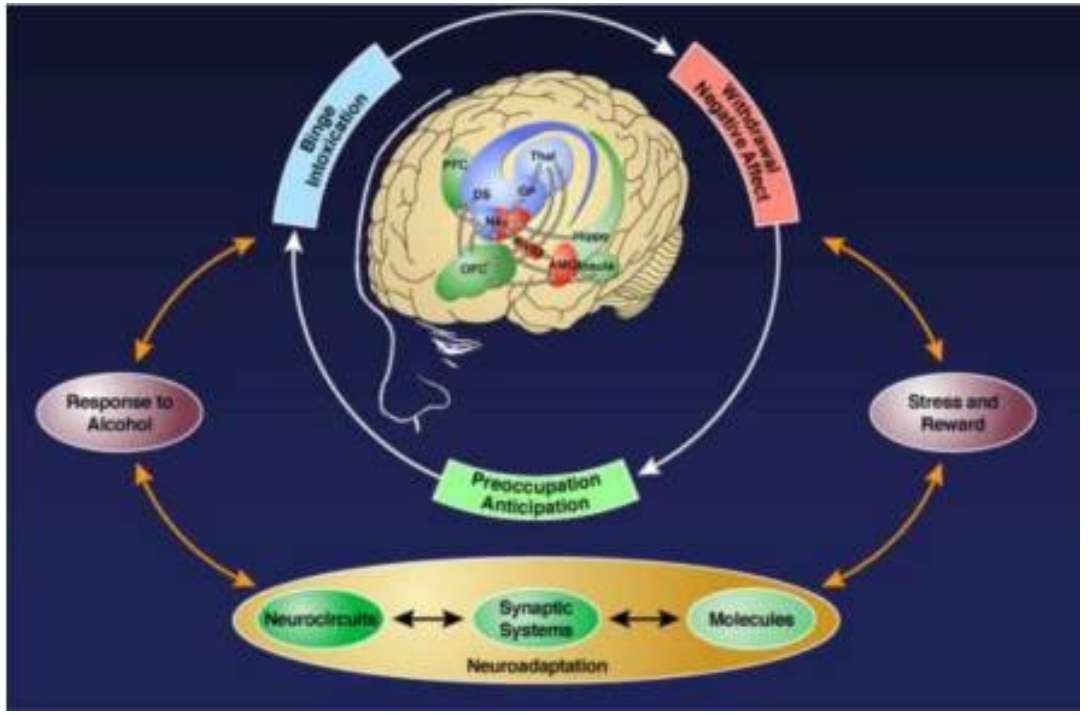
NON-DISEASE MODEL

- Substance use disorder is driven by choice, not compulsion
- Drug use is a rational choice
- Spontaneous remission indicates addiction is not a disease
- Morality and de-moralization are drivers for substance use disorders
- Diseased “identity” stigmatizes pts and does not allow for change

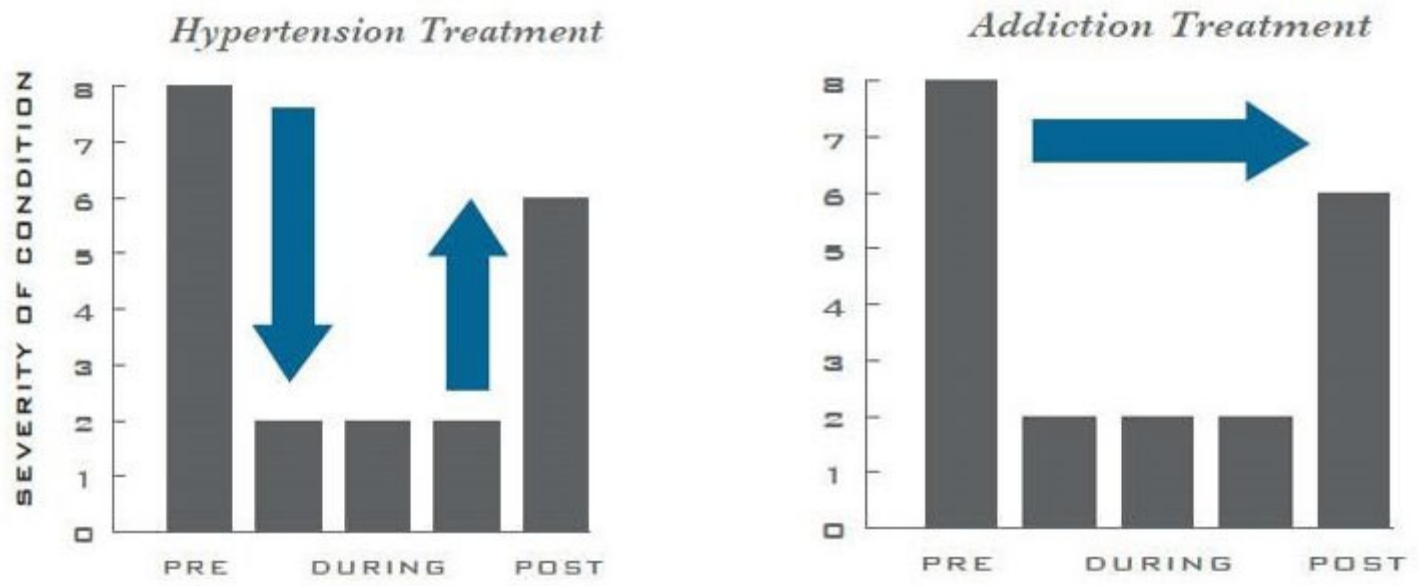
Substance Use Disorders as a Chronic Disease

CHRONIC DISEASE

- Social Determinants of Health
- Heritability
- Relapsing and remitting
- Early intervention increases rate of remission
- Success in treatment is dependent on adherence and duration of treatment



Substance Use Disorders as a Chronic Disease



If chronic management is needed for HTN, DM, COPD why don't we use it for substance use disorders?

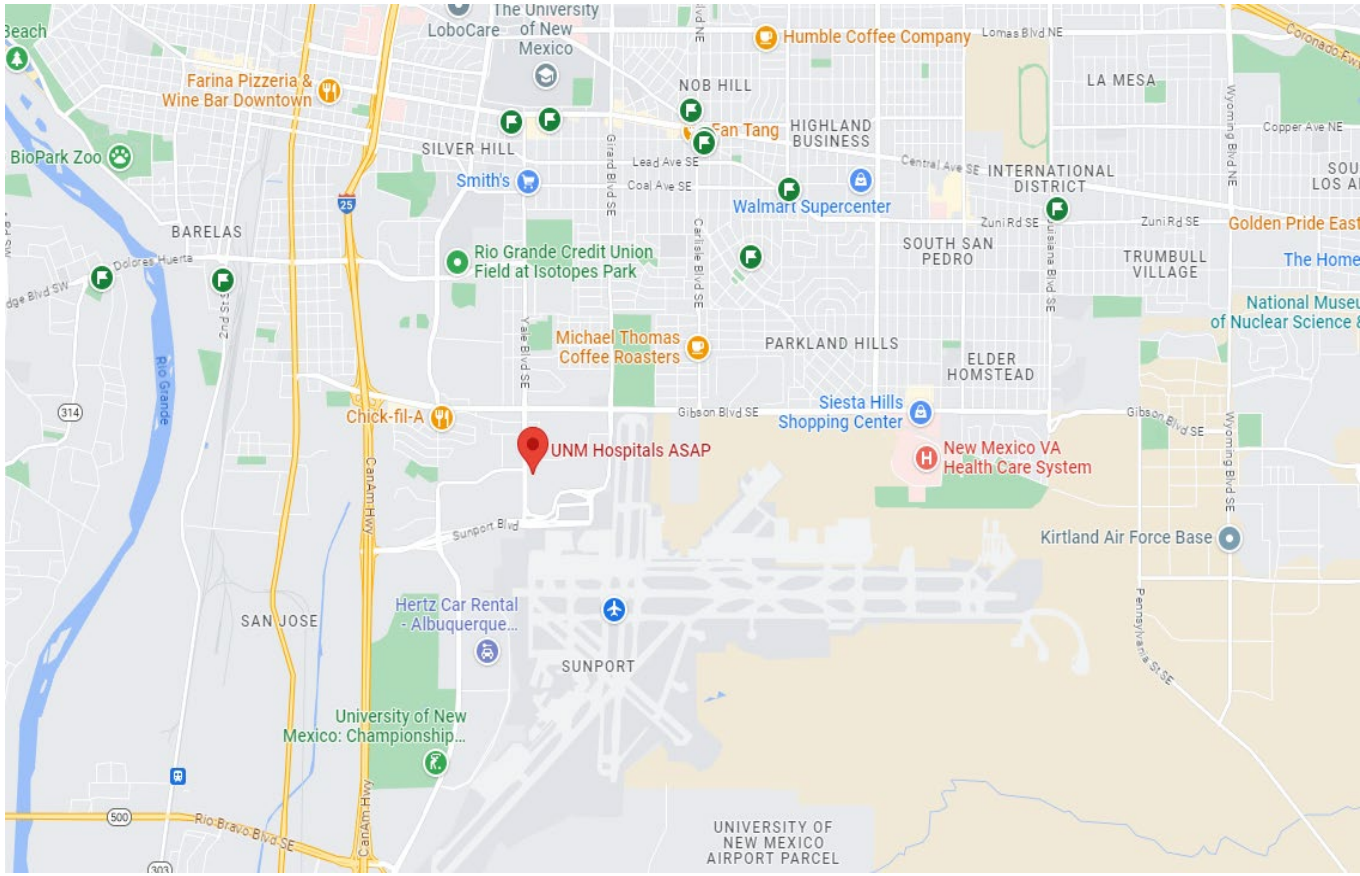
Addiction and Substance Abuse Program

- Multidisciplinary evidence based outpatient treatment program for substance use disorders
  - Medical management
    - Opioid treatment program (Methadone)
    - Office based opioid treatment (Buprenorphine)
    - Walk- in medical and psychiatric providers
    - Dual diagnosis care
    - Primary care

Mission: Our mission is to provide high quality, safety-focused, evidence-based substance use disorder and co-occurring outpatient behavioral health disorder treatment to improve the physical, spiritual and emotional health of our patients and our community.

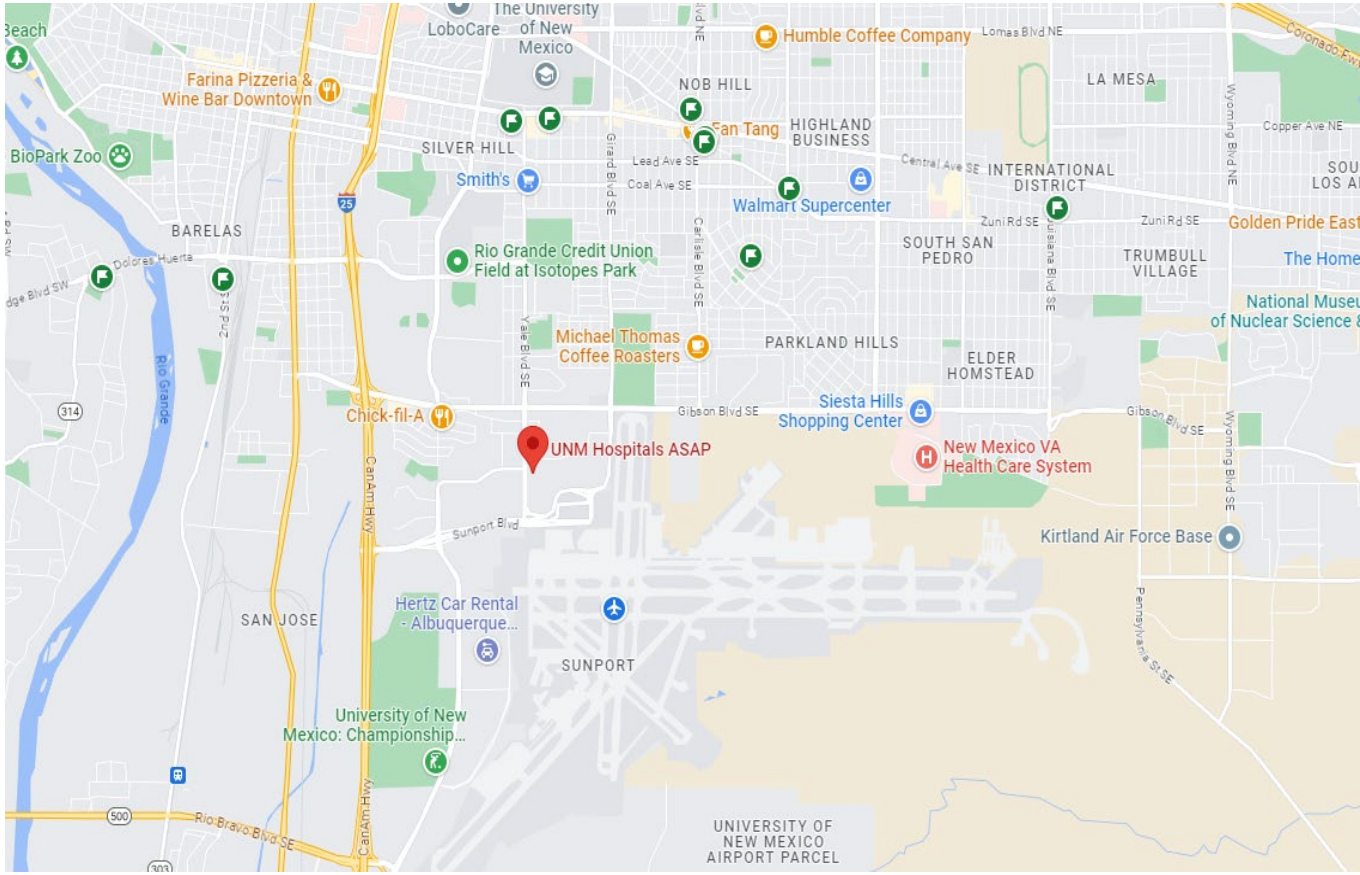
Addiction and Substance Abuse Program

- Multidisciplinary evidence based outpatient treatment program for substance use disorders
  - Clinical Management
    - Walk-in counseling
    - Weekly therapeutic groups schedule
    - Evidence based treatment for trauma
      - CPT
      - PE
    - Intensive outpatient program
    - Contingency management therapy
    - Case management assistance



Addiction and Substance Abuse Program

- Specialized care for specific populations
  - Management of SUD during pregnancy
    - Close coordination with UNM Milagro Clinic
    - Coordination of care from outpatient to inpatient care
  - Adolescent treatment
    - Dual diagnosis care for Adolescents
  - Dual diagnosis care
    - Specialized academic clinic for patient with significant psychiatric needs



Treatment Approach and Foundational Philosophy

- Substance use disorders are a chronic disease
- Treatment is dedicated to evidence-based practice
- Treatment addresses the biopsychosocial dysfunction of illnesses
  - Medication + therapy + social support = greatest chance of remission
- The Spirit of Motivational Interviewing (MI)
  - Non-judgmental
  - Be inquisitive
  - Meet patients where they are
  - Each patient is an individual
  - Address patient suffering with empathy

Comorbid Psychiatric Illness and Substance Use Disorder

-treating co-occurring psychiatric disorders such as anxiety, depression, or PTSD for example is critical to achieving optimal outcomes

-patients are often self-medicating the sx of these co-occurring disorders in the first place

-if they remain poorly controlled their recovery will be jeopardized

OPIOID CRISIS

- The opioid epidemic represents one of the most devastating public health crises in United States history. Currently in its fourth decade, it reflects few signs of near-term attenuation.

- Data from the CDC indicate that there were an estimated 100,306 drug overdose deaths in the United States during the 12-month period ending in April 2021, an increase of 28.5% from year before.

- Estimated overdose deaths from opioids increased to 75,673; up from 56,064 the year before.1 People with Opioid Use Disorder (PWOUD) represent a population with high need for access to evidence-based drug treatment and health care services.

- PWOUD face significant health disparities, including a lack of access to the life-saving FDA-approved treatment buprenorphine.

Stigma

- Addiction appears to be among the top (if not the top) most stigmatized conditions across different societies
- Compared to other mental illnesses, people have more stigmatizing and discriminatory views toward those with addiction disorders
- Olson et al. (2003): people in US, UK, Australia thought people with SUDs should receive less priority in healthcare

John D. Ehrlichman, former Nixon aide, interview with Dan Baum:

“The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.”

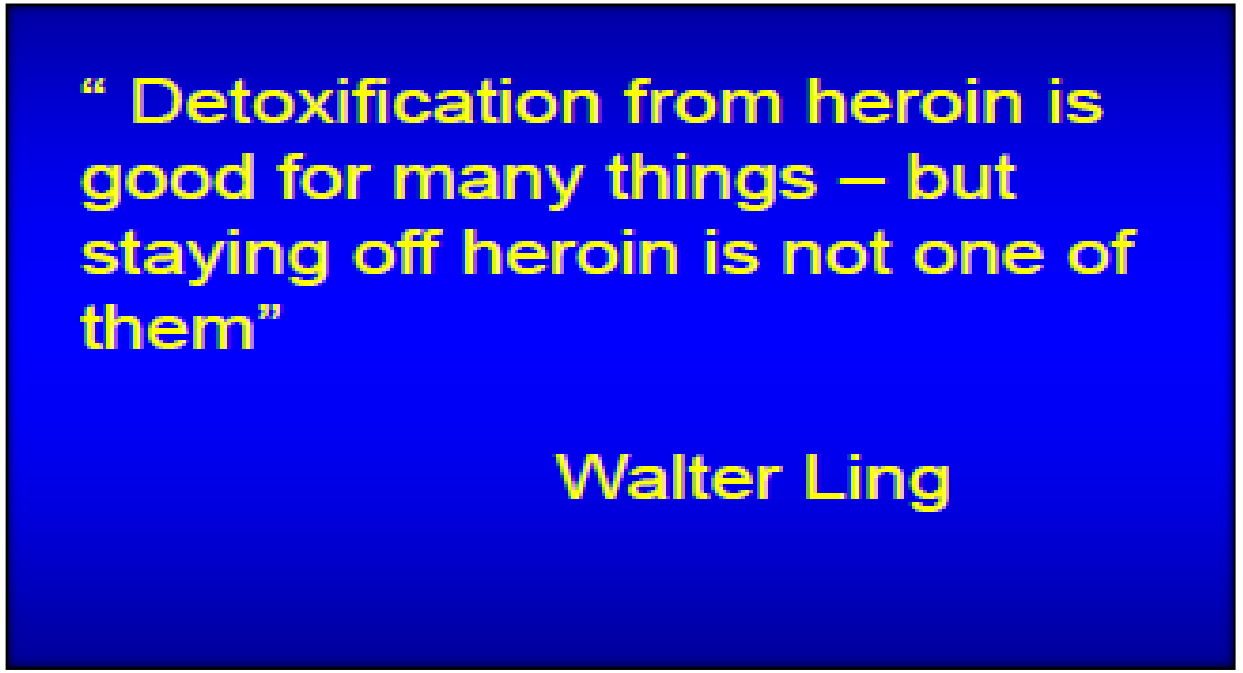
The War on Drugs has become a war on people, most of whom suffer from a chronic relapsing disease. Stigma, discrimination and criminalization remain the largest barrier to effective treatment.

Health-associated stigma

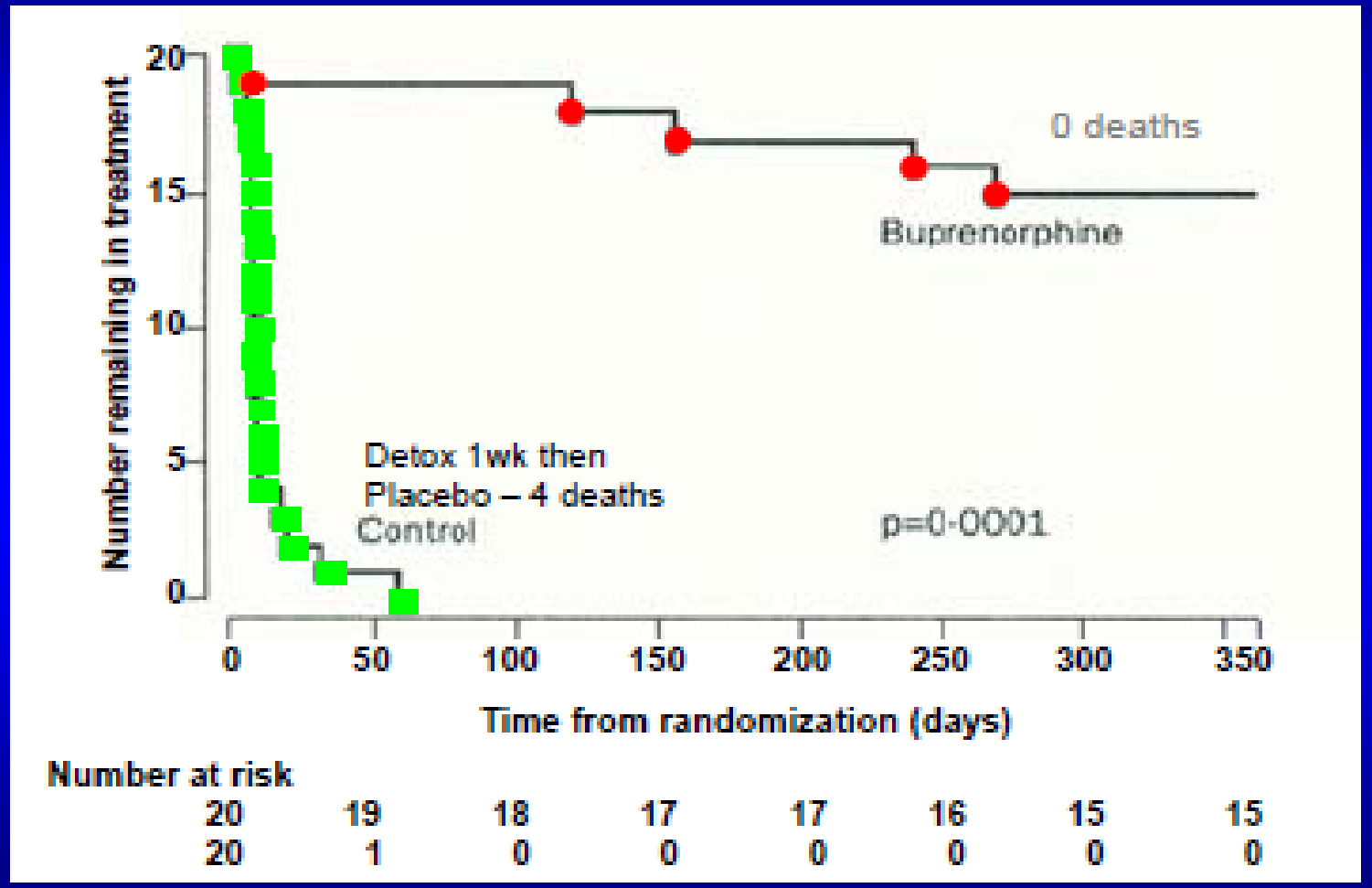
- Involves a socio-cultural process in which social groups are devalued, rejected and excluded on the basis of a socially discredited health condition
- Social subordination
- Jeopardizes Self-determination and disempowers

Weiss MG, Ramakrishna J, Somma D. Health-related stigma: rethinking concepts and interventions. Psychol Health Med 2006; 11: 277–87.

Powers M, Faden R. Social Justice: The Moral Foundations of Public Health and Health Policy. New York, NY: Oxford University Press; 2006.


“ Detoxification from heroin is good for many things – but staying off heroin is not one of them”
Walter Ling

Buprenorphine Maintenance vs Detox. RCT of cumulative retention in treatment



Kakko, et al, Lancet, 2003

Similarities with Other Chronic Diseases (Type II Diabetes, HTN, Asthma)

- **Genetic impact is similar**
- **The contributions of environment and personal choice are comparable**
- **Medication adherence and relapse rates are similar.**
- **Long term maintenance treatments proven most effective. (McLellan, JAMA 2000)**

Implications

- As in all chronic diseases, treatment should be continuous rather than episodic
- Goal should be improvement, not “cure”
- Available treatment leads to substantial improvement in:
  - Reduction of alcohol and drug use
  - Increases in personal health and social functioning
  - Reduction in threats to public health and safety
  - Reduction in monetary costs
  - Reductions in mortality

FDA Approved Medications for Opioid Use Disorders

Methadone- Agonist

Buprenorphine- Partial Agonist

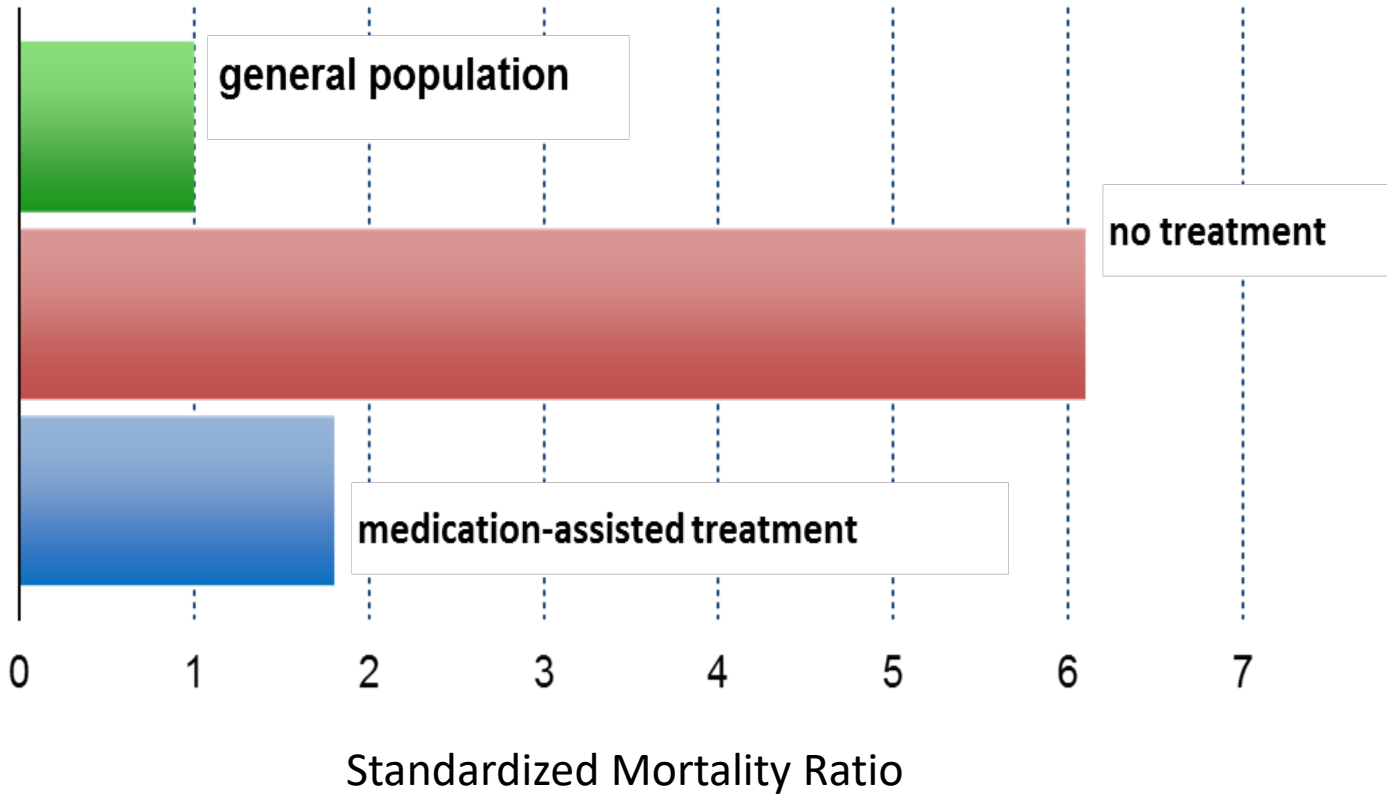
Naltrexone [Oral and Injectable]- Antagonist

Benefits of Pharmacotherapy:

Decreased Mortality with Methadone and Buprenorphine

[NOT shown with naltrexone]

Death rates:



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

Other Benefits of Pharmacotherapy

Medication can be one part of a more comprehensive treatment

Often the “hook” that leads to treatment engagement

Importance of treating underlying illnesses [eg PTSD, hepatitis C]

Importance of helping stabilize life [employment, housing]

Importance of helping create positive social networks

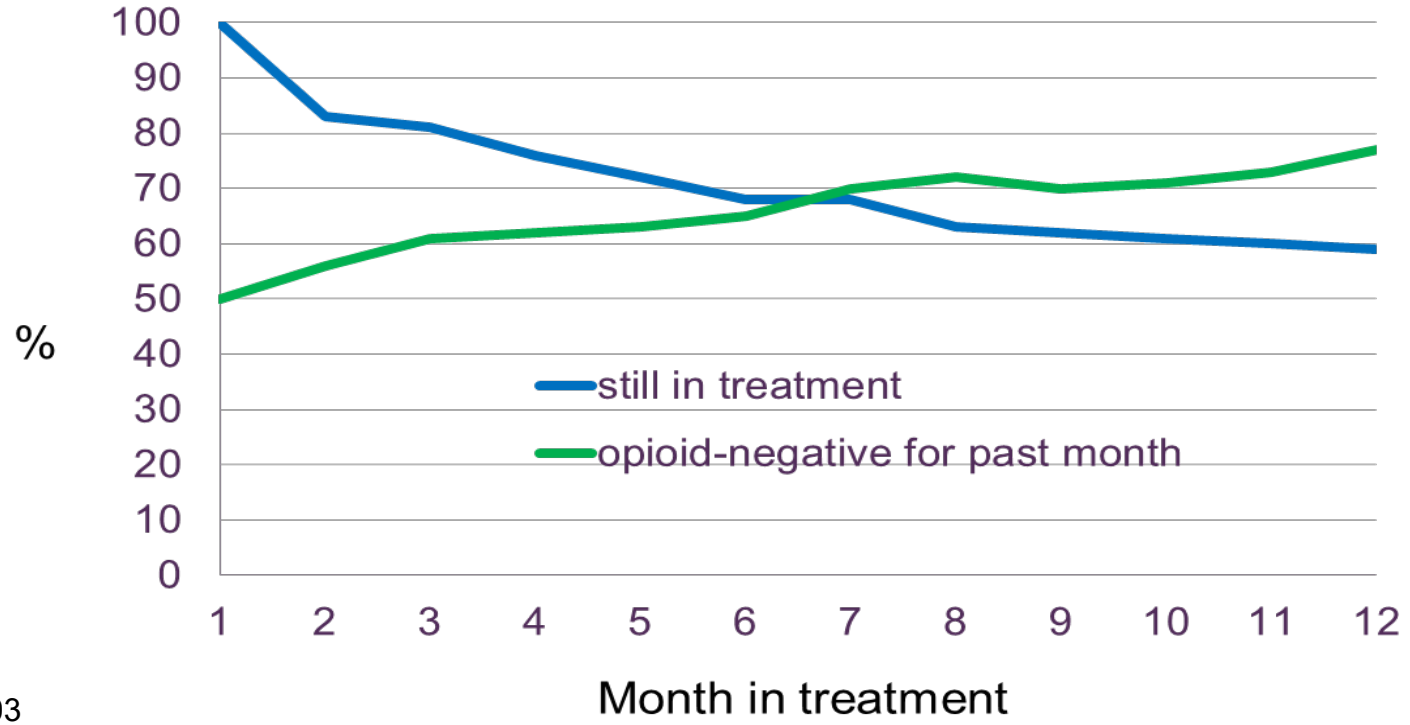
Importance of helping learn coping skills, relapse prevention strategies, emotion regulation

How Long Should Treatment Be?

FOR AS LONG AS IT BENEFITS THE PATIENT

Treatment Retention and Decreased Illicit Opioid Use

Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids



Kakko et al, 2003
Soeffing et al., 2009

…And yet

More than 80% of patients intend to continue buprenorphine treatment for 1 year or more (Bentzley 2015)

Fewer than 10% of patients stop treatment because they want to continue illicit use or do not like buprenorphine treatment

Treatment discontinued due to

- some states and insurers mandating lifetime limits on OUD treatment
- involuntary discharge based on
  - missed treatments
  - Ongoing substance use,
  - logistic conflicts,
  - Interpersonal conflicts with staff (Gryczynski 2014)

Suggested Approach

- Continue maintenance as long as patient is benefitting from treatment (decreased substance use, meeting employment, educational, relationships goals)
- Note: Provider can have discussions regarding reduction in dose with improving stability or patient preference however:
- **Caution patients about discontinuing medication too early in treatment**
- **EVERY MAJOR STUDY has shown that treatment retention improves outcomes**
- **Brief withdrawal periods are unlikely to result in long-term abstinence**
- Worst case scenarios
  - with continuing medication: $?
  - with stopping medication: relapse, arrest, jail, OD, death

But isn’t it switching from one addiction to another?

Dependence versus addiction

- Dependence DOES NOT equal addiction
- **Tolerance and withdrawals happen with many medications**
- **But to have addiction, you also need loss of control, compulsive use, consequences [it effects a person psychologically, socially, spiritually]**

Exchanging One ‘Drug’ for Another

HEROIN / ILLICIT OPIOIDS	PHARMACOTHERAPY WITH METHADONE/BUP /NTX
Illegal	Legal / Prescribed
Avoiding ‘Dope Sick’	Medical treatment
Criminal charges / felony	Lawful
Pharmacologic uncertainty ◦ Adulterants / ‘Cutting’*	Known dosages/potency ◦ Pharmacologic grade
Unemployment	Employment
Getting ‘High’ or ‘Buzzed’	No euphoria
Increased criminal behavior	Decreased criminal behavior
IDU / high risk behavior	Daily PO/SL medication
Increased HepC HIV STI	Decreased Communicable Dzs
Financial ruin	Financial self-sufficiency
Homelessness	Stable housing
Familial separation	Familial stability
Overdose/death	Reduced mortality

Stigma, Recovery and Pharmacotherapy

Recovery

- It is possible, and likely, but we often do not hear of these stories
- **Medications are an ESSENTIAL part of recovery for most people**
- "Reclaiming of the self"
- Remission leads to:
  - Improved health and reduced mortality
  - Stable housing
  - Purpose [employment, crime free life]
  - Community engagement; stable fulfilling relationships; sober friends
  - Self-efficacy

Significant Lack of Buprenorphine Providers – treatment gaps exist

30 million live in counties with **NO** buprenorphine providers

<10% practice in rural counties

Traditionally marginalized minority populations with less access to MOUD/buprenorphine and worse outcomes re: OUD

Rosenblatt et al. 2020

Recommendations from The National Academy of Sciences

1. Opioid use disorder is a treatable chronic brain disease.

2. U.S. Food and Drug Administration (FDA)-approved medications to treat opioid use disorder are effective and save lives.

3. Long-term retention on medications to treat opioid use disorder is associated with improved outcomes.

4. A lack of availability of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.

Recommendations from The National Academy of Sciences

5. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population.

6. Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available **all classes of FDA-approved medication** for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.

7. Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis.

The best chances for achieving and sustaining remission of OUD and recovery include the use of evidence-based MOUD e.g. buprenorphine (often most practical and accessible)

Typically encourage patient to start with buprenorphine-naloxone (Suboxone)

- Safer – respiratory depression ceiling as partial agonist
- Difficult to overdose on buprenorphine unless mix with etoh, bzd, z-drug (removes ceiling)
- Much lesser incidence of tolerance and opioid induced hyperalgesia vs full agonist
- More readily available in virtually any outpatient medical clinical setting
  - DEA/SAMSHA Waiver has been removed recently
- Less stigmatizing
- Due to methadone having an extremely long half, the transition from methadone to buprenorphine is extremely difficult – but possible, often unpleasant for patient, risk of relapse high
- However, crucial not to be paternalistic the population – if they prefer methadone – don't fight them,
  - Patients with severe mental illness and/or psychosocial instability often benefit from structure

While counseling, case mgmt and peer support i.e. Nonpharmacological therapies are important, they have not shown to have significant impact on OUD patients' outcomes

-with respect to retention and treatment, relapse and overdose

Lack of availability or engagement with these behavioral interventions/services should not be reason to withhold treatment with MOUD e.g. buprenorphine

Duration of Treatment

- Clinical evidence suggests that a longer duration that a patient with OUD remains in treatment with 1 of the 3 evidence-based medications recommended here is associated with better treatment outcomes, including recovery for problematic substance use, and death due to opioid overdose.
- Clinical evidence from multiple trials consistently shows that when patients are taken off of evidence-based pharmacotherapies for OUD, that relapse rates soar as high as 90%. These high relapse rates are associated with high rates of lethal opioid overdose.
- For this reason, patients should be encouraged to continue either opioid replacement therapy or mu-opioid antagonist therapy as long as possible, including indefinitely.

Individuals with a diagnosis of opioid use disorder should be screened for the following psychiatric comorbidities in order to maximize their chances of responding to treatment:

1. Alcohol use (including identification of "risky drinking," and/or alcohol use disorder).
2. Benzodiazepine/sedative hypnotic use (including identification of risky use of sedative hypnotics, and/or anxiolytic/sedative/hypnotic use disorder).
3. Tobacco use disorder.
4. Methamphetamine use disorder.
5. Major depressive disorder.
6. Posttraumatic stress disorder.
7. Generalized anxiety disorder.
8. Suicidal ideation.

Individuals with a diagnosis of opioid use disorder should be screened for the presence of end-organ damage, and conditions signifying risks of higher medical complications:

1. Complete blood count (to evaluate for acute infections)
2. Basic metabolic panel (to evaluate electrolytes and renal function)
3. Liver function testing (to evaluate hepatic function)
4. Pregnancy (for females ages 11-50)
5. Screen for hepatitis C
6. Screen for HIV
7. Evaluate cardiac status (history of myocardial infarction within 6 weeks, congestive heart failure, untreated/unstable dysrhythmias)
8. Evaluate for abscesses/cellulitis (IV drug use)
9. Evaluate the risk of sleep disordered breathing (E.g. STOP-BANG Screen)
10. Evaluate for severe COPD

Individuals with a diagnosis of opioid use disorder should have a thorough evaluation of their psychosocial needs, in order to best position them for success in treatment, including:

1. Housing status
2. Employment/income
3. Insurance status
4. Primary care provider relationship
5. Social support network (friends, family, religious community)
6. Transportation
7. Criminal justice involvement

If a patient who is on maintenance opioid replacement therapy with methadone or buprenorphine is found to have opioids in their urine drug screen or reports a recent relapse to opioid use, what should the response be?

- Often bup dose subtherapeutic → increase dose!
- Increase structure and support via more frequent clinic visits and/or shorten duration of scripts, encourage counseling, groups, coping skills development
- It is not appropriate to discontinue treatment in response to a relapse, or to detoxify a patient from opioid replacement unless the plan is to transition them to treatment with a mu-opioid antagonist (Very rare)

If a patient on maintenance therapy with naltrexone, methadone, or buprenorphine is found to have cocaine, methamphetamine, or cannabis in their urine drug screen, what should the response be?

- The appropriate response to a patient using cocaine, methamphetamine, or cannabis is to evaluate whether the use of those substances constitutes a substance use disorder, and if so, to develop a treatment plan to address that substance use disorder.
- Treatment with naltrexone, methadone, or buprenorphine is not expected to affect the use of other addictive substances (with the exception of naltrexone's effect on alcohol use). For this reason, it would not be appropriate to discontinue treatment with naltrexone, methadone, or buprenorphine solely based on that patient using those other substances.

The status quo is unacceptable

We aim to develop a new, progressive and aggressive approach to address the Opioid Crisis and the tremendous YPLL

Centered on removing as many barriers to buprenorphine access as possible

Low Barrier Buprenorphine as treatment modality concept

We attempt to remove as many barriers as possible to buprenorphine access

Low threshold to initiate treatment

- Diagnosis of OUD only

Buprenorphine in addition to other forms of MOUD as first-line treatment for OUD is critical to combating the overdose crisis

Buprenorphine is a safe and life-saving medicine, but availability to persons with OUD is **significantly limited**

Harm Reduction / Public Health Perspective

- Approach buprenorphine like Narcan, saturate OUD population to prevent overdose

Empowers people to break the cycle of use and withdrawal so that they can focus on other priorities in their lives

- Housing, relationships, employment
- Reduces recidivism

Harm reduction… “is about offering options that can help people. It includes stable housing, access to life-saving drugs like Naloxone that reverse an opioid overdose, drug checking [e.g. fentanyl test strips] that can detect adulteration in the drug supply, syringe exchange services…” and connection to myriad psychosocial resources, among other services

-Drug Policy Alliance

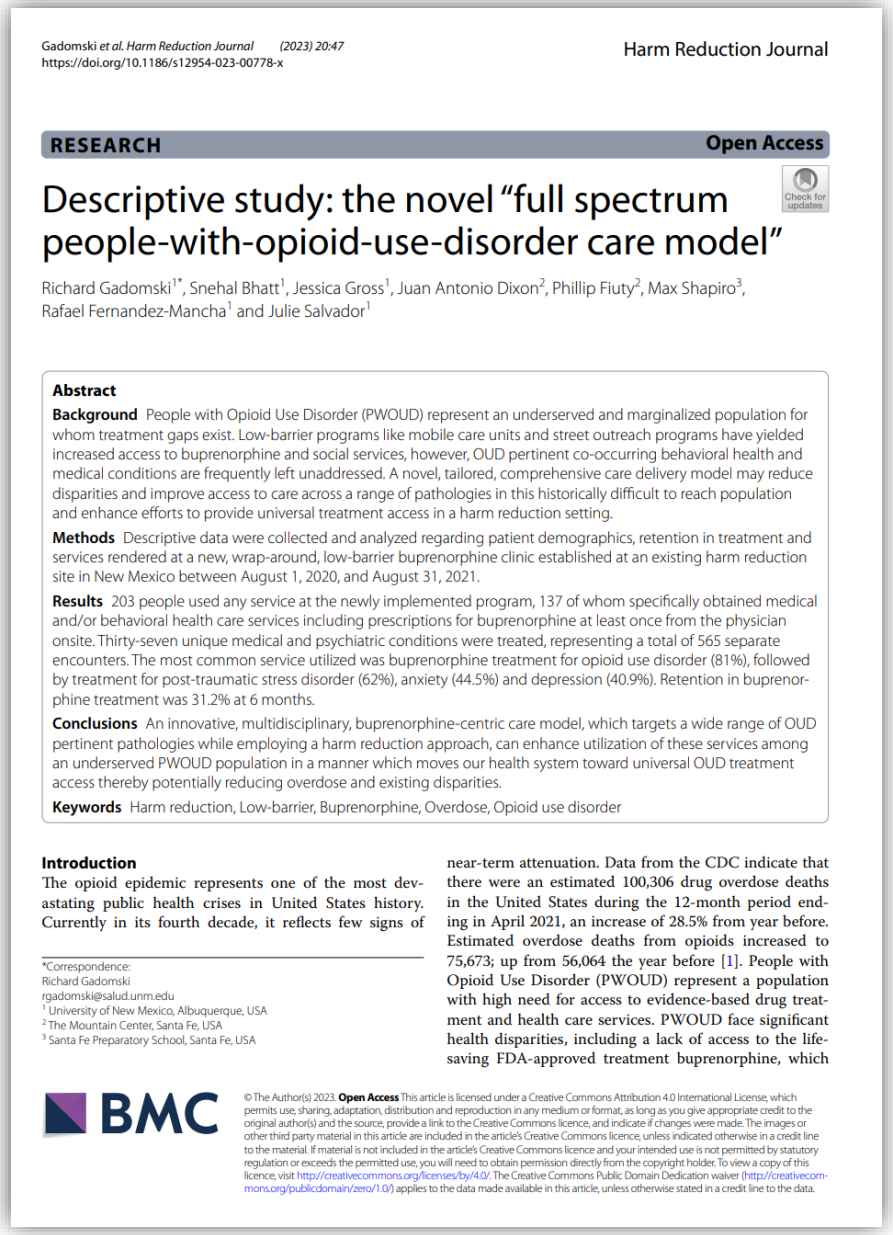
Co-localized Services with Harm Reduction/Syringe Services Provider

Mountain Center SSP/Harm Reduction site in Espanola = Safe Space for Persons with OUD/PWUD

- Harm reduction philosophy involves meeting PWUD where they are right now, non-judgmental, low pressure approach
- Creates safe space and sense of community for PWUD in Espanola/RAC

People with OUD/PWUD historically difficult to engage population in terms of medical/psychiatric treatment

Critical to our approach to the program was the desire to bring buprenorphine and medical services to an existing SSP and harm reduction site, where the target treatment population already congregates, has a sense of community and feels safe



Gadomski *et al. Harm Reduction Journal* (2023) 20:47
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Harm Reduction Journal

RESEARCH Open Access

Descriptive study: the novel "full spectrum people-with-opioid-use-disorder care model"

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Abstract

Background People with Opioid Use Disorder (PWOUD) represent an underserved and marginalized population for whom treatment gaps exist. Low-barrier programs like mobile care units and street outreach programs have yielded increased access to buprenorphine and social services, however, OUD pertinent co-occurring behavioral health and medical conditions are frequently left unaddressed. A novel, tailored, comprehensive care delivery model may reduce disparities and improve access to care across a range of pathologies in this historically difficult to reach population and enhance efforts to provide universal treatment access in a harm reduction setting.

Methods Descriptive data were collected and analyzed regarding patient demographics, retention in treatment and services rendered at a new, wrap-around, low-barrier buprenorphine clinic established at an existing harm reduction site in New Mexico between August 1, 2020, and August 31, 2021.

Results 203 people used any service at the newly implemented program, 137 of whom specifically obtained medical and/or behavioral health care services including prescriptions for buprenorphine at least once from the physician onsite. Thirty-seven unique medical and psychiatric conditions were treated, representing a total of 565 separate encounters. The most common service utilized was buprenorphine treatment for opioid use disorder (81%), followed by treatment for post-traumatic stress disorder (62%), anxiety (44.5%) and depression (40.9%). Retention in buprenorphine treatment was 31.2% at 6 months.

Conclusions An innovative, multidisciplinary, buprenorphine-centric care model, which targets a wide range of OUD pertinent pathologies while employing a harm reduction approach, can enhance utilization of these services among an underserved PWOUD population in a manner which moves our health system toward universal OUD treatment access thereby potentially reducing overdose and existing disparities.

Keywords Harm reduction, Low-barrier, Buprenorphine, Overdose, Opioid use disorder

Introduction

The opioid epidemic represents one of the most devastating public health crises in United States history. Currently in its fourth decade, it reflects few signs of near-term attenuation. Data from the CDC indicate that there were an estimated 100,306 drug overdose deaths in the United States during the 12-month period ending in April 2021, an increase of 28.5% from year before. Estimated overdose deaths from opioids increased to 75,673; up from 56,064 the year before [1]. People with Opioid Use Disorder (PWOUD) represent a population with high need for access to evidence-based drug treatment and health care services. PWOUD face significant health disparities, including a lack of access to the life-saving FDA-approved treatment buprenorphine, which

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- one stop shopping **biopsychosocial** treatment, harm reduction and recovery support for PWID/OUD
- Progressive and Aggressive approach to opioid overdose crisis and related morbidity

Care Model: Comprehensive services tailored to the needs of our vulnerable and high-risk population

Broad Mental health rx / buprenorphine + Sublocade

Counseling, including trauma focused therapy

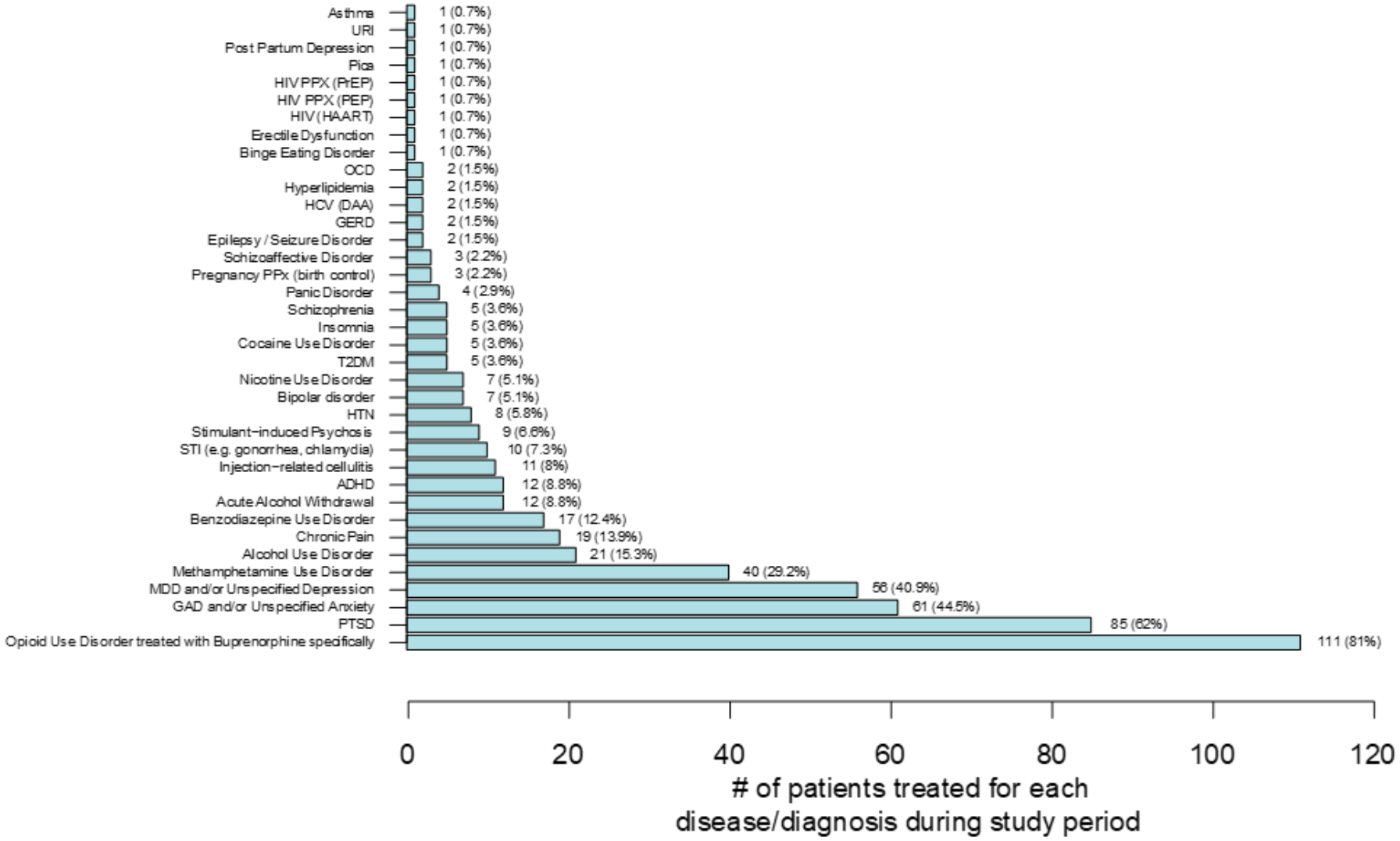
Harm reduction, including SSP, overdose prevention

Peer support & Case Mgmt

Targeted medical services:

- **Hepatitis C Virus Treatment**
  - Facilitated by Project ECHO support and new staff role: "Recovery Support Services Manager" among other responsibilities to ensure coordination and seamless access to recovery services
- PrEP (HIV Pre Exposure Prophylaxis for MSM, Sex workers, PWID
  - PEP (HIV Post Exposure Prophylaxis e.g needle stick)
- **HIV Anti-Retroviral Initiation** and referral (ECHO Support)
- Primary Care "light" with referral as needed
- Reproductive Health Access / Birth Control
- Cellulitis (antibiotics) and Wound Assessment with referral as needed

Medication Treatment Rates for Various Diagnoses Among Clinic Patients within Study Period



Challenges

Stigma – Enormous Barrier!

- Public –
  - Prevailing public narrative of disease as choice, moral failure
- Providers – decreased access
- Patients (internalized)

Patient retention

- 30% patient retention at 6 months typical
  - Psychosocial instability – homeless, transportation etc
  - Stigma
  - OUD/Addiction = chronic relapsing disease

Lack of awareness/education re: effective treatment

Operationalizing clinic protocols during COVID

Pharmacy level barriers to buprenorphine access

Buprenorphine initiation

Partial agonist

- High binding affinity, lower receptor activation

Need to avoid precipitated withdrawals

Comfort meds

- Clonidine
- Loperamide
- Zofran
- Methocarbomol
- NSAIDS
- **Pre-existing benzos on board not absolute contraindication**

Bup start: 2 methods…..

Microdose vs Macrodose

Microdose *(Bernese method)*

Good for people who do not want or fear any withdrawal sx

Depends on patients goals and health literacy, psychosocial stability

- Patient does not stop using opioids. Instead they start at low dose and increase buprenorphine gradually.
- Outpatient microdosing induction schedule for buprenorphine–naloxone
- Day 1: 0.5 mg once a day
- Day 2: 0.5 mg twice a day
- Day 3: 1 mg twice a day
- Day 4: 2 mg twice a day
- Day 5: 3 mg twice a day
- Day 6: 4 mg twice a day
- Day 7: 12 mg (stop other opioids)

Macrodose Bup Start

Better for fentanyl users, psychosocially unstable, familiar with withdrawal and may experience frequently due unstable access

How to do it

- Fentanyl:
  - Wait 12 to 24 hours out from last illicit use for short acting opioids
  - Must be in sufficient withdrawal to start bup/Suboxone to avoid precipitating withdrawal
  - Can give person SOWS but typically if has been at least 12 hours out and patient is experiencing GI sx, they are ready
    - At this point can cut tiny corner off strip and place under tongue to gauge readiness
  - When ready, start with 8mg strip SL
    - Wait 2 hours, if still cravings/withdrawal → Take second 8mg strip SL
    - Wait 2 hours, if still cravings/withdrawl →Take third 3mg strip SL
    - Goal is to get patient up to 24mg on first day if needed – often is in setting of fentanyl

Case Vignette

A 30 year old man currently experiencing homelessness with PMH pertinent for OUD, AUD, PTSD, GAD presents to your outpatient primary care office to establish care. His priority is treatment for OUD. His best friend recently died from a fentanyl overdose, and the patient is now future oriented and motivated for recovery. He says he is not able to abstain from fentanyl use for more than 12 hours without intolerable withdrawals. He is experiencing baseline anxiety, hypervigilance, avoidance behavior related to trauma and nightmares. He has not had a drink in 4 days and is not experiencing withdrawal symptoms but is prone to periodic binge episodes with “blackouts.”

1. Treatment considerations / plan

In PC outpatient setting, buprenorphine most viable, practical and effective medicine for OUD.

Same-day start buprenorphine-naloxone SL formulation (Suboxone), if at all possible

However, in this case with buprenorphine on board cannot use Naltrexone for AUD, thus alternative would be Acamprosate (creat?)

Consider SSRI – first line for PTSD and GAD

- Consider clonidine or prazosin for other PTSD sx

Consider Gabapentin for anxiety and AUD

Encourage peer support / counseling / CM but these should not be a barrier to immediate buprenorphine access

Provide Narcan!

Trauma -focused therapy important with respect to PTSD

Structural factors that Contribute to OUD

We must resist the temptation to view OUD solely through the lens of mental health pathology thereby medicalizing a phenomenon which is itself the symptom of socioeconomic decay and governmental policy paralysis.

Addressing the structural causes of the opioid epidemic, such as a poorly functioning mental health system, poverty, racial injustice, and housing affordability, are ongoing challenges in the United States.

In addition to making MOUD as widely available as possible including in jails and prisons, public health approaches such as the decriminalization of the individual possession of small amounts of all drugs thereby diverting people with SUDs into voluntary treatment rather than incarceration – as has been done in Portugal and Oregon – are also promising policy strategies.

Methadone should be deregulated to increase ease of access, naloxone should be distributed aggressively and widely to help reverse overdoses as they are occurring, and Overdose Prevention Centers (OPCs) should be considered viable tools at our disposal to stem the tide of the overdose crisis and funded accordingly. (see glossary)

Conclusion

The main goal of buprenorphine treatment is two fold:

- Prevent overdose amidst and overdose crisis
- Mitigate the psychosocial disarray caused by OUD and break the vicious cycle of opioid use and withdrawal so that people can focus on other more important priorities to them in their lives
  - Housing, jobs, relationships, overall quality of life

Public Health

- Ultimately, the overarching focus must be on humane evidence-based services including harm reduction, rather than shunting people who are suffering towards the criminal justice system and exacerbating mass incarceration in the setting of four decades of rising drug overdose deaths

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Thanks, Questions!?