

Caring For Homeless Patients With Opioid Use Disorders: Clinical Guidelines

Quantum Units
Education

Affordable. Dependable. Accredited.

www.quantumunitsed.com

Summary of Recommended Practice Adaptations For the Care of Homeless Patients with Opioid Use Disorders:

These recommendations of the HCH Clinicians' Network were approved by the Advisory Committee on Adapting Clinical Practice for Homeless Patients with Opioid Use Disorders, whose members have expertise in homeless health care, primary care, addiction medicine, psychiatry, harm reduction therapy, and drug overdose prevention.

Recommended Clinical Adaptations:

HISTORY

- Use clinical history-taking as a critical opportunity to engage the patient and establish trust; focus on fostering a positive, mutually respectful relationship between the provider and patient.
- Ask about physical and mental health and history of drug use, beginning with open-ended questions. Ask about personal experience as an overdose survivor and witness, including manifestations of overdose related trauma.
- Ask about cultural background, living situation, history of trauma/abuse, and legal problems.

PHYSICAL EXAMINATION

- Look for physical evidence of opioid use, intoxication, or withdrawal.
- Look for signs of skin and soft tissue infection; test for HIV/HBV/HCV infection and end-organ damage including liver failure.
- Look for indications of severe depression, suicidal intent, cognitive disorders, and sequelae of trauma/abuse.

DIAGNOSTIC TESTING & ASSESSMENT

- Test patients for comorbidities that are strongly associated with opioid use disorders, including polysubstance use and sexually transmitted/ bloodborne infections.
- Evaluate findings from the clinical history, physical exam, and diagnostic testing to determine diagnosis and severity of opioid use disorder; identify any contraindications to medication-assisted treatment or acute conditions requiring a higher level of care.

PLAN OF CARE

- Work collaboratively with patients to develop realistic, attainable, short-term goals for the management of opioid use disorders, including a personalized overdose risk reduction plan and other harm reduction strategies.
- Determine treatment approach and setting based on patient needs and preferences, available resources, and affordability. Also consider motivations for seeking care, previous treatment experience, duration of disorder at current severity, use of heroin vs. pills, method of use, source of opioids (prescribed vs. illicitly obtained), and co-occurring disorders.
- Plan for close follow-up by a case manager and regular diagnostic evaluation with allowance for frequent and unscheduled visits.

EDUCATION, SELF-MANAGEMENT

- Review fundamental concepts of opioid use disorder management (treatment alternatives, side effects, risks and benefits); teach clients who are actively using opioids how to practice harm reduction; teach those currently abstaining to recognize signs and symptoms of relapse.
- Provide opioid safety education to all patients with substance use disorders and to patients taking opioid analgesics on the effects of opioids, including the possibility of overdose and interactions of opioid agonists with other medications/ drugs of abuse.

- Educate patients about overdose risks, recognition and response. Offer naloxone (if possible) to any patient undergoing tolerance changing events such as medically supervised withdrawal procedures or medication assisted treatment induction.
- Utilize tools such as motivational enhancement techniques and brief office-based counseling to help assess patients' level of readiness for behavioral change.

TREATMENT, MANAGEMENT

- Offer medication-assisted treatment to any patient with an opioid use disorder.
- Encourage use of nonpharmacologic interventions, whether patients are receiving medication-assisted treatment or not: harm reduction therapy, peer mentoring, peer support groups, acupuncture, and stable housing with access to supportive services including employment assistance
- Offer needle exchange and naloxone to individuals using injected opioids, to the extent permitted by law and available resources.
- Encourage more physicians serving homeless and other disadvantaged populations to seek training and certification to prescribe buprenorphine.
- Encourage more primary and specialty care providers serving homeless and other disadvantaged populations to collaborate and integrate care with addiction treatment programs, including methadone maintenance and detoxification programs.
- Develop more directly observed therapy (DOT) programs to monitor use and avoid misuse/ diversion of opioid agonist medications.

ASSOCIATED PROBLEMS, COMPLICATIONS

- Carefully assess for comorbidities that can complicate or interfere with treatment of opioid use disorders. Manage co-occurring conditions simultaneously.
- Provide opioid safety education on the effects of opioids including the possibility of overdose to all patients with a history of substance use and to patients taking opioid medications for pain management.
- Institute regular monitoring of all medications prescribed for and taken by the patient to prevent prescription of lethal or nontherapeutic medication combinations and to reduce risk of prescribing medications that will trigger relapse in patients with substance use disorders.
- If diversion/misuse of opioid agonists is suspected, explore patient motivations; re-evaluate the plan of care; implement strategies to minimize risk of diversion/ misuse (random drug tests, alternate day dosing, prescription monitoring program, directly observed therapy). Balance overall benefits of continuing MAT with potential harms.

FOLLOW-UP

- Determine frequency of follow-up based on stability of the patient and his/her living situation and risk of diversion/ misuse/ abuse of medications used for treatment of opioid use disorders or other substances.
- At each visit, assess for behaviors outside the treatment plan, including a psychosocial assessment. Consider causes related to homelessness – missed appointments due to competing priorities or unexpected events (e.g., in jail, delayed by another appointment), stolen medications (e.g., assault, theft in shelter).
- Provide medical respite care facilities where patients can convalesce when ill, recuperate following hospitalization, or receive end of life care. Facilitate entry into permanent housing with supportive services on site or in the community, to alleviate many associated problems and complications.

Recommended Programmatic Adaptations:

SERVICE DELIVERY DESIGN

- Design service delivery systems based on meeting patient needs, promoting consistency in practice, and supporting staff that work with challenging patients.
- Consider use of unconventional treatment sites (e.g., mobile methadone vans), addiction counseling on a drop-in basis, flexible treatment goals and desired outcomes, and creative strategies for recruiting patients into treatment.
- Establish collaborative relationships with methadone maintenance providers, detoxification programs, and other inpatient and outpatient addiction treatment programs for cross referral and coordinated care.
- Integrate primary and behavioral health care and use a harm reduction approach to the management of opioid use disorders. Use multidisciplinary clinical teams working at the same location. Locate treatment activities in places where homeless individuals with substance use disorders congregate. Provide recovery-oriented support services (e.g., peer mentoring, group therapy, employment assistance).

OUTREACH AND ENGAGEMENT

- Use outreach workers in the community to facilitate initial engagement with and provide support to people at risk for opioid overdose. Do outreach in partnership with a consumer/peer counselor as much as possible.
- Provide ongoing opportunities for group therapy to patients with opioid use disorders.
- If possible, provide medication-assisted treatment where homeless people live (e.g., shelter-based treatment with buprenorphine).
- Use a team approach in care planning and coordination to facilitate engagement.

STANDARDS OF CARE

- Adapt clinical practices to optimize care for patients who are homeless or at risk of becoming homeless considering the recommendations contained in this guide.
- Offer medication-assisted treatment to any patient with an opioid use disorder.
- Address acute and chronic medical problems related to drug use.
- Offer naloxone to patients with an opioid use disorder and offer needle exchange to injecting drug users, to the extent permitted by law and available resources.
- Advocate for improved access for homeless and other underserved populations to a broader range of interventions for the management of opioid use disorders.

INTRODUCTION

Opioids are opium derivatives and related synthetic substances that suppress pain, produce euphoria, and are employed to treat neurological and behavioral disorders resulting from opioid misuse. Although they are invaluable therapeutic agents, these powerful drugs are also addictive; and medication errors, misuse, overdose, and poisonings cause numerous fatalities annually. Illicit use of opioids – both heroin and prescribed analgesics such as oxycodone, hydrocodone, and fentanyl – has reached epidemic proportions in the United States ([Preda & Dunayevich 2013](#), [SAMHSA 2012 Sep](#), [Alford 2007](#)). In 2008, over 36,000 people died in the U.S. as a result of drug overdose. The majority of these deaths involved prescription opioid analgesics ([CDC 2011](#)). Opioid use disorders¹ occur along a continuum of severity, with different patterns of use in urban and rural areas and within different subpopulations – e.g., more heroin use in urban areas, involving older, more ethnically diverse users; more non-heroin opioid use in rural areas by younger, non-Hispanic Whites ([SAMHSA 2012 Jul](#)). Opioid use is frequently a component of polysubstance use disorders.

Opioid poisonings and overdose deaths occur throughout all segments of society, but clinicians serving people who are homeless² or unstably housed report that these individuals are at especially high risk for both opioid use disorders and fatal overdoses, exacerbated by their limited access to medication-assisted treatment and to overdose prevention therapy ([HCH Clinicians' Network 2006 Oct](#) & [2009 Feb](#)). A five-year study of 28,033 homeless people who had received treatment from the Boston Health Care for the Homeless Program between 2003 and 2008 found that drug overdose had replaced HIV as the leading cause of death among homeless adults in Boston and was responsible for one-third of fatalities of those between the ages of 25 and 44. Opioid analgesics and heroin were implicated in 81% of overdose deaths. Homeless adults aged 25–44 were nine times more likely to die than comparably aged housed adults in Massachusetts, and those aged 45–64 were 4.5 times more likely to die. ([Baggett 2013](#)).

¹ **Opioid use disorder:** “A problematic pattern of opioid use leading to clinically significant impairment or distress,” as manifested by at least two of 11 diagnostic criteria specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM–5), 2013. Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder.

² A **homeless person**, as defined by the Bureau of Primary Health Care, is “... an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered to be homeless if that person is ‘doubled up,’ a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. *A recognition of the instability of an individual's living arrangement is critical to the definition of homelessness.*” [emphasis added] (*Principles of Practice: A Clinical Resource Guide for Health Care for the Homeless Programs*, Bureau of Primary Health Care/HRSA/HHS, 3/1/99; PAL 99–12.) [The authors of these adapted practice guidelines understand that ‘*experiencing homelessness*’ is a more respectful and accurate way of designating individuals with unstable living situations than labeling them as ‘*homeless*.’ The latter expression is occasionally used in this document for the sake of brevity, but should be understood to connote a variable condition rather than a permanent characteristic.]

Numerous factors associated with homelessness may increase the risk of developing severe opioid use disorders and make treatment more difficult – including complex and poorly treated comorbidities, insufficient resources to meet basic needs, minimal social supports, and lack of access to specialty care. People experiencing homelessness are less likely to have clean, safe and comfortable locations to use opioids, which results in rushed and riskier drug use behaviors. Other realities of homelessness that may precipitate or exacerbate these disorders are high vulnerability to physical/ sexual abuse and living with unrecognized or untreated behavioral health problems, including psychological sequelae of trauma or abuse and cognitive impairment. These factors also make adherence to medical and mental health treatment plans and personal risk reduction plans more difficult. Chronic health conditions often associated with opioid use disorders that require regular, uninterrupted treatment – such as HIV infection and mental illness – are difficult to manage in unstable living situations. *“The relationship between chemical dependence and homelessness is interactive; one condition does not necessarily cause the other, but each can exacerbate problems associated with the other. Substance abuse can be both a precipitating factor and a consequence of homelessness.”* ([Zerger 2002](#))

Barriers to treatment for homeless people with opioid use disorders

Limited access to addiction treatment and fragmented health care delivery systems present significant obstacles to medical care for homeless people with substance use disorders, many of whom have serious co-occurring disorders ([Ibid.](#)). Lack of safe and affordable housing, instability, and social isolation complicate treatment. Lack of health coverage and other financial resources may make medication-assisted treatment unaffordable. Limited family and peer support for maintaining sobriety present barriers to recovery. Homeless people with uncontrolled opioid use disorders are at high risk for incarceration. Access to medication-assisted treatment during and after incarceration is limited; only 55% of prisons in the United States provide methadone to inmates and only 14% provide buprenorphine. Many correctional facilities oppose pharmaceutical treatment of opiate dependence as a matter of policy, preferring abstinence-only programs for incarcerated individuals; and following release, most prisons do not offer referrals to treatment programs. ([Nunn 2010](#)) A criminal history related to drug use may create additional barriers to housing, employment, and public assistance benefits. Discrimination based on race, gender, sexual orientation, or chemical dependence exacerbates financial and structural barriers to care.

Opioid-dependent, homeless people are frequently denied care by the medical community because they are stereotyped as “drug seeking” or “difficult.” Barriers to effective treatment and management of opioid use disorders also include poor understanding of addiction treatment and recovery by medical practitioners, the unwarranted assumption that substance abuse treatment for homeless people is unsuccessful, reluctance of physicians to use opioid agonist treatment despite its demonstrated efficacy, lack of authorization for nurse practitioners and physician assistants to prescribe opioid agonist medications, and exclusionary clinical guidelines requiring housing stability as a prerequisite for treatment with opioid agonists ([Alford 2007](#), [Hersh 2011](#), [Zevin 2011](#), [Stancliff 2012](#)).

Successful interventions & promising practices

Despite these impediments, both research and clinical experience suggest that health outcomes and quality of life can be significantly improved with a comprehensive, client-centered approach to the management of opioid use disorders and comorbid conditions. Practitioners with expertise in homeless health care, primary care, addiction medicine, psychiatry, harm reduction, and overdose prevention recommend the following interventions to promote successful treatment of homeless patients with opioid use disorders: a harm reduction/ low-threshold model of care ([Denning & Little 2011](#), [Zevin 2011](#), [Stancliff 2012](#)); explicit overdose prevention and management training and naloxone rescue kit access ([Wheeler 2012](#), [Walley 2013](#)); integration of primary care with mental health and addiction services provided by a multidisciplinary clinical team ([Meinbresse 2013](#), [Goyer 2011](#)); use of creative outreach strategies and unconventional treatment sites with flexible service access ([Bonin 2010](#)); intensive case management and peer support to improve treatment adherence and promote recovery ([Alford 2007](#), [Herinckx 2008](#)); flexible, individualized treatment goals established in collaboration with patients ([Wisner 2011](#)); and provision of/ referral to transitional or permanent housing with supportive services including employment assistance ([Perlman & Parvensky 2006](#), [Herinckx 2010](#), [HCH Clinicians' Network 2006 Oct, 2009 Feb](#)).

Several studies have demonstrated the feasibility of office-based opioid treatment (OBOT) for homeless patients using sublingual buprenorphine. Study results published in 2007 by researchers in Boston demonstrated that opioid-dependent homeless and housed cohorts receiving OBOT with buprenorphine/naloxone had comparable outcomes (did not differ in risk for treatment failure during follow-up and had similar proportions of treatment successes), despite the homeless cohort's greater social instability, medical and psychiatric comorbidities, and chronic drug use ([Alford 2007](#)). In 2011, The San Francisco Department of Public Health reported results from a two-year OBOT-buprenorphine/naloxone pilot program in which over 80% of patients were injecting heroin at baseline, 40% of whom were homeless. Positive outcomes included a one-year retention rate of 61% and a rapid and dramatic decline in opioid use ([Hersh 2011](#)). A 32-month pilot study in New York City demonstrated that buprenorphine/naloxone could be successfully used to treat homeless heroin users using a harm reduction model of care ([Stancliff 2012](#)).

Studies involving homeless recipients of methadone maintenance treatment (MMT) have focused on treatment retention rates for heroin-dependent injection drug users (IDUs) at high risk for HIV infection, client factors involved in MMT retention, and the association between longer MMT retention and improved outcomes for individuals with co-occurring opioid dependence and HIV infection. A study of street-recruited IDUs in Denver, Colorado, 1996–2000, found that 60% of those who entered MMT remained for at least 90 days, indicating the viability of methadone maintenance even for more marginalized drug users ([Booth 2004](#)). This study also supports the efforts of outreach interventions in facilitating treatment entry and retention for homeless heroin users who may not have been contemplating treatment at the time they were contacted. A study of adult IDUs entering a licensed MMT program in Massachusetts, 1996–2002, found that homeless patients were 15% less likely than housed patients to remain in MMT for 1 year or more ([Lundgren 2007](#)). Subjects who were younger,

male, homeless, uninsured, and had previously used residential treatment were significantly more likely to have remained in MMT for 6 months or less compared with their counterparts. A prospective study of HIV-infected IDUs in Vancouver, Canada, 1996–2008, found that MMT was positively associated with adherence to antiretroviral therapy (ART), whereas homelessness and frequent heroin use were negatively associated with ART adherence ([Palepu 2011](#)). Homeless subjects were slightly younger and more likely to inject heroin daily than their non-homeless counterparts.

Research on the clinical effectiveness of naltrexone for the treatment of opioid dependence in homeless/marginal populations is scarce. In general, the clinical utility of oral naltrexone has been limited by poor treatment adherence and retention; the majority of patients who are prescribed this medication do not adhere and drop out rapidly ([ASAM 2013](#)). Behavioral interventions such as contingency management with vouchers and involvement of significant others in treatment monitoring have been shown to improve naltrexone adherence, increase treatment retention, and reduce opioid use ([Carroll 2001](#)). Recent studies of opiate-addicted, unemployed adults have found poor to modest treatment adherence using extended-release injectable naltrexone (XR-NTX) without incentives; adherence rates are substantially higher when employment-based reinforcement incentives are made contingent on treatment ([Everly 2011](#), [DeFulio 2012](#)).

Purpose of this document and intended audience

The purpose of this document is to educate clinicians, other direct service providers, and program administrators about optimal care for people with opioid use disorders who are homeless or marginally housed, addressing clinical and programmatic issues. The development of these adapted practice guidelines was precipitated by 1) a significant increase in deaths from opioid overdose reported nationwide, particularly among people experiencing homelessness ([NIDA 2013](#), [Malone 2013](#), [Baggett 2013](#), [Preda & Dunayevich 2013](#)); 2) the awareness that opioid use disorders remain a pervasive public health problem contributing to the spread of infectious diseases and crime ([Alford 2007](#), [Herinckx 2008](#), [Stancliff 2012](#)); and 3) a recognition of the need for evidence-based practice guidelines for the care of underserved populations with opioid use disorders.

The same standards of care are warranted for people experiencing homelessness as for people with stable housing. Nevertheless, primary care providers who routinely serve homeless individuals recognize an increased need to take living situations and co-occurring disorders into consideration to develop a feasible plan of care. The practice adaptations recommended in this document are based on a comprehensive review of published reports and the consensus opinion of experienced homeless services providers and recipients with expertise in primary care, addiction medicine, psychiatry, harm reduction therapy, and overdose prevention. These recommendations are intended to be consistent with the clinical practice guidelines listed below. Their purpose is to facilitate adherence to these standards in the care of impoverished, displaced persons with multiple medical and psychosocial problems, many of whom lack safe and stable housing, affordable and accessible health care, and financial and social resources to meet basic needs, including nutritious food, clothing, shelter, and transportation.

Recommendations for the Care of Homeless Patients with Opioid Use Disorders

Diagnosis and Evaluation

HISTORY

Major recommendations:

- **Use clinical history-taking as a critical opportunity to engage the patient and establish trust; focus on fostering a positive, mutually respectful relationship between the provider and patient.**
- **Ask about physical and mental health and history of drug use, beginning with open-ended questions. Ask about personal experience as an overdose survivor and witness, including manifestations of overdose related trauma.**
- **Ask about cultural background, living situation, history of trauma/abuse, and legal problems.**

Rationale: Many people experiencing homelessness have had negative experiences with the health care system, so developing a therapeutic relationship is a key objective in addition to getting an accurate history. Both are important for developing a successful plan to address opioid use disorders.

Evidence: Expert consensus. Although there is limited scientific evidence to support these recommendations, many clinicians with expertise in homeless health care, primary care, addiction medicine, psychiatry, and harm reduction therapy find this approach to history-taking helpful.

Sources: [Alford 2007](#), [Bonin 2010](#), [Greenberg & Rosenheck 2008](#), [Highley 2008](#), [Hwang 2008](#), [Khoury 2010](#), [Kushel 2003](#), [SAMHSA 2013](#), [Wisner 2011](#)

- **Initial history** Recognize that many people with a history of homelessness have negative associations with medical settings. Clinical history-taking is an important opportunity to foster a positive, mutually respectful relationship between the provider and patient that should be reinforced at every subsequent encounter. Allow patients to tell their story and listen nonjudgmentally. Build confidence that as their provider, you have their best interest at heart. Briefly explain your clinical background and what your facility might have to offer them. (Health care settings serving homeless people range from triage sites to comprehensive primary care clinics.) Explain at the outset that you are going to ask about their physical health, mental health, and use of prescribed and nonprescribed drugs. Many of these questions can be asked over time and are helpful in building rapport, developing an appropriate treatment plan, and fostering a successful collaborative relationship.
- **Medical history** Ask patients to describe their physical health and listen for several minutes without interrupting. Use reflection – a kind of supportive interruption – to show them that you heard exactly what they said. Then ask specifically about individual and family history of conditions associated with opioid use disorders, including traumas, personal losses, and chronic pain. Due to recent concerns regarding EKG QTc intervals and methadone treatment, primary care providers of

patients known to have opioid use disorders should obtain thorough cardiac histories, including history of syncope, congestive heart failure, arrhythmias, and cardiac surgery ([Martin 2011](#)). This information is useful for safe patient management if referred to a methadone treatment program.

Ask whether patients have ever been hospitalized, and if so, where and for what reason(s). Inquire about other health care providers and whether there is a regular source of primary care. Ask about all current and past medications and dietary supplements taken, including contraceptives, over-the-counter medicines, herbal remedies, dietary supplements, and any “borrowed” medicine prescribed for others. Ask about any problems adhering to prescribed treatment and any adverse or strange side effects noticed. Assess ability to take pills daily and return for follow-up care; ask about regular routines and prior experience with medical treatment.

- **Psychiatric history** Ask patients to tell you about their mental health and any “problems with stress, low energy, difficulty focusing, or mood swings.” Ask if they have ever seen a psychiatrist or therapist and if so, whether they were given a diagnosis. Ask if they have ever been treated for depression, anxiety, or other mental health concerns and if they are currently experiencing any of these problems. PTSD, depression, and anxiety are strongly associated with opioid use disorders, and may be exacerbated by personal or witnessed overdose experience. Ask patients if they are bothered by “thoughts or sensations that seem unusual or supernatural (hallucinations)” and if they have ever considered suicide. Recognize that psychiatric illness can complicate treatment of opioid use disorders and other comorbidities.
- **History of drug use** *or every new patient*, begin the interview with questions about cigarette use, which are expected in a medical setting and nonthreatening. Then follow up with questions about personal and family history of alcohol use and drug use, including nontherapeutic use of prescribed medications. Follow-up questions can be standardized questions suggested by the [National Institute on Alcohol Abuse and Alcoholism](#), and the [National Institute on Drug Abuse](#), or questions like: “Have alcohol or drugs been a problem? Have you needed treatment for alcohol or drug problems?” Patients are open to answering these questions when asked in this nonjudgmental way. Begin with open-ended questions; resist the urge to interject questions that are too specific with an agenda. Ask about current and past drug use in different ways, depending on the setting and what you have already learned about the patient. Remember that patients may not give a full history at the first encounter. Later disclosure should not lead to a conclusion that patients are not concerned about their health.

If personal drug use is acknowledged, inquire about both perceived benefits associated with drug use and any drug-related problems the patient has experienced (e.g., blackouts/seizures, suicidal thoughts/actions, endocarditis, other infections requiring treatment/ hospitalization, withdrawal symptoms, previous nonfatal overdose, legal issues related to drug/alcohol use). Document any previous treatment for substance use disorders and attempts at recovery. Ask specifically about participation in a methadone or buprenorphine program, attempts to moderate substance use, previous experience with 12-Step groups, and other self-help and peer group strategies. Ask patients

whether they have ever overdosed, witnessed an overdose, or received training to prevent, recognize, or respond to a drug overdose.

SUGGESTED QUESTIONS TO ELICIT INFORMATION ABOUT DRUG USE

- **Are you seeking care for a drug problem?** If so, explore the patient's motivations for seeking care. *Were you required by the legal system or family/peer pressure to seek care?* Patients may be highly motivated to obtain care whether they are seeking treatment voluntarily or because they feel pressured to do so. Careful, nonjudgmental eliciting of patient goals is essential. Atypical/ unconventional motivations may be acceptable but require careful evaluation and follow-up.
- **Have you ever received treatment for your drug problem before?** If so: *What worked well, what did not, and why do you think relapse occurred? What do you think might be helpful this time, and how might you do things differently? What coping skills have you developed in dealing with homelessness/ unstable housing that might be utilized during this attempt at recovery/treatment?* If not: Ask if the patient has ever self-treated a drug problem before, including home detox, tapering, or experience with illicitly acquired buprenorphine or methadone.
- **What happens when you stop taking the drug or can't obtain the usual drug or amount?** *Have you ever had a stroke or seizure after you stopped taking a drug?* Explore type of withdrawal symptoms and time until withdrawal symptoms occurred.
- **Describe in detail any period of time when you were able to maintain sobriety.** *Were you housed?* If so: *What type of housing? What types of support were you utilizing (e.g., Alcoholics Anonymous, Narcotics Anonymous, counseling, church, yoga, other exercise)? What happened or what did you stop doing before you began using again?*
- **Have you or has anyone in your family ever used pills or drugs prescribed for pain?** If so: *What pills/drugs were used and how (swallowed, injected, sniffed, smoked)? How much of the drug(s) was used and when?* If considering medication-assisted treatment for patients using opioids, ask: *When was the last time you used? How much did you use? What are you feeling now? How long is the current "run" since the last treatment or sobriety?*
- **Have you or a family member ever had any odd experiences after taking a prescribed or nonprescribed drug?** If so: *Who had such experiences, using what drug(s)? Please describe the odd experience.* This question is designed to assess the possibility of drug-induced psychosis (delusions, hallucinations). Ask patients known to have a psychotic disorder seeking treatment for opioid dependence whether their psychosis has gotten worse after they stopped using opioids; there is some evidence that opioids have anti-psychotic effects. Individuals who answer yes may need closer psychiatric follow-up.
- **What are positive and negative effects of drug use?** Compare patient- versus provider-identified benefits and adverse consequences of using. *Have you or has anyone in your family attempted suicide after taking a prescribed or nonprescribed drug and/or alcohol?* If so: *What drug(s)/ alcoholic drink(s) were used? Please describe what happened.* Ask specifically about drug overdose: *Have you ever overdosed? Witnessed a drug overdose? Were any fatal?* If so, offer overdose prevention and response materials including naloxone and assess for trauma/PTSD. If not, discuss personal strengths and planned drug use decisions: *What strategies do you use to protect yourself from overdose?* Patients who have used or are using illicit drugs need reassurance that the information they provide to you will not be accessible to police or the criminal justice system, within specified limits of confidentiality.
- **Is a health care provider coordinating all of your prescribed medications?** If yes, ask for the provider's name, phone number, and area of clinical expertise, if known—e.g., *primary care provider? specialist in treating substance use disorders?* Patients may not be willing to disclose this information about a provider who is supplying medications that they are abusing. It is important to gain the patient's trust regarding the importance of sharing this information in order to best serve their needs.

Screening tools such as [CAGE](#), [AUDIT-C](#), [DAST](#) and substance dependence check lists can help determine where a patient is within the spectrum of substance use disorders. A validated scale for assessing withdrawal is the Clinical Opiate Withdrawal Scale ([COWS](#)). In homeless health care settings that serve patients with a high prevalence of substance use disorders, the majority of patients “screen in.” The added value of substance use screens is questionable with high prevalence populations when direct questioning and observation confirm the presence of these disorders. In lower prevalence settings or with patients who have not disclosed a substance use problem, validated screening tools may be more useful. ([Wisner 2011](#)) Screening instruments can stimulate a fruitful discussion of substance use between patient and provider.

- **Legal problems** Many homeless people come to clinics seeking legally-mandated treatment for opioid use disorders, but providers may have difficulty meeting the court's requirements for truly random urine tests with an intact chain of custody, mandatory group attendance, and reports to probation or parole officers. Asking about legal issues related to substance use can be helpful in identifying patients at increased risk for chronic substance dependence. Ask about the patient's current/past legal problems and if there is a history of incarceration. If so, ask whether the person ever received medical, mental health, or substance abuse treatment while incarcerated. Ask whether legal problems created difficulty accessing treatment because the offense involved physical or sexual violence. Ask about custody of children and any problems with Child Protective Services. Request information about any probation or parole requirements. Behavioral health disorders are major contributors to the high rate of homelessness among incarcerated people; and a history of incarceration is associated with interrupted treatment, increased risk of infectious diseases, and barriers to employment and housing following discharge ([Greenberg & Rosenheck 2008](#)).
- **Trauma/ abuse** Be aware of the association between trauma and substance use disorders ([Khoury 2010](#)). A high percentage of homeless people have experienced physical, sexual, and/or emotional abuse as children and as adults; many have been mistreated for their sexual orientation and/or gender identity. Homeless women and transgender persons are among those at highest risk for sexual and physical assault ([Kushel 2003](#)). Elicit information about a history of trauma/ abuse: *Has anyone ever hurt you? Are you safe now? Have you had to have sex in exchange for drugs?* Inquire about head injuries, falls, assaults, accidents, participation in military combat or contact sports, and if the patient has ever been knocked unconscious or been in a coma. *Did you ever hit your head or pass out? Do you have bad dreams?* If so, inquire about symptoms associated with traumatic brain injury (TBI): difficulty concentrating, headaches, seizures, short and long-term memory loss, excessive emotional reactions/ frequent mood changes and irritability, dizziness, fatigue, insomnia, impulsivity, distractibility, and poor organizational/ decision making skills. Significant numbers of people experiencing homelessness report histories of blows to the head, often related to severe physical abuse sustained in childhood, motor vehicle accidents, falls, or military combat ([Highley 2008](#); [Hwang 2008](#)). This information can be helpful in identifying patients at higher risk of opioid misuse (e.g., trauma survivors and those with chronic pain), as well as patients who may have trouble adhering to the treatment plan (impulsivity), and may suggest the need for a more structured treatment plan.

- **Living situation & social support** Ask patients about their living situation to determine residential stability and identify environmental factors that may threaten health and safety. (*Where are you currently staying? Is the place where you live adequate? overcrowded? safe? Do you live there with other people?*) Ask where they sleep and spend time during the day and how they can be contacted. Ask explicitly about access to food, water, shelter, restrooms, and a place to store medications. ([Bonin 2010](#)) If patients are known to be homeless, try to understand the circumstances that precipitated homelessness. Inquire about cultural background, faith community/other affiliations, and current relationships to assess family/community supports. Recognize that an unstable living situation and lack of social support are among the factors that can increase risk of treatment failure/relapse for patients with opioid use disorders, and that more clinical support and case management are required to mitigate these risks ([Alford 2007](#)).
- **Perceived aspirations, strengths & challenges** Ask patients about their aspirations, personal strengths, and goals to promote self-esteem, celebrate resilience, and encourage realistic self-assessment, all of which are important for behavioral change. Recognize that a large percentage of homeless drug users have histories of childhood trauma and are preoccupied with meeting basic daily needs. In asking about goals or aspirations, it may be helpful to focus more on the present and near future than the past.

What do you wish were different in your life?

What are your strengths—things you are good at?

What has given you the strength to survive despite homelessness?

What barriers or issues are preventing you from making your wishes come true?

How do you learn best and remember things?

What are your goals or plans for the next 1–6 months?

What is your one-year plan? What are your plans for the next two years or longer?
- **Review of systems** Ask patients about specific symptoms related to opioid use that are not elicited by the clinical history – issues regarding skin lesions, pain, current problems with memory/ mood/ anxiety, current symptoms of withdrawal or intoxication. If looking for symptoms of opioid withdrawal, for example, ask about sweats, chills, gastrointestinal upset or diarrhea, bone pain, etc.

“We are not treating an illness or a lab value, but a person. Understanding that person within the context of his or her life is critical to everything we do as clinicians. Fractured lives, lack of support from family or other relationships which have often been damaged by drug-seeking behavior, lack of vocational and social context – these are among the factors that make the situation of homelessness relevant to the care of individuals with opioid use disorders. Every individual has a story, and the more we know about our patients’ stories and situations, the more appropriately we can treat them.”

— Ansell Horn, FNP, Lutheran Healthcare, Brooklyn, New York

PHYSICAL EXAMINATION

Major recommendations:

- **Look for physical evidence of opioid usage, intoxication, or withdrawal.**
- **Look for signs of skin and soft tissue infection; test for HIV/HBV/HCV infection and end-organ damage including liver failure.**
- **Look for indications of severe depression, suicidal intent, cognitive disorders, and sequelae of trauma/ abuse.**

Rationale: Because a history of substance use related problems may not be initially revealed, it is important to look for physical signs of drug use, including use of prescribed medications, alcohol, and nicotine. Injection of heroin is a common vehicle of HIV and hepatitis B/ C infection. Uncontrolled mental health disorders can complicate medication-assisted therapy and should be treated simultaneously. All of these conditions are among comorbidities commonly seen in homeless patients with opioid use disorders.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, and psychiatry. Sources: [SAMHSA 2013](#), [Preda 2013](#), [Bonin 2010](#)

- **Physical evidence of opioid usage/ intoxication/ withdrawal** Look for signs of injecting (trackmarks over veins, abscesses and other soft tissue infections, old scars); signs of intranasal drug use (snorting) such as swollen nasal mucosa or a deviated septum; and for current signs/ symptoms of intoxication (somnolence, small pupils) and withdrawal (yawning, dilated pupils, piloerection, tachycardia and hypertension, lacrimation hyperthermia).
- **Medical examination** Perform a comprehensive medical examination, including analysis of laboratory test results. Look for:
 - Skin and soft tissue infection
 - Signs of HIV infection
 - Presence of hepatitis B or C
 - Signs of end-organ damage including liver failure (low platelet count, low albumen, physical signs of cirrhosis)Remember that conditions related to cigarette smoking are among the most common causes of morbidity and mortality in substance users.
- **Mental status examination** Look for:
 - Indications of severe depression, including suicidal intent
 - Difficulty understand directions
 - Ability to follow 2 and 3 step directions
 - Thought content that is predominantly bizarre or paranoid
 - Thought processes that are difficult to follow
- **Physical evidence of trauma/ physical abuse** Look for acute or sub-chronic injuries like bruising and healing fractures to assess current safety.

DIAGNOSTIC TESTING & ASSESSMENT

Major Recommendations:

- **Test patients for comorbidities that are strongly associated with opioid use disorders, including polysubstance use and sexually transmitted/ bloodborne infections.**
- **Evaluate findings from the clinical history, physical exam, and diagnostic testing to determine diagnosis and severity of opioid use disorder; identify any contraindications to medication-assisted treatment or acute conditions requiring a higher level of care.**

Rationale: Many homeless patients have comorbidities that complicate the management of opioid use disorders; they should be assessed during the clinical history for health conditions that may complicate treatment for opioid use disorders. Laboratory tests are important to facilitate diagnosis and guide treatment planning.

Evidence: Expert consensus of practitioners in homeless health care with expertise in primary care, addiction medicine, and psychiatry. **Sources:** [Wisner 2011](#), [HCH Clinicians' Network 2014](#)

Diagnostic Testing

Test patients for comorbidities strongly associated with opioid use disorders, including polysubstance use, chronic infections transmitted by injection drug use/sexual contact/congregate living in shelters or jails; and other conditions that may complicate treatment. Use urine toxicology/ blood serology to detect the presence of opioids in patients suspected of opioid use disorders, and to monitor patients on prescription opioids. Testing should be targeted at specific goals.

- **Baseline laboratory evaluation:** complete blood count (CBC), complete metabolic panel (CMP), liver function tests, lipid profile, urine toxicology (with patient's permission). Consider serum toxicology as an adjunct or if urine is unobtainable.

- **Infectious disease evaluation:**

Sexually transmitted/bloodborne infections: gonorrhea, chlamydia, syphilis (RPR), trichomoniasis, bacterial vaginosis, monilia (Candida Albicans), HIV infection (HIV antibody), hepatitis B (HBV antibody and antigen) and C (HCV antibody)

Tuberculosis: The [CDC](#) recommends tuberculin skin testing (TST/PPD) or TB blood testing (QFT/ T-Spot) for people living or working in locations where TB disease is more common, including homeless shelters, prison or jails; and for people who use illegal drugs. TB testing is recommended every six months for homeless patients because of their higher risk for contact with active tuberculosis and unpredictable follow-up. Various agencies, including homeless shelters, require proof of TB testing. ([HCH Clinicians' Network 2014](#))

- **Pregnancy test:** Use human chorionic gonadotropin (hCG) urine test for pregnancy in women of child bearing potential. Recognize that opioid-dependent women who are homeless typically have high-risk pregnancies due to inadequate nutrition and rest, limited prenatal care, maternal and fetal exposure to fluctuating levels of drugs in the mother's bloodstream, as well as exposure to HIV, HCV, and other bloodborne pathogens associated with injection drug use ([ASAM 2013](#)).

Assessment

Diagnosing Opioid Use Disorders

- **Essentials for initial evaluation** Use information from the history and initial physical examination for diagnosis of opioid use disorder. Determine level of severity to identify patients with mild enough syndrome who might respond to detox and/or non-medication-assisted outpatient treatment, and to identify patients with contraindications to buprenorphine treatment or acute conditions requiring a higher level of care (e.g., hospitalization for severe alcohol/ heroin addiction).
- **Diagnostic criteria** In the American Psychiatric Association's [Diagnostic and Statistical Manual, Fifth Edition \(DSM-5\)](#), published in May 2013, the DSM-IV criteria for substance abuse and substance dependence have been combined into single substance use disorders specific to each substance of abuse within a new 'Addictions and Related Disorders' category. Legal problems have been dropped, and craving is added as a criterion. Each substance use disorder is divided into mild, moderate, and severe subtypes. Severity is based on the number of criteria satisfied: *2–3 criteria indicates a mild disorder; 4–5 criteria, a moderate disorder; 6 or more criteria, a severe disorder.*

DSM-5 Diagnostic Criteria for Opioid Use Disorder:

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of an opioid.

Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

11. Withdrawal, as manifested by either of the following:
 - a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal, pp. 547–548).
 - b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.
- Note:** This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Opioid use disorder can be classified by severity as mild [meeting 2–3 criteria], moderate [4–5 criteria], or severe [6 or more criteria].

Source: *American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013*

DSM-IV criteria for substance use disorders are still in common use, despite the flaws that led to their replacement in the DSM-5. For example, criteria specified in the [*Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision \(DSM-IV-TR\)*](#) have been used to diagnose ***substance dependence***, defined as “a syndrome characterized by a maladaptive pattern of opioid use, leading to clinically significant impairment or distress,” as manifested by at least 3 of the following and occurring in a 12-month period:

1. Tolerance (marked increase in amount; marked decrease in effect);
2. Characteristic withdrawal symptoms (substance taken to relieve withdrawal);
3. Substance taken in larger amount and for longer period than intended;
4. Persistent desire or repeated unsuccessful attempt to quit;
5. Much time/activity to obtain, use, recover;
6. Important social, occupational, or recreational activities given up or reduced;
7. Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous).

When the FDA approved buprenorphine/naloxone, methadone, and naltrexone for the treatment of “*opioid dependence*,” DSM IV language was used. FDA approval and labeling of these medications has not yet reflected DSM-5 diagnostic changes. Under the DSM-5, most patients with “***severe opioid use disorder***” will be candidates for maintenance therapy with buprenorphine/naloxone, methadone, or naltrexone; some patients with “***moderate opioid use disorder***” may also be candidates.

Not all physicians use the Diagnostic and Statistical Manual for Mental Disorders. The American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine (ASAM) issued a consensus statement that distinguishes addiction from physical dependence. ASAM's diagnostic criteria for Addiction are listed below:

ASAM Diagnostic Criteria for Addiction

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction is characterized by:

- a. Inability to consistently Abstain;**
- b. Impairment in Behavioral control;**
- c. Craving;** or increased “hunger” for drugs or rewarding experiences;
- d. Diminished recognition of significant problems** with one’s behaviors and interpersonal relationships; and
- e. A dysfunctional Emotional response**

Source: *American Society of Addiction Medicine. Public Policy Statement: Definition of Addiction, 2011*
available at www.asam.org/for-the-public/definition-of-addiction

- **Challenges in diagnosis:**

Pseudoaddiction – behavior with characteristics of addiction but rational, considering the patient's situation (e.g., inadequately treated chronic pain patients. May also apply to some patients who “self treat” underlying mental health disorders.) (See [Weissman 1989](#).) *Pseudoaddiction should be ruled out before making a substance use disorder diagnosis.*

Physical dependence – may not be present in patients who have abstained for a period of time (e.g., incarcerated people), but severe opioid use disorder can still be diagnosed based on other criteria and past history of physical dependence.

Plan & Management

PLAN OF CARE

Major Recommendations:

- **Work collaboratively with patients to develop realistic, attainable, short-term goals for the management of opioid use disorders, including a personalized overdose risk reduction plan and other harm reduction strategies.**
- **Determine treatment approach based on patient needs and preferences, available resources, and affordability. Also consider motivations for seeking care, previous treatment experience, duration of disorder at current severity, use of heroin vs. pills, method of use, source of opioids (prescribed vs. illicitly obtained), and co-occurring disorders.**
- **Plan for close follow-up by a case manager and regular diagnostic evaluation with allowance for frequent and unscheduled visits.**

Rationale: The realities of homelessness (residential instability, extremely limited resources, lack of social supports) make adherence to a plan of care more difficult. Written goals and treatment plans that are realistic and change in response to changing circumstances are particularly important to assure appropriate care for these patients. Many homeless patients have obtained buprenorphine on the street and are familiar with its use prior to presentation at primary care clinics.

Evidence: Expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, psychiatry, and harm reduction therapy.

Sources: [Alford 2007](#), [ASAM 2013](#), [Denning & Little 2011](#), [Hwang 2011](#), [Tsao 2012](#), [Weissman 1989](#)

Factors to Consider in Deciding Whether/ What Kind of Treatment is Required:

- **Diagnostic criteria** Do patients meet DSM–5 criteria for opioid use disorder (specified on page 16)? If so, how severe is their disorder? (How many criteria for opioid use disorder are met?) (Clinicians may find the Worksheet for the Diagnosis of Opioid Use Disorders in Appendix B helpful in determining severity level.)
- **Patient-centered goals** *Work collaboratively with patients to develop a series of realistic, attainable, short-term goals for the management of opioid use disorders, including overdose prevention and other harm reduction strategies* (e.g., not using needles with drugs). The plan of care should include a personalized overdose risk reduction plan as a potential victim or witness of drug overdose/ poisoning. The care plan should also be sufficiently flexible to allow patients time to meet basic needs and legal/ employment obligations. Goals should be reviewed and revised periodically, consistent with changes in treatment, behavior, and living situation. It is essential that providers take time to elicit patient goals nonjudgmentally and tailor suggested treatments to these goals, recognizing that motivation toward a positive goal is a fundamental tenet of any behavior change.
- **Treatment approach consistent with patient needs and preferences** *Work with patients to determine which treatment approach(es) within available options might best meet their individual needs and preferences.* Know what treatment approaches are available in your community. Some communities offer only methadone or only buprenorphine for the pharmacological management of opioid use disorders.

Residential care and addiction counseling are not universally available. Recognize that successful outcomes of treatment for opioid dependence are strongly associated with treatment retention. Careful assessment of patient values and preferences at the outset will help to promote treatment adherence and prevent dropout.

- *For patients who do not want medication-assisted treatment or who find programs requiring abstinence as a prerequisite for treatment unsuitable or unrealistic*, keep the door open and encourage harm reduction. Providers following principles of harm reduction must be prepared to work with patients who may be or appear to be under the influence of addictive substances. (A detailed discussion of harm reduction therapy is available in [Denning & Little 2011](#), and on pp. 44–47 in Appendix A of this document.)
 - *For patients considering MAT who don't want to discontinue heroin use*, explain that methadone and buprenorphine may 'block' the effects of heroin but overdose is still a danger; that using buprenorphine immediately after using heroin can precipitate withdrawal; and that when heroin effects wear off, if the correct dose of opioid agonist medication is taken, patients should feel alert and not in withdrawal.
 - *For patients who are very intoxicated*: Patients who are intoxicated may not be able to process or remember complex discussions about treatment alternatives. Give clear, concise messages – e.g., “Come back tomorrow at [a specified time].” or “Come back when we can talk better.” As you walk them to the door, observe their gait to be sure they are safe. They may not remember signing a consent form or instructions, etc. A patient falling off the chair and not rousable could be dangerously intoxicated or overdosing; call 911.
- **Previous treatment experience** A history of unsuccessful treatment is not a contraindication to further treatment. Careful assessment will help the provider understand in what respects previous treatments were helpful or unhelpful. Changes in patient motivation and values can make a previously unsuccessful treatment effective or warrant a different treatment modality.
 - **Duration of disorder** People with opioid use disorders of many years' duration almost certainly need intensive, long-term interventions. Shorter-term disorders may respond to less intensive interventions.
 - **Duration of disorder at current level of severity** Severity of opioid use disorders may vary over time. Obtaining information about past history of severe problems in a patient with seemingly mild current problems can be very helpful in decisions for selecting and monitoring treatments.
 - **Heroin vs. pills** It is common for individuals to begin opioid use with prescription pills from their own prescription or a diverted source. In most localities heroin remains the least expensive, potent opioid available. As their opioid use disorder increases in severity and they experience financial and other losses, many individuals progress to heroin use. Risks of serious harm and severe opioid use disorders occur among both pill and heroin users.

- **Injecting vs. other forms of use** There are multiple forms of opioid use. Cultural and individual factors as well as availability may determine drug choices and routes of administration. Both injection and noninjection (oral, intranasal) opioid use can result in severe opioid use disorders (dependence/ addiction) and other adverse consequences. Injecting drug users are at high risk for skin and soft tissue infections (cellulitis, cutaneous/ subcutaneous abscesses) and bloodborne pathogens (HIV, HBV, HCV).
- **Source of opioids** Treatment decisions and harm reduction strategies may be influenced by the source of opioids (medically prescribed, illicitly obtained, sharing with a partner/ family member/ friend). Nonjudgmental questioning may reveal factors that will influence treatment effectiveness.
- **Patient- vs. provider-identified adverse consequences of opioid use** Provider identified or socially recognized harms (overdose, infection, risky behavior, criminal justice problems) may not motivate the decision to seek treatment unless the patient is able to recognize those harms and how they may be reduced by a given treatment intervention. In general, people are more highly motivated to move toward a positive goal than away from a negative consequence.
- **Motivations for seeking care** Individuals with opioid use disorders seek care for a variety of reasons. Some present for treatment after witnessing the death of an acquaintance from overdose, violence, or illness related to drug use. Concerns about the effect of substance use on health, safety, or quality of life may not be the primary reasons for seeking care, however. The criminalization of drug abuse and social attitudes toward drug abusers can also influence the decision to seek care. Many homeless patients present for treatment as a requirement of the criminal justice system. Others seek treatment as a result of severe pressure from important people in their lives (family members, employers). Some patients present with atypical or unconventional motivations. Research has indicated that both internal and external motivators can be effective in engaging drug-dependent individuals in treatment, although a client's personal valuation of treatment and recovery is likely to be an important determinant of treatment retention, which is strongly linked to positive outcomes in the long term ([Anglin 1998](#), [Prendergrast 2009](#)). In reality, motivations are often complex and changing.
- **Existence of co-occurring disorders** Other substance use disorders, pain problems, mental health disorders, and cognitive impairment can also affect treatment choice. "Clients said to have co-occurring disorders [COD] have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. ... For most homeless clients with COD, the impact of substance use disorders and mental illness bears a direct relationship to their homeless status." ([CSAT 2005, TIP 42](#)) The relationship to homelessness may or may not be causal, however, and is highly dependent upon financial and family resources available to the client.
- **Close follow-up** by a case manager is recommended for homeless patients with opioid use disorders, with allowance for frequent and unscheduled visits ([Alford 2007](#)).

- **Regular diagnostic evaluation** is important to ensure that a diagnosis of opioid use disorder is not masking poorly managed chronic pain or other co-occurring disorders ([Tsao 2012](#), [Hwang 2011](#), [Weissman 1989](#)).

(See the Treatment, Management section, pp. 28–49, for more detailed information about treatment alternatives, including advantages and disadvantages of different modalities for homeless patients.)

EDUCATION, SELF-MANAGEMENT

Major Recommendations:

- **Review fundamental concepts of opioid use disorder management (treatment alternatives, side effects, risks and benefits); teach clients who are actively using opioids how to practice harm reduction; teach those currently abstaining to recognize signs and symptoms of relapse.**
- **Provide opioid safety education to all patients with substance use disorders and to patients taking opioid analgesics on the effects of opioids, including the possibility of overdose and interactions of opioid agonists with other medications/ drugs of abuse.**
- **Educate patients about overdose risks, recognition and response. Offer naloxone (if possible) to any patient undergoing tolerance changing events such as medically supervised withdrawal procedures or medication-assisted treatment induction.**
- **Use tools such as motivational enhancement techniques and brief office-based counseling to help assess patients' level of readiness for behavioral change.**

Rationale: Understanding how to minimize risks associated with opioid use and involvement in self-management goal setting are matters of survival for opioid-dependent people who are homeless. Discussing risks and benefits of available treatment options with these patients can build trust, inspire hope, and foster readiness for behavioral change. Overdose prevention and response education is warranted by the alarming increase in the number of deaths from opioid overdose/ poisoning, particularly in marginalized populations.

Evidence: Expert consensus of practitioners experienced in homeless health care with expertise in addiction medicine, overdose prevention, and harm reduction therapy. *Sources:* [Doe-Simkins 2013](#), [Edgington 2011](#), [Morrison 2007](#), [SAMHSA 2013](#), [Walley 2013](#), [Wheeler 2012](#), [WHO 2013](#)

Education

Management of Opioid Use Disorders

- **Treatment options** Explore the advantages and disadvantages of various treatment options with patients/clients, including use of medication-assisted treatment, side effects, risks and benefits. Be prepared to repeat this discussion, as needed, at subsequent encounters.
- **Harm reduction** Teach clients who are actively using addictive drugs to practice harm reduction, including overdose prevention and avoidance of exposure to bloodborne diseases. Teach clients who are currently abstaining to recognize signs and symptoms of relapse.
- **Drug-drug interactions** Explain possible interactions of methadone/ buprenorphine/ naltrexone with other medications (e.g., antiretroviral therapy for HIV infection) or drugs (alcohol, other CNS depressants) they may be taking, and whether particular foods, dietary supplements, or exercise might alter the physical or psychological effects of medications used for treatment of opioid use disorders.
- **Chronic brain disease** Explain how misuse of opioids and other addictive substances can change the brain. Help patients understand that opioid use disorder is a chronic disease that may never go away but can go into remission with appropriate treatment and ongoing attention to personal health.
- **Educational materials** Provide written educational materials in the first language of patients you serve, using simple terminology and large print with graphic illustrations to compensate for any visual limitations. Don't presume that patients can't read or understand written information just because they are homeless.

Overdose Prevention and Response Education

In response to an alarming increase in the number of deaths from opioid overdose/ poisoning, particularly in marginalized populations, homeless services providers recommend the following interventions to protect both patients with opioid use disorders and patients whose chronic pain is managed with opioids:

- **Opioid safety education** *To all patients with a history of substance use and patients taking opioid medications for acute or chronic pain management, provide opioid safety education on the effects of opioids, including the possibility of overdose.* Discuss risks for overdose, including: mixing different drugs/medications with opioids (such as alcohol, benzodiazepines, stimulants like cocaine or methamphetamine, antihistamines, sleeping pills); changes to their pain management regimen; resuming opioid use after a period of abstinence; comorbidities that may increase overdose risk (COPD, viral hepatitis, etc.); leaving substance use treatment or jail; the changing quality and strength of illicit substances; and the different strengths, function and duration of prescription opioids.
- **Overdose prevention & response education** *Offer overdose education to any opioid-dependent patient undergoing tolerance changing events, such as medically supervised withdrawal procedures or medication-assisted treatment induction.* (See inclusion criteria for opioid overdose prevention interventions, listed below.) Patients should receive education on overdose management; how to communicate with primary caregivers, friends, and family; high risk of accidental overdose/ unintentional poisoning from polysubstance use or medication errors; and what to do in the event of an overdose.

Directly prescribe naloxone³ or refer patients to community based organizations that provide naloxone rescue kits and teach overdose response techniques.

What You Need To Know About Opioid Overdose:

1. Prevention – the risks:

- Mixing substances
- Abstinence- low tolerance
- Using alone
- Unknown source
- Chronic medical disease
- Long acting opioids last longer

2. Recognition

- Unresponsive to sternal rub with slowed breathing
- Blue lips, pinpoint pupils

3. Response – What to do:

- Call for help (Dial 911).
- Rescue breathe.
- Deliver naloxone.
- Continue rescue breathing.
- If no response after 3-5 minutes, deliver naloxone again.
- Stay until help arrives.

³ Naloxone (Narcan®) is an opioid antagonist that is used to counteract life-threatening effects of opioid overdose on the central nervous system and respiratory system, allowing an overdose victim to breathe normally. It has been used routinely in Emergency Medicine for nearly 50 years. Naloxone may be sprayed into the nose or injected into a muscle, vein, or under the skin. It is a temporary drug that wears off in 20–90 minutes ([Harm Reduction Coalition](#)). “Naloxone is not a controlled substance as defined by federal or state law, but is a prescription drug subject to the general laws and regulations that govern all prescriptions in regular medical practice. Prescribing naloxone to ODUs is fully consistent with state and federal laws regulating drug prescribing.” (Temple University Law School's [Project on Harm Reduction in the Health Care System](#)) Detailed state-by-state information about which practitioners are authorized to prescribe or dispense naloxone and to whom naloxone may be legally prescribed or dispensed is available on the [PrescribeToPrevent](#) website.

Make naloxone rescue kits readily available in non-locked areas of clinics and shelters, and train all staff how to use them to revive individuals experiencing opioid overdose. It is especially important to train outreach workers and shelter staff how to recognize and respond to drug overdoses experienced by homeless people. The expiration date of naloxone in on-site rescue kits should be checked regularly.

Since 1996, laypersons who are at risk for overdose or likely to witness an overdose have been given naloxone “rescue kits” by community-based organizations like needle exchange programs. Over 50,000 individuals have been given naloxone kits and trained to use them at the 200+ naloxone distribution programs in the United States, resulting in over 10,000 overdose reversals ([Wheeler, 2012](#)). Communities with high rates of layperson possession of naloxone rescue kits have experienced a 46% reduction in fatal opioid overdose ([Walley 2013](#)). An international review of interventions for homeless persons discussed peers giving naloxone to others they see overdosing as a promising intervention to reduce drug-related deaths ([Wright & Tompkins 2006](#)). Recently, naloxone prescription programs have started in several health care settings throughout the United States, targeting people at risk for opioid overdose ([Doe-Simkins 2013](#), [CDC 2012 Feb](#)). Access to naloxone varies by state. For more information, see www.prescribetoprevent.org.

- **Inclusion criteria for opioid overdose prevention interventions** Conduct overdose prevention education and consider providing naloxone rescue kits to patients who meet the following criteria:
 1. Taking high doses of opioids for long-term management of chronic pain.
 2. Receiving rotating opioid medication regimens (and thus at risk for incomplete cross-tolerance).
 3. Discharged from emergency medical care following opioid intoxication or poisoning.
 4. At high risk for overdose because of a legitimate medical need for analgesia, coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids.
 5. Completing mandatory opioid detoxification or abstinence programs.
 6. Recently released from incarceration and a past user or abuser of opioids (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).
 7. Engaged in any opioid use with known or suspected respiratory/renal/ hepatic/cardiac disease or HIV/AIDS.

Sources: [SAMHSA Toolkit for Prescribers](#), [Albert 2011](#)

Some experts would recommend opioid overdose prevention intervention for all individuals taking opioids whether prescribed or not, and for loved ones of patients and concerned community members. For more information about inclusion criteria for opioid overdose prevention interventions, see: [Dasgupta 2009](#), [Leavitt 2010](#), [Wermeling 2010](#), [PrescribeToPrevent.org](#)

- **Overdose response policy** Develop an organizational policy for responding to drug overdoses that occur on site. Train clinic and outreach staff to recognize signs of withdrawal and relapse.
 - **Policy consistency with overdose prevention efforts** Examine existing program policies for overt or de facto contradiction with overdose prevention efforts. For example, are clients allowed to retain control of
-

a prescription medicine including a naloxone rescue kit that they may have acquired from another program? Do clients risk exclusion from program services for syringe possession, encouraging secretive drug use?

- **Counseling** *Address overdose and any overdose-related trauma in client counseling.* Adapt screening instruments to ask specifically about overdose-related trauma.
- **Commemoration** Recognize that many lives are lost to preventable overdose deaths and that patients may not have the space or opportunity to grieve these losses without shame or judgment. Consider creating a permanent space (memorial wall/ table used as a memorial space) for remembering homeless people who were lost as a result of drug overdose and other causes, and for celebrating staff and clients who save lives.
- **Resources** The Substance Abuse and Mental Health Administration (SAMHSA) has published an [Opioid Overdose Prevention Toolkit](#) designed to equip communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. This resource addresses issues for first responders, treatment providers, and those recovering from opioid overdose. Components of the toolkit, available online, are listed below:

Information for Prescribers	Family Members
Safety Advice for Patients	Facts for Community Members
Resources for Overdose Survivors and	Essentials for First Responders

Education of Providers about the Treatment and Management of Opioid Use Disorders

Despite extensive scientific evidence of their efficacy, FDA approved medications for the treatment of opioid dependence are underutilized, especially by general practitioners. The American Society for Addiction Medicine conducted a survey to determine the reasons why. Investigators concluded that primary factors preventing appropriate access to and utilization of these medications include the following: 1) few physicians trained to diagnose or treat opioid addiction; 2) unique legal and regulatory issues surrounding the provision and administration of these medications; and 3) restrictions on MAT utilization imposed by public and private insurers (pre-authorization requirements, limitations on dose and duration of dosing, and patient co-pays significantly different from those for medications used to treat other chronic diseases) ([ASAM 2013](#))

- *Physicians working in homeless health care should be educated about patient selection for the treatment of severe opioid use disorder and how best to minimize and respond to drug misuse or diversion.* Consider completion of training and certification to prescribe medication-assisted treatment of opioid dependence/addiction in an office-based setting.
- *Primary and specialty care providers serving marginalized populations should also attend trainings in addiction medicine to deepen their understanding of substance use disorders.* Concepts such as ‘loss of control’ and ‘compulsion to use’ enable the provider to distinguish severe substance use disorder from less harmful substance use. Many people who abuse opioids also abuse other addictive substances, such as methamphetamine and cocaine, for which there are no current pharmacological interventions.

Understanding the critical need for counseling in the management of addiction is essential, regardless of what substances are being used.

Self-Management

- **Goals** Short-term goals should be realistic and attainable given a patient's self-reported coping skills and/or demonstrated resilience.
- **Behavioral change** *Use motivational enhancement techniques and brief office-based counseling to help engage patients and determine their readiness for behavioral change* ([HCH Clinicians' Network 2009](#)). Assessment of level of readiness to change guides any intervention for patients with opioid use disorders, including further education and support. Medical respite care programs can be an ideal setting in which to work with homeless patients on motivating readiness to change. Respite staff are expected to be competent in understanding and recommending various avenues to change, including 12-Step participation, harm reduction therapy, and medication-assisted treatment. ([Edgington 2011](#)).

Motivational Interviewing (MI) is "a client engagement, motivational enhancement, and counseling process that has been widely used in mental health and substance abuse treatment settings and has been adapted for the needs of clients in homelessness rehabilitation ([SAMHSA 2013 TIP 55](#)).” MI is useful to help patients explore and resolve ambivalence about behavioral change ([Morrison 2007](#); [HCH Clinicians' Network 2000](#)). Originally developed by William R. Miller and Stephen Rollnick ([Miller & Rollnick 2002](#)) to help problem drinkers, this counseling approach has been successfully applied to address a variety of behaviors that affect health, including smoking, other drug use, physical activity, and sexual practices.

Brief counseling intervention The acronym FRAMES was coined to summarize the six elements that are critical to a brief intervention to change substance abuse behavior ([Miller & Sanchez 1994](#)):

- Feedback is given to the individual about personal risk or impairment.
- Responsibility for change is placed on the participant.
- Advice to change is given by the provider.
- Menu of alternative self-help or treatment options is offered to the participant.
- Empathic style is used in counseling.
- Self-efficacy or optimistic empowerment is engendered in the participant.

A brief intervention consists of five basic steps that incorporate FRAMES and remain consistent regardless of the number of sessions or the length of the intervention ([SAMHSA 1999](#)):

1. Introducing the issue in the context of the client's health
2. Screening, evaluating, and assessing
3. Providing feedback
4. Talking about change and setting goals
5. Summarizing and reaching closure

TREATMENT, MANAGEMENT

Major Recommendations:

- Offer medication-assisted treatment to any patient with an opioid use disorder.
- Encourage use of nonpharmacologic interventions, whether patients are receiving medication-assisted treatment or not: harm reduction therapy, peer mentoring, peer support groups, acupuncture, and stable housing with access to supportive services including employment assistance.
- Offer needle exchange and naloxone to individuals using injected opioids, to the extent permitted by law and available resources.
- Encourage more physicians serving homeless and other disadvantaged populations to seek training and certification to prescribe buprenorphine.
- Encourage more primary and specialty care providers serving homeless and other disadvantaged populations to collaborate and integrate care with addiction treatment programs, including methadone maintenance treatment and detoxification programs.
- Develop more directly observed therapy (DOT) programs to monitor use and avoid misuse/ diversion of opioid agonist medications.

Rationale: Choice of medication-assisted treatment for opioid use disorders depends on access to care, which is more limited for homeless than for stably housed persons. Although the feasibility of office-based MAT with buprenorphine has been demonstrated regardless of housing status, this medication is financially beyond the reach of many impoverished people living in states that have opted not to expand their Medicaid program to include childless adults. Limited numbers of physicians authorized to prescribe buprenorphine and the exclusion of physician assistants and nurse practitioners from prescribing privileges present additional barriers to care; in many areas, PAs and NPs are the only medical providers available to homeless people. Although methadone maintenance is less expensive and with comparable efficacy, access varies from community to community; waiting lists for admission to an opioid treatment program are long, and homeless people may not have the means to get to clinics at times when they are open.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, psychiatry, and harm reduction therapy.

Sources: [Alford 2007](#), [Altice 2011](#), [ASAM 2013](#), [Herinckx 2008](#), [Herinckx 2010](#), [Hersh 2011](#), [Hwang 2009](#), [Kraybill & Zenger 2003](#), [Martin 2013](#), [SAMHSA 2013](#), [Stancliff 2012](#), [White 2011](#), [Zevin 2011](#)

Treatment of opioid use disorders is necessary to prevent high morbidity and mortality, and has been proven to reduce harms related to opioid use. Successful treatment has been demonstrated to reduce HIV incidence, lower hepatitis B&C risk, minimize involvement with the criminal justice system, and decrease drug overdose rates ([CDC 2002](#), [Alford 2006](#), [VA/DoD 2009](#), [Altice 2011](#), [White 2011](#), [NIDA 2012 Apr](#)).

Special Considerations for Patients Experiencing Homelessness:

- **Lack of stable housing** Although instability and lack of social support are conditions of homelessness known to correlate with treatment failure, there is evidence that with case management support provided by the treatment program, medication-assisted treatment with buprenorphine is just as effective for people who are homeless as for those who are housed ([Alford 2007](#)). *Lack of stable housing is NOT a contraindication to medication-assisted treatment.* Housing stability often determines level of care, with unsheltered persons ending up in residential treatment facilities or with more intensive monitoring than is required for persons with stable housing.

- **Lack of social support** Be aware that care provided to homeless populations may differ from the community standard of care. Longer duration of opioid use and lack of support from family or friends during treatment and recovery account for part of this discrepancy (Alford 2007). *Treatment programs serving people with opioid use disorders who are homeless can mitigate their lack of social support with more comprehensive care management and peer support services.* (See pp. 48–49 for examples.)
“Social support is associated with lower rates of mental health problems, such as depression and suicidal ideation, fewer physical illness symptoms, decreased substance abuse, and less risky drug and sexual behavior among homeless individuals” (Hwang 2009). Provision of supportive services that address the myriad needs of these patients (medical, psychosocial, and material) is a vital component of any treatment modality.
- **High overdose risk** Regardless of the form of treatment for opioid use disorder, tolerance is altered upon engagement in treatment. This creates a potential paradox: As a first step in addiction recovery, treatment can decrease overdose risk; but treatment can reduce tolerance and significantly increase the risk of fatal overdose for patients who cycle between abstinence and opioid use. Overdose risk also increases for persons utilizing alcohol or other prescribed/nonprescribed medications/drugs. *Be aware that opioid agonist treatment is associated with a lower fatal overdose rate than heroin use, and that detox is associated with a higher fatal overdose rate than heroin use* (WHO 2013, WHO 2009).

"Recent periods of abstinence are a major risk factor for fatal opioid overdose. ... [T]he period immediately following release from prison and the period immediately following discharge from a detoxification facility pose a significantly elevated risk of overdose. The main causes of increased overdose mortality are loss of tolerance and erroneous judgment with respect to dosage when returning to opiate use following a period of abstinence. ...Many patients also cease opioid dependence treatment prematurely, which is associated with a return to out-of-treatment levels of opioid overdose risk."

– [World Health Organization 2013](#)
- **Therapeutic use of illicitly acquired opioid agonists** Many homeless people with an opioid use disorder have had previous, often successful experiences with illicitly acquired buprenorphine and/or methadone. *Exploring patients' experience with illicitly acquired medications is a good opportunity to evaluate the appropriateness and anticipated benefits of these treatments.*
- **Special issues for patients with co-occurring pain** *For patients with co-occurring opioid use disorders and acute or chronic pain, a strategy that recognizes the need to treat both problems simultaneously to achieve a successful outcome should be implemented.* Methadone and buprenorphine can be part of that strategy, as they have powerful analgesic effects, especially when used in split doses (Martin 2013, Alford 2006). Non-medication-assisted therapies for both pain and addiction problems should also be pursued. Oral methadone and buprenorphine without naloxone in injectable or patch form are FDA approved for analgesia. Sublingual buprenorphine, labeled for addiction, is sometimes used off-label for treatment of chronic pain. Local insurance or pharmacy benefits may limit its use by requiring testing or counseling, etc. for coverage. Pharmacy benefit limits are especially significant for homeless patients using safety net services. Recognize that tramadol hydrochloride (Ultram®), an opioid mu receptor agonist prescribed for analgesia, has addiction potential similar to other

opioids but is often mistakenly used as if it did not. Be aware that low Vitamin D levels have been linked to high use of opioid analgesic medication by patients in chronic pain. Prescribing opioid analgesics for homeless patients with addiction disorders is challenging due to the frequent lack of subjective and functional improvement and the frequency of adverse outcomes ([Wisner 2011](#)).

- **Special issues for opioid-dependent pregnant women who are homeless** An exceptionally vulnerable population, these patients are at high risk for pregnancy complications and require immediate referral to both opioid treatment programs and high-risk obstetric programs. As noted by the American College of Obstetricians and Gynecologists, opioid use in pregnancy is not uncommon, and the use of illicit opioids during pregnancy is associated with an increased risk of adverse outcomes ([ACOG 2012](#)). *The current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone, but emerging evidence suggests that buprenorphine also should be considered.* Induction on buprenorphine is generally done on an inpatient basis for safety reasons. *If office-based maintenance treatment is indicated, buprenorphine alone should be used, not buprenorphine/naloxone.*

➤ **Factors to Consider in Determining Appropriate Treatment Setting:**

1. **Co-occurring conditions** Select a treatment setting with the greatest capacity to provide care for co-occurring conditions on site, recognizing that success often depends on effective treatment of the patient's other conditions.
2. **Suitability & location** Select a treatment setting suited to the patient's personality and coping skills that is easily accessible and (if possible) not in the same area where drugs of abuse were obtained.
3. **Residential programs** For patients who need a residential treatment setting, be aware that some residential programs are more supportive than others of MAT recipients. A number of residential programs deny admission to individuals receiving buprenorphine or methadone maintenance treatment. Some therapeutic communities have a harsh “boot camp” atmosphere and punish residents for undesirable behavior. Many clients do not do well in these punitive settings. Providers may need to educate staff in residential programs and halfway houses that medication-assisted treatment with methadone or buprenorphine is *not* equivalent to the use of illicit substances.
4. **Treatment needs** Considerations in selecting a medication-assisted treatment setting should include whether or not the patient needs detoxification, is a candidate for maintenance treatment, and/or requires opioid analgesia.
5. **Level of care** [Patient Placement Criteria guidelines](#) available from the American Society of Addiction Medicine (ASAM) can help with level of care determinations. Some state agencies use them for placement. The recently released edition includes adjustments for homelessness. In reality, treatment setting is usually determined by available local resources and patient preferences. Substance abuse counselors can be helpful in discussing treatment options and available programs with patients before linking them to care.

Medication-Assisted Treatment for Opioid Use Disorders

“Medication-assisted treatment (MAT) is the use of pharmacological medications in combination with counseling and behavioral therapies to provide a ‘whole patient’ approach to the treatment of substance use disorders ([SAMHSA](#)).” Currently there are three FDA approved medications for the treatment of opioid dependence: **methadone**, **buprenorphine/naloxone**, and **extended-release injectable naltrexone**. These medications are available for use in detoxification or maintenance modalities.

Methadone is an opioid agonist that is available for treatment of opioid use disorders primarily in strictly regulated opioid treatment program settings. Buprenorphine is a partial agonist with very strong affinity for the mu receptor that is intended for sublingual administration. In the U.S., it is combined with naloxone to deter the risk of abuse via injection. Buprenorphine alone (Subutex®) is used in situations of lower risk of misuse or diversion such as supervised detoxification, and in pregnancy or in situations where it is the only available option due to cheaper price. The combination of buprenorphine/naloxone (available as Suboxone® film or generic buprenorphine/naloxone combination tablets) is more often used for longer term maintenance treatment. ([ASAM 2013](#), [Yokell 2011](#)) Buprenorphine is available in office-based settings from specially trained physicians who have received a special DEA certification.⁴ Oral and injected naltrexone formulations are available for relapse prevention to patients who are abstinent from opioids for seven days. Extensive information about these modalities is available in [ASAM 2013](#), [Yokell 2011](#), [VA/DoD 2009](#), [WHO 2009](#), and in several reviews on these topics: [Bart 2012](#), [NIDA 2012 Apr](#), [ONDGP 2012](#), [Preda & Dunayevich 2013](#), [White & Mojer-Torres 2010](#).

“Methadone and buprenorphine used as detoxification medications can suppress withdrawal symptoms and curb cravings. When used as maintenance medications the suppression of withdrawal and craving helps to reduce non-medical opioid use. Naltrexone can only be administered to fully detoxified patients, but as a maintenance medication it can essentially eliminate the rewarding effects of self-administered opioids, thereby dramatically reducing use.”

— *American Society of Addiction Medicine* ([ASAM 2013](#))

Detoxification

“Detox” or detoxification usually refers to the initial necessary step of assisting a patient through a period of withdrawal. Withdrawal from opioids is intensely unpleasant for individuals with opioid use disorders. Although it is not usually associated with mortality, withdrawal from opioids without

⁴ “The use of buprenorphine for the treatment of opioid addiction is governed by the federal Drug Addiction Treatment Act of 2000, commonly referred to as ‘DATA 2000’ (Public Law 106-310, Title XXXV, Sections 3501 and 3502). This legislation ... allows physicians to treat opioid addiction with FDA-approved controlled drugs in office-based settings. Specifically, DATA 2000 allows physicians to use buprenorphine and other controlled substances in CSA Schedules III, IV, and V, which have been approved by the FDA for the treatment of opioid dependence, to treat patients in office-based settings, provided certain conditions are met. DATA 2000 thus has enlarged treatment capacity by lifting the requirement that patients who need opioid agonist treatment can receive such treatment only in specially licensed opioid treatment programs (OTPs), often referred to as ‘methadone clinics’.” *Source:* Federation of State Medical Boards. [Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office](#), April 2013.

medical supervision can be potentially life threatening for those with severe coronary artery disease. Increased demands on the heart due to elevated pulse and blood pressure during withdrawal could precipitate a myocardial infarction resulting in death. Moreover, “abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise ([ACOG 2012](#)).” Detox may be an initial step in treatment but alone has very poor efficacy for achieving successful long-term outcomes, which places patients without additional treatment or therapies at very high risk for overdose.

Detox begins with a medical assessment, admission physical exam, vital statistics monitoring, and in some models, management of already prescribed medications to provide relief from withdrawal symptoms during detoxification. Because medications used for detoxification are often abused if not used in a controlled environment, they may be prescribed only for patients entering a recognized detox and rehabilitation program. For patients requesting medication to “help with [opioid] detox,” well-meaning providers have been known to prescribe codeine, hydrocodone, or a benzodiazepine. (Note: Buprenorphine, when prescribed by a qualified physician, is the only opioid currently approved for the treatment of opioid dependence in an office-based setting; it is illegal for a physician to write a prescription for any other opioid for the treatment of opioid dependence) These medications are not indicated for treatment of opioid use disorder, and providers should use caution in prescribing them for symptomatic treatment of withdrawal symptoms in patients with opioid dependence.

Quetiapine (Seroquel) can be a helpful symptomatic treatment for agitation associated with withdrawal, but it also has abuse potential and a street value. Although *clonidine* helps with autonomic withdrawal symptoms (increased blood pressure, sweats, goose bumps), there is the potential for hypertensive crisis if it is overused and then abruptly stopped. Treatment with clonidine is limited to two weeks for this reason. *Promethazine* PO or suppositories can be used to alleviate nausea/vomiting, and *loperamide* is useful to stop diarrhea during withdrawal from opioids.

Factors Favoring Detox / Short-term Treatment with Tapering

(This could include non-opioid symptomatic treatment “kickpack,”⁵ methadone detox with taper over 21 days or a similar period, and buprenorphine stabilization and taper over days to as long as 1 year.)

1. Short period and moderate degree of opioid use disorder
2. Non-injection forms of use
3. No history of prior treatment with relapse
4. Strong support from family, community, or substance abuse treatment program
5. Patient and provider understanding that this type of treatment is often not effective in achieving long-term abstinence
6. Patient preference

⁵ A “kickpack” refers to nonopioid medications used for relief of withdrawal symptoms (e.g., quetiapine for agitation, clonidine for autonomic symptoms, promethazine for nausea, loperamide for diarrhea). See above for risks associated with these medications.

Advantages of detox/ short-term treatment:

- **Affordability** Maintenance treatment following detoxification may not be available due to a patient's insurance status/lack of insurance or ability to pay cash. In some states, methadone is not a covered benefit under Medicaid. Methadone maintenance is not a covered benefit under Medicare. Buprenorphine coverage is limited in some State Medicaid programs, and is often financially out of reach due to its higher cost and lack of prescribers who accept Medicaid or even regular insurance. Methadone clinics often have a sliding fee schedule; but if clients can't pay their fees, they are detoxed only. In many areas, clinicians are still providing MAT on a cash-only basis, drastically limiting a homeless patient's ability to afford maintenance treatment.
- **Availability** Limited access to authorized providers of maintenance treatment makes detox the only available treatment alternative for many homeless people with opioid dependence. Access to OTP's providing methadone maintenance may be limited and waiting lists are long in some areas. Office-based treatment for opioid dependence can only be provided by credentialed physicians, and buprenorphine is the only medication currently approved for office-based treatment ([VA/DoD 2009](#)), except as part of isolated studies of medical maintenance ([White 2011](#)). DATA 2000 implies that there may be other FDA-approved medications for this indication, but none has been added as of February 2014. In order to prescribe buprenorphine, physicians must complete a training course and receive a waiver granted by the Drug Enforcement Administration (DEA) ([ONDCP 2012](#)). Only a limited number of patients can be served by an authorized buprenorphine prescriber (30 in the first year, 100 in follow-up).

Provision of medication-assisted treatment with buprenorphine has been slow to catch on in the medical community ([Hersh 2011](#), [Stancliff 2012](#)). Clinical follow-up for stabilization and maintenance therapy can be burdensome and unpredictable for providers already overwhelmed with meeting primary care needs of an underserved population. Lack of experience with this treatment modality prevents clinicians from appreciating its efficacy. Prescribing limitations for midlevel providers exacerbate the lack of provider availability. Consequently, treatment following a detox stay simply may not be available to underserved populations.

- **Bridge to long-term addiction treatment** Comment from one consumer: "Now that BUP is offered, people are staying in detox long enough to make them ready to enter an addiction treatment and recovery program."

Disadvantage:

- **High risk of lethal overdose** Detox and short-term treatment may leave patients at high risk of overdose death by lowering tolerance in those with high risk of relapse to drug use at their previous tolerated dose ([Zevin 2011](#)).

Detox and Maintenance Treatment Considerations:

- **Treatment efficacy** Use of methadone and buprenorphine to treat severe opioid use disorders gives better results than medication-free treatment in almost all randomized controlled studies ([Mattick 2009](#), [Jerry & Collins 2013](#)). In long-term studies of chronic heroin users, less than 10%–

20% achieve abstinence without methadone or buprenorphine maintenance treatment, and relapse to opioid abuse occurs in more than 80% without long-term use of methadone or buprenorphine, regardless of what other kinds of treatment patients are receiving ([Ball 1991](#), [Sees 2000](#), [Kakko 2003](#)). Methadone and buprenorphine significantly reduce mortality rates, IV drug use, crime, HIV infection, and relapse, while increasing employment and improving health status and social function ([CDC 2002](#), [Altice 2011](#), [NIDA 2012 Apr](#)). Nevertheless, the consumer community has mixed feelings about both agents ([White 2011](#)).

- **Harm reduction vs. harm production** No medical intervention is entirely without the potential for adverse effects. Both methadone and buprenorphine have well-established safety records but also the potential to cause harm. In each case a careful evaluation must be done weighing the benefits and harms of medication-assisted modalities. Consequences of not treating must also be considered. Due to the frequency of dire consequences in patients with untreated severe opioid disorders, it is often appropriate for clinicians to offer these treatments to patients who have some increased risk of adverse effects. Efforts must be made to make sure that patients are aware of these issues and give informed consent.
- **Combating common myths** Unfortunately many myths are present as street lore (and even among professionals) that discourage opioid users from considering maintenance treatment. The most prevalent of these is the idea that *use of buprenorphine or methadone is substituting one addiction for another*. This can usually be combated by explaining what is meant by addiction in medical terms and showing the much better health outcomes from MAT compared to street drug use including normalization of various metabolic, neurological, and immunological states. Another common myth is that *withdrawal from methadone or buprenorphine is worse than withdrawal from heroin*. Withdrawal is different from these longer half-life drugs than from short half-life drugs but is usually less acutely severe. It is also commonly heard that *methadone “eats up the bones.”* Explaining that opioid use may affect testosterone in men, that vitamin D levels are commonly low in opioid users, and that these conditions are correctable is usually helpful.
- **Addiction counseling** The federal application for a waiver that permits a trained and qualified physician to prescribe buprenorphine for outpatient treatment of opioid dependence requires providers to ensure that patients engage in addiction counseling. If not offered within the prescribing provider’s practice, there must be evidence that the provider has the ability to refer and that patients engage in counseling. Research suggests that medication-assisted treatment of opioid use disorders combined with effective evidence-based counseling provides outcomes superior to either intervention by itself ([McClellan 1993 Apr](#), as cited in [ASAM 2013](#)). However, *lack of access to/ interest in/ compliance with counseling is often a serious barrier to medication-assisted treatment for opioid use disorders*. Access to addiction counseling may be especially difficult for people experiencing homelessness due to lack of transportation, lack of health insurance, lack of availability and accessibility of (limited) community resources, and if employed, lack of time or fear of loss of income from taking time away from work.

Recent studies by [Schwartz](#) and [Fiellin](#) found that counseling added no significant benefit to opioid agonist treatment with methadone or buprenorphine, concluding that limited availability of drug counseling services should not be a barrier to initiating MAT alone. Nevertheless, many practitioners experienced in the care of homeless people contend that treatment of opioid dependence in this population optimally includes counseling and provision of/referral to other needed medical, psychological, and social services ([HCH Clinicians' Network 2006 Oct](#)). Counseling can be provided by various service providers, including medical providers, nurses, mental health professionals, and substance abuse counselors. In homeless health care settings, the most effective counseling may be from an available member of the staff whom the patient trusts, even if the staff member is not an addiction specialist. Professional counseling is often supplemented by peer mentorship or coaching, featuring a “one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery” ([CSAT 2009](#)). The important role of formal and informal peer mentors is increasingly recognized as a component of successful treatment programs. (See p. 49 for more information.)

Factors Favoring Outpatient / Office-Based Maintenance Treatment with Buprenorphine

1. Support from significant other or family
2. Lack of significant other and family members who are using substances or are chaotic and destabilizing
3. Realistic expectations
4. Existing relationship with a primary care physician or psychiatrist willing and licensed to prescribe buprenorphine
5. Ability to understand and adhere to program policies and procedures
6. Complying with institutional rules may be difficult for patients with opioid use disorders, especially when this co-occurs with cognitive disorders, unstable housing, and psychiatric disorders. Some successful programs employ flexibility based on patients' needs.
7. Increased flexibility of office-based settings compared to opioid treatment program (OTP) settings may actually favor patients who have difficulty with rigid rules.
8. Availability of intensive case management services, especially during initial treatment period ([Alford 2007](#))
9. Multiple unsuccessful attempts at treatment do not necessarily preclude future success.
10. Lack of contraindications to buprenorphine therapy, such as:

“There is substantive research evidence that long-term, positive outcomes (both at the patient and system-level) can be achieved in primary care and other outpatient settings with buprenorphine maintenance treatment, even for traditionally vulnerable patient populations (i.e.. those who have HIV, are homeless or marginally housed, or are extremely low SES (Alford et al, 2007; Parran et al, 2010; Sullivan et al, 2008; Fiellin et al, 2008; Korthuis et al, 2011; Stancliff et al; 2012).”

— [ASAM 2013](#), *The Effectiveness of Pharmacotherapies for the Treatment of Opioid Disorders: A Systematic Review*

Medical contraindications:

- Need for other opioid analgesic for pain management.
 - Buprenorphine acts as a blocker to other opioids and may interfere with analgesic effects of other opioid analgesics.
 - Note: Some patients with chronic pain and addiction can be managed with buprenorphine, as it works as a strong analgesic when used in divided doses.
- Acute medical conditions needing stabilization
 - Note: Patients may be appropriate for buprenorphine therapy after stabilization, such as upon hospital discharge.

Psychiatric contraindications:

- Too disorganized to take medication regularly
 - Note: Opioid dependence (especially heroin dependence) requires a fairly high level of organization for most patients, although the effort required may create chaos in other areas of life. Patients who are organized enough to maintain an opioid dependence usually are organized enough to take buprenorphine when adequate support is provided.
- Suicidality or other acute conditions needing stabilization
 - Note: Patient may be appropriate for buprenorphine therapy after stabilization, such as at hospital discharge.

Substance-related contraindications:

- Unsupervised / uncontrolled benzodiazepine (BZD) use. Buprenorphine overdose when combined with benzodiazepine use has been rare in the U.S. experience but was reported in France with injection BZD use.
- Other nonmedical sedative hypnotic use—e.g., carisoprodol (Soma)
- Any alcohol use is a potential issue because it depresses CNS function and can increase risk for overdose.
- Note: Recognize that risks associated with discontinuing MAT are very high. Alternatives may be unavailable, unacceptable, or inappropriate for the management of opioid addiction. Weigh risks and benefits of discontinuing versus continuing buprenorphine maintenance. (Using heroin or methadone with benzodiazepines or alcohol is more dangerous.)

11. Lack of contraindications to office-based treatment, such as:

- No safe place to keep medication.
- Patient unable to create safe home environment and prevent risk of children's exposure to medication.
- Patient at very high risk of diverting medication.
- Note: These safety considerations may be surmountable with programmatic adaptations – e.g., intensive case management, prescribing at variable intervals, and bringing treatment to the patient by providing directly observed therapy in shelters.

12. Patient values and preference

Advantages of buprenorphine maintenance treatment:

- Demonstrated efficacy in eliminating withdrawal – usually effective within minutes to hours of first dose, with most patients not experiencing any withdrawal after 2–3 days.
- Demonstrated efficacy in reducing craving for opioids; may reduce alcohol use ([Nava 2008](#)); does not change craving for other drugs.
- Effect of blocking other opioids helpful in discouraging patients from trying to use when on buprenorphine.
- Proven safety over long-term use.
- Comparable efficacy in office-based settings regardless of housing status ([Alford 2007](#)).
- Ceiling effect for overdose:
 - Pharmacology studies suggest that buprenorphine alone or combined with other opioids probably has less risk of overdose than methadone. It is practically impossible to overdose on buprenorphine alone or buprenorphine combined with other opioids. ([CSAT Buprenorphine Information Center](#))
 - Fatal overdoses of buprenorphine combined with other sedatives, including benzodiazepines and alcohol, can still occur, however.
- Can be helpful for individuals with severe opioid use disorder and pain when used in split dose.
 - Most patients can dose once a day and have full effects; some patients benefit from split dose, which is logistically easy to accomplish.
 - Patients describe the experience of taking buprenorphine as “feeling normal” (i.e., not feeling “under the influence”). Some patients, especially those with severe anxiety / complex PTSD, cannot tolerate what normal feels like to them. Those who have used short-acting opioids such as heroin for years have conditioned themselves to fear alertness, which has come to mean that they will shortly be in withdrawal (within 2–4 hours). They gradually learn that it is safe to be alert if they are on a long-acting opioid.
 - Adaptable to patients experiencing homelessness: Ability to prescribe/ dispense as frequently as daily, or as infrequently as monthly or less often is very helpful to people with variable capacity to manage and store medications and a high degree of transience. Wide availability of buprenorphine nationally is helpful to populations that may be transient.

Disadvantages:

- Initial induction can be challenging; requires patient to abstain from opioids for period of time to avoid “precipitated withdrawal.” Some patients cannot tolerate even short periods of withdrawal.
- Changing from long-acting opioids—especially methadone—may require tapering methadone dose over a long period and then 48 hours or more of abstaining before it is safe to start buprenorphine induction. “Transfers are possible between a >30-60 mg/day of equivalent methadone dose (high-dose transfer), although dose reduction to ≤ 30 mg/day followed by a normal transfer is preferred.” (National Alliance of Advocates for Buprenorphine Treatment's [Suboxone Dosing Guide](#))
- Some people need more structure than outpatient buprenorphine prescribing can provide.

Elements of Planning for Office-Based Treatment with Buprenorphine:

If the patient is selected for office-based treatment with buprenorphine, consider whether detox alone or maintenance treatment is warranted. There is no imperative to decide in advance whether to use detoxification or maintenance. Patients can be treated with buprenorphine as long as necessary, taper at any point, and be readmitted if a relapse occurs. However, maintenance treatment has better outcomes.

Cost considerations: “In general, buprenorphine-naloxone (Suboxone) medication costs are approximately five times more than methadone (~\$3.50–\$5.00 per dose versus ~\$0.50–\$1.50 per dose); the administration costs are approximately comparable though in very different settings (dedicated methadone clinic versus office setting); and the clinical effects on reductions of opioid use and opioid use-related health and social problems are quite comparable.” ([ASAM 2013](#) Report III by Chalk et al., p.66) Buprenorphine/naloxone medication (\$148/\$260 for 30 generic tablets 2–.5 mg/8–2 mg) at a national retail pharmacy in December 2013) is more expensive than methadone but less expensive than extended-release injectable naltrexone and can be administered by specially trained generalist physicians in a range of clinical settings. Maintenance treatment following detoxification may not be available to homeless patients, however, due to lack of insurance or resources to pay cash.

As of June 2013, every state Medicaid program covered buprenorphine/naloxone as an outpatient pharmacy benefit, either in the film form (Suboxone®) or in the generic sublingual tablet formulation. Nevertheless, there are significant variations among the states in the range and duration of covered benefits and prior authorization requirements, which often create a “de facto denial of access.” ([ASAM 2013](#), Report I by Rinaldo & Rinaldo) Buprenorphine may be prohibitively expensive for patients who are not eligible for Medicaid (e.g., live in states that have opted not to expand their Medicaid program to cover single childless adults with income at or below 138% of poverty, as authorized by the Patient Protection and Affordable Care Act of 2010). In 2011, 79.3% of homeless patients served by HCH clinics had incomes at or below 100% of poverty, and 62.4% had no health insurance at all ([HRSA UDS 2011, HCH grantees](#)). For uninsured patients who do not qualify for Medicaid, patient assistance options are extremely limited. Thus, access to MAT with buprenorphine/naloxone may be limited by cost and lack of trained prescribers who accept Medicaid or even private insurance ([Murphy 2014](#)). In many areas, clinicians are still providing medication-assisted treatment on a cash-only basis, drastically limiting a homeless patient’s ability to afford maintenance treatment.

Retail Costs of FDA Approved Buprenorphine Products at a National Retail Pharmacy Chain

Drug Name	Active Ingredients	Dosage Form/Route	Amt	Strength	Price
buprenorphine hydrochloride and naloxone hydrochloride (generic)	buprenorphine hydrochloride; naloxone hydrochloride	Tablet/ Sublingual	30 30	8-2 mg 2-.5 mg	\$259.99 \$147.99
Suboxone® (Brand name)	buprenorphine hydrochloride; naloxone hydrochloride	Tablet/ Sublingual	30 30	8-2 mg 2-.5 mg	\$369.99 \$214.99
Suboxone® (Brand name)	buprenorphine hydrochloride; naloxone hydrochloride	Film/ Sublingual	30 30	8-2 mg 4-1 mg	\$291.99 \$251.99
buprenorphine hydrochloride (generic)	buprenorphine hydrochloride	Tablet/ Sublingual	30 30	8 mg 2 mg	\$155.00 \$77.99
Subutex® (Brand name)	buprenorphine hydrochloride	Tablet/ Sublingual	30 30	8 mg 2 mg	\$368.00 \$205.99

Sources: [FDA](#) & CVS Pharmacy, 12/13/2013

Beginning treatment If buprenorphine maintenance treatment is chosen, plan alternatives for initiating treatment, called **induction**. The patient *must* be in withdrawal before maintenance treatment is initiated. “The goal of the induction phase is to find the minimum dose of buprenorphine at which the patient discontinues or markedly diminishes use of other opioids and experiences no withdrawal symptoms, minimal or no side effects, and no uncontrollable cravings for drugs of abuse.” ([CSAT 2004](#))

Determining dosage: Induction is begun by administering small doses of buprenorphine to determine at what point cravings and symptoms of withdrawal abate, in order to calculate the total daily dose needed. Procedures for induction are covered in the DEA-mandated physician training. The standard protocol starts with a 2/0.5 mg strength tablet, with subsequent gradual up-titration. Because a number of opioid-dependent homeless patients have used buprenorphine illicitly before seeing a prescribing physician, a more rapid induction may be successful by taking their experience into consideration. However, such patients may ask for a high dose because buprenorphine has a street value; so observe them after they have taken the suggested dose to be sure that it is safe for them. Health Care for the Homeless providers report beginning patients on a minimum daily dose (8 mg), but increasing the dosage if they experience any cravings whatsoever, to avoid relapse.

Determining induction setting – in-office (supervised) vs. “home”(unsupervised): Availability of staff for induction days in primary care settings, the patient’s comfort level using the medication for self-induction, availability of staff for on-call contact during induction, and previous ongoing use of methadone (tissue stores) are important considerations in determining where induction for buprenorphine maintenance treatment will occur. Many patients who are opioid dependent and are using opioids just to avoid getting sick have tried buprenorphine purchased on the street, and thus are familiar with its use. For such patients, the main risk of using unsupervised induction is precipitated withdrawal. A more serious concern is about precipitating withdrawal in patients who are buprenorphine naïve. For patients less motivated to pursue maintenance therapy, there is higher risk for diversion with unsupervised induction. Regardless of setting, the induction period is an ideal time to discuss overdose risk due to potential tolerance changes, rotating from one opioid to another, and potential for polydrug use during this period.

Problems getting patients induced: It is essential for patients to be in withdrawal before the induction process begins. Buprenorphine binds very tightly to the mu opioid receptor and will displace any other opioid from the receptor, precipitating an immediate withdrawal reaction. (The naloxone component of Suboxone is not relevant to this.) Those who are not already in withdrawal will become ill almost immediately. Some patients who have spent many years trying to avoid the acute discomfort associated with withdrawal may have trouble allowing themselves to experience it purposely. Opioids can be detected in urine for up to 72 hours. A patient can be in withdrawal with a positive opioid screen; if there are no opioids in urine toxicology results, question your diagnosis and/or the test results. Understand what tests your toxicology lab uses, how to interpret them, and whom to contact for expert consultation. A patient who has left an abstinence treatment program or has been discharged from jail but has not yet started using opioids will not be in withdrawal. It is possible to start these patients on

buprenorphine without fear of inducing precipitated withdrawal. These are patients for whom initiation of medication-assisted treatment may be most critical.

Barriers to “on demand” enrollment and induction: Commonly, homeless patients come to clinics in withdrawal and want to get started on buprenorphine immediately. Treatment on demand may be necessary for patients who have little control of their location. Guidelines outline a number of preliminary steps before buprenorphine therapy can be started (history and physical, labs, and documentation of opioid dependence, the most important requirement), which can make “on demand” enrollment and induction challenging. Documenting opioid dependence can be done at one visit, however; and induction plans can be made during the same visit, including giving the patient a small prescription to fill and bring back for observed ingestion. *If patients must return for induction on another day, consider providing a motel voucher or respite bed the night before, in order to maximize the chances of the patient's coming to the clinic in withdrawal.* HCH clinicians in Colorado use this strategy prior to important clinical procedures (e.g., colonoscopies), and appointments (e.g., Social Security) with very good results.

Factors Favoring Treatment in an Opioid Treatment Program [OTP] with Buprenorphine

(In some areas buprenorphine is available from narcotic treatment programs as an alternative to methadone.)

1. Patient would benefit from daily observed dosing.

- Benefit may also be primarily to the community or family of patients at high risk of diverting medication or with home settings in which it is impossible to keep medication away from others it could harm.

2. Contraindications to office-based treatment

3. Patient is able to attend OTP at location and specific hours when it is open.

- Homeless patients and those in rural settings may not have the means to get to the clinic at specific times.
- Many OTP's were specifically designed with the needs of working people in mind. (Not all homeless people are regularly employed.)

4. Ability to understand and adhere to program policies and procedures

- OTP's generally have strict guidelines based on state and federal regulations.

5. Patient values and preference

Advantages of buprenorphine in OTP:

- Ability to establish a daily routine for taking medication;
- Decreased worry about losing or having medication stolen, lost, or diverted in other ways;
- A strong connection to counseling; and
- Other advantages of a highly structured program.

Disadvantages:

- Limited availability of such programs.
- Many patients wish to avoid associating with and congregating around other people with a history of addiction.
- Many people are unable to tolerate a highly structured environment.

Factors Favoring Treatment in an Opioid Treatment Program with Methadone

Methadone maintenance in an opioid treatment program has a long track record of success and was the only effective treatment available for severe opioid use disorders for decades. Detailed information about methadone maintenance is available at: [VA/DoD 2009](#), [CSAT 2005 TIP 42](#), [Bart 2012](#), [Mattick 2009](#), [ONDCP 2012](#), [Preda & Dunayevich 2013](#), and [White & Mojer-Torres 2010](#).

1. Patient would benefit by daily observed dosing

- Benefit may also be primarily to the community or patients family such as patients with a high risk of diverting medication or home settings in which it is impossible to keep medication safe from others it could harm.

2. Patient is able to attend OTP at location and specific hours when it is open.

- Homeless patients and those in rural settings may not have the means to get to the clinic location at specific times.
- Many OTP's were specifically designed with the needs of working people in mind. (Not all homeless people are regularly employed.)

3. Ability to understand and adhere to program policies and procedures

- OTP's generally have strict guidelines based on state and federal regulations

4. Lack of contraindications to methadone treatment

5. Patient values and preference

Advantages of methadone in OTP:

- Ability to establish a daily routine for taking medication
- Decreased worry about losing or having medication stolen or lost or diverted in other ways
- Strong connection to counseling and other advantages of a highly structured program

Disadvantages:

- limited availability of such programs.
- Many patients wish to avoid associating with and congregating around other people with a history of addiction; and many people are unable to tolerate a highly structured environment.
- Some patients may require high doses for full effect.
- Does not change craving for other drugs

The sedating and anxiolytic opioid effects of methadone are considered an advantage by some patients and a disadvantage by others.

“Currently, no standards exist that guide clinicians to match patients with methadone treatment. [Kleber \(2007\)](#) suggests that methadone may be more suitable for patients with the following characteristics:

- unstable lifestyle (e.g., homeless or marginally housed)
- would benefit from the structure of regular attendance in a dispensing situation
- would benefit from the wider range of services available at a comprehensive methadone maintenance program
- few financial resources or uninsured or underinsured

Additionally, patients who lack social support might also benefit from the more systematized environment that is characteristic of the methadone treatment paradigm. Pinto and associates (2010), however, emphasize that the decision as to which medication is prescribed is based on understanding the known pharmacology of the drugs, patient characteristics and preferences, and ultimately on the clinicians' opinions.”

— [ASAM 2013](#), The Effectiveness of Pharmacotherapies for the Treatment of Opioid Disorders: A Systematic Review, Appendix 1, p. 32

Elements of Planning for Methadone Maintenance Treatment (MMT):

Cost considerations: MAT with methadone is the least expensive alternative for medication-assisted maintenance treatment; medication costs average \$30 –\$40 per monthly dose, and total costs range from approximately \$6,000 to \$12,000 per year, depending upon the nature and frequency of counseling and social services provided. “Various studies have seen clinically and statistically significant reductions in opioid use and opioid use-related incidence of infectious diseases and crimes with averted costs ranging from two to four times the costs of methadone per year. There are few enduring clinical benefits from methadone detoxification and thus very low cost-effectiveness or cost-offset from this short term treatment.” ([ASAM 2013](#), Report III by Chalk et al., p.66)

Methadone maintenance is not a covered benefit under Medicare, and in some states it is not a covered benefit under Medicaid. As of May 2013, 31 state Medicaid fee-for-service programs were found to cover methadone maintenance treatment provided in outpatient narcotic treatment programs. Some of these states provide additional public funding through the SAPT block grant/ state funds for OTP's; and in 3 other states, methadone treatment is funded only through SAPT and/or state or county funds. In 17 states, there is no Medicaid fee-for-service funding of methadone maintenance treatment in their state programs. (See tables specifying which state Medicaid programs cover MMT and which do not, in [ASAM 2013](#), Report I, by Rinaldo & Rinaldo.) In many states, MMT is more available than buprenorphine maintenance treatment (BMT) for uninsured and Medicaid patients. Working patients with private insurance may have access to buprenorphine but not to methadone. Access varies from community to community and significantly depends on health insurance coverage. Methadone clinics often have a sliding fee schedule; but if clients can't pay fees for MMT, they receive detox only.

Beginning treatment: Induction is conducted within OTP's. Methadone is typically dispensed on site in oral form (with take home privileges for certain stabilized patients), rather than prescribed at these specialized clinics. ([ASAM 2013](#), Report III by Chalk et al.)

Dosage: varies from about 30 mg/day to over 100 mg/day, depending upon genetic and opioid use histories of particular patients ([ASAM 2013](#), Report III by Chalk et al.).

Factors Favoring Office-Based Maintenance Treatment with Naltrexone:

Naltrexone is an FDA approved alternative to opioid agonist treatment for patients with opioid dependence. A long acting opioid antagonist available in both oral and injectable formulations, it does not produce euphoria and is not addicting. Medication compliance and retention rates with naltrexone treatment are low, however, limiting its clinical effectiveness. Patients may continue to experience cravings and may not be motivated to maintain adherence to the medication regimen. ([ASAM 2013](#) – Report III) Recent studies of opioid-dependent adults have found that “oral naltrexone, with or without psychotherapy, was no better than placebo or no pharmacological treatments with regard to retention in treatment, use of the primary substance of abuse, or side effects ([Minozzi 2011](#)); and that extended-release injectable naltrexone (XR-NTX) had poor to modest retention rates which improved with employer-enforced incentives contingent on treatment ([Everly 2011](#), [DeFulio 2012](#)). No specific studies involving people who are homeless are available. Naltrexone is likely to be most useful for patients who are highly motivated to achieve abstinence (employed, younger/ having used drugs for only a short time, under threat of legal sanctions) and when a family member or close friend is available to administer and manage the medication ([WHO 2009](#), [ASAM 2013](#)).

1. Support from significant other or family
2. Abstinence mandated as condition of employment or under threat of legal sanction
3. Contraindications to buprenorphine or methadone maintenance
4. Patient preference and values

Advantages of naltrexone maintenance therapy:

- Clinical effectiveness in eliminating opioid use with adherence to prescribed medical regimen – extremely effective in blocking actions of self-administered opioids: 24–36 hours (oral); up to 30 days (injectable)
- Safely blocks the risk of overdose when taken
- Can be stopped abruptly without withdrawal symptoms

Disadvantages:

- Unpopular with opioid-dependent patients (strong side effects, long pre-treatment withdrawal requirements)
- Not compatible with the need for opioid analgesic therapy (blocks the effects of opioid analgesics)
- May be intolerable for patients with severe opioid dependence
- Risk of fatal complications
- Poor adherence/retention rates for oral formulation except with mandatory treatment
- High costs of injectable formulation
- No evidence of enduring benefits when used only in detox regimens
- Increases risk of overdose when treatment stops and tolerance is decreased

Elements of Planning for Maintenance Treatment with Extended-Release Injectable Naltrexone:

Cost considerations: The average cost of a single monthly injection of extended-release naltrexone averages between \$850 and \$1,100 depending on insurance coverage; per monthly dose is approximately \$700 ([ASAM 2013](#) p.67) /\$850 – \$1,100 ([AATOD 2011](#)). In 2013, Medicaid coverage of injectable sustained release naltrexone (Vivitrol®) was known to be available in 42 states; nevertheless, utilization management requirements (prior authorization, quantity limits, step therapy) in some states limit access to this treatment modality. Depot naltrexone is covered by Medicare and by many commercial third party carriers. “There is no doubt about the clinical effectiveness of naltrexone in eliminating opioid use but very poor patient retention rates for the oral medication and high costs of the injectable medication compromise definitive economic conclusions about this medication at this time” ([ASAM 2013](#), Report III by Chalk et al., p. 176).

Beginning treatment: Patients with opioid dependence must be fully withdrawn from all opioids for up to 7–10 days before beginning naltrexone treatment. “Unfortunately, during this period, many patients relapse to use of opioids and are unable to start on naltrexone.” ([VA/DoD 2009](#))

Dosage: Administered via intramuscular injection, extended-release naltrexone is effective for 30 days. There is no need to adjust dosage for weight, height, age, gender, or health status; a single injection of 380 mg maintains blood levels above 1 ng/cc 4–5 weeks. ([AATOD 2014](#)) The minimum duration of naltrexone maintenance treatment is 6–12 months. Because naltrexone is an antagonist, it can be stopped abruptly without withdrawal symptoms; however, careful clinical evaluation of relapse risk is recommended prior to discontinuation. ([Kleber 2007](#))

Risks: “Both oral and extended-release formulations of naltrexone have been associated with patient deaths due to accidental opioid overdoses while taking either of these medications. In many cases, overdosing may be due to the blocking effect of naltrexone, with relapsing patients taking large amounts of opioids to try to overcome the blockage. In addition, patients treated with extended-release naltrexone may have reduced tolerance to opioids and be unaware of their potential sensitivity to the same, or lower, doses that they used to take of opioids. For such patients who relapse after a period of abstinence, the dosages of opioids previously used may have life-threatening consequences, including respiratory arrest and circulatory collapse.” ([ASAM 2013](#), Report III by Chalk et al.) “Patients with severe opioid dependence should be cautious taking naltrexone; also, naltrexone is not recommended for people with cirrhosis who have a Child’s severity rating of C or above.” ([WHO 2009](#), p. 46) *For these reasons, medication-assisted treatment with naltrexone may not be appropriate for homeless patients with opioid dependence whose severity level and comorbidities could place them at risk for adverse consequences.*

Pros and Cons of Maintenance Medications for Treatment of Opioid Dependence

	METHADONE	BUPRENORPHINE/ NALOXONE	NALTREXONE
Pros	<ul style="list-style-type: none"> • Effective in engaging and retaining patients; • Reduces withdrawal and craving symptoms • Reduces opioid but not non-opioid abuse • Reduces risk of infectious diseases • Highly structured - ability to establish daily routine for taking medication • Strong connection to counseling • Decreased worry about loss/diversion of medication 	<ul style="list-style-type: none"> • Similar efficacy to that of methadone • Overdose risks are far lower than for methadone • Far more accessible than methadone - available from specially trained primary and generalist physicians • Suboxone film reduces risk of diversion 	<ul style="list-style-type: none"> • Extremely effective in blocking actions of self-administered opioids: 24-36 hours (oral); up to 30 days (injectable) • Safely blocks risk of overdose when taken • Can be stopped abruptly without withdrawal symptoms • Most useful to highly motivated patients likely to achieve abstinence (e.g., healthcare professionals)
Cons	<ul style="list-style-type: none"> • Limited availability • Many patients unable to tolerate highly structured environment • Sedating and anxiolytic opioid effects (pro for some patients) • Does not change craving for other drugs • No evidence of enduring benefits when used only in detox regimens 	<ul style="list-style-type: none"> • Initial induction requires abstinence to avoid precipitated withdrawal • Increasing evidence of lethal intranasal/ injection abuse • Fatal overdoses can occur if combined with other sedatives (benzodiazepines, alcohol). • No evidence of enduring benefits when used only in detox regimens 	<ul style="list-style-type: none"> • Unpopular with patients (strong side effects, long pre-treatment withdrawal requirements) • Risk of fatal complications • Poor adherence rates for oral formulation except with mandatory treatment. • High cost of injectable formulation • Blocks effects of opioid analgesics • Increases risk of overdose when treatment stops and tolerance is decreased • No evidence of enduring benefits when used only in detox regimens • Least useful for homeless patients

Sources: American Society of Addiction Medicine. (2013). *The Effectiveness of Pharmacotherapies for the Treatment of Opioid Disorders: A Systematic Review*; World Health Organization (2009). *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*

"Any of these potent, safe medications [methadone, buprenorphine, and naltrexone] can provide important assistance in reducing opioid use among addicted patients. However, it is equally clear that most opioid addicted patients concurrently suffer from related physical and mental problems, deteriorated personal and social relationships and often inability to self-support a productive lifestyle. The role of counseling, social services, monitoring with consequences and peer supports can provide much of what these potent medications cannot provide. But these medications can also offer pharmacological assistance in stabilizing signs and symptoms that so often lead to patient termination from so-called abstinence-oriented treatments. It is simply efficient and prudent to combine the best of recovery-oriented social services with these medications to offer patients the best chance of a full recovery." — American Society of Addiction Medicine ([ASAM 2013](#)), pp. 24–25

Non-Medication-Assisted Treatment for Opioid Use Disorders

Non-medication-assisted treatments can play a critical role on the road to recovery, even for patients receiving opioid agonist treatment. Engaging people in recovery activities; helping them find sober environments, education/ training opportunities, and harm reduction therapy; teaching stress management and distress tolerance skills; recognizing and providing treatment for comorbidities including PTSD, TBI, and other substance abuse – these and other non-pharmacologic interventions often make the difference between treatment failure and continued progress toward recovery despite periodic setbacks.

- **Harm Reduction Therapy** Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. This approach can be beneficial regardless of treatment modality. It is particularly supportive to and respectful of people experiencing homelessness, who regularly interact with systems and situations that limit self-determination and lack respect. Harm reduction therapy relies on collaboration, respect, and stage-based interventions, and acknowledges self-defined, positive change. Therapists focus on client-defined priorities and acknowledge that any improvement that reduces harm is beneficial, whether or not substance use is continued.

Recommendations:

1. **Set the stage for honest communication to foster the therapeutic relationship.** *View everything you do as treatment, from the briefest hello to an ongoing therapy relationship.* View all interactions as in the service of building and maintaining the therapeutic relationship, knowing that relationship is the key to all behavioral change. Provide space and time for client and therapist to “move toward” each other (share perspectives, build mutual trust, collaborate on strategies to address expressed concerns), based on client readiness to engage at each step of this process.
2. **Avoid punitive sanctions for drug use** *Policies regarding opiate or other drug use during treatment should be as permissive as possible given safety (overdose) concerns.* Refusing or significantly restricting services in response to illicit drug or alcohol use will only increase chances that clients will try to deceive providers and engage in other behaviors that are interpreted as “drug seeking.” More frequent contact, honest exchange of conflicts, and adjusted dosing schedules should be the primary interventions. Consider use of a treatment contract/ patient-provider agreement that specifies expectations of the client and the therapist/ treatment provider to promote mutual accountability. Such agreements should change over time in response to changes in the plan of care and in the client’s function and behavior. ([Wisner 2011](#))
3. **Flexible dosing schedules/locations, etc.** Recognize that flexibility is key to beginning a therapeutic relationship. *Services should offer drop-in or sidewalk sessions, drop-in support groups, regular therapy appointments, and psychiatric medications.* This means meeting and engaging individuals on the street, in the waiting room, or outside a bathroom door to begin the process of developing a trusting relationship in which people can, over time, bring themselves to the therapeutic encounter and begin to see that relationship as a resource rather than as an intrusion.

Key Elements of Harm Reduction Practice

- **Low threshold** - Locate treatment activities in places where homeless individuals with substance use disorders congregate – e.g., street corners, community drop-in centers, needle exchanges, primary care clinics, soup kitchens, food pantries.
- **Integrated** - Harm Reduction-informed treatment provides integrated care for drug problems, mental illness, and other psychosocial problems based on the client's hierarchy of needs. Therapeutic approaches include motivational interviewing, cognitive-behavioral skills training, stress reduction, mindfulness, substance use management, life skills coaching, and nonverbal approaches such as drumming and somatic experiencing.
- **Trauma Informed** - Program structures and therapist expectations must avoid replicating the characteristics of traumatic experiences, including coercion, intrusion, loss of control, powerlessness, loss of trust, and physical/ emotional attacks.
- **Respectful, collaborative therapeutic relationship** - 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.

– Patt Denning, PhD and Jeannie Little, LCSW, Harm Reduction Therapy Center, San Francisco, California

4. **Flexible dosing schedules/locations, etc.** Recognize that flexibility is key to beginning a therapeutic relationship. Services should offer drop-in or sidewalk sessions, drop-in support groups, regular therapy appointments, and psychiatric medications. This means meeting and engaging individuals on the street, in the waiting room, or outside a bathroom door to begin the process of developing a trusting relationship in which people can, over time, bring themselves to the therapeutic encounter and begin to see that relationship as a resource rather than as an intrusion. Keep the door open for individuals who aren't ready to ask for help. For opioid-dependent individuals seeking help for co-occurring conditions, adapt your practice to provide easy access to appropriate treatment modalities consistent with their values and preferences. Because medications have harmful side effects, however, 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.
5. **Chronic stress must also be treated.** Inability to tolerate painful emotions can often lead to opioid dependence and relapse. Lifestyle issues, psychiatric issues, and stress associated with homelessness are alleviated by opioids. Addiction treatment programs should provide clients with opportunities for respite, relaxation, and fun.
6. **Use appropriate medications to treat underlying depression and anxiety.** Avoid prescribing benzodiazepines for patients receiving medication-assisted treatment for opioid use disorders. When taken in combination with opioid agonists/partial agonists (methadone/ buprenorphine), benzodiazepines are associated with possible long-term worsening of depression and anxiety disorders and can result in excessive sedation/lethal drug overdose. Be aware that methadone may increase the serotonergic side effects of SSRIs (Treatment Guidelines, *Medical Letter*, Jun 2013; 11(130).)

7. **Assess stage of change for all targeted behaviors, symptoms, etc.** Recognize that people may be ready to take action and adhere to different treatment recommendations at different times.
8. **Welcome people in crisis who present with difficult behaviors.** Work with difficult behaviors rather than prohibiting them. *Practice radical inclusion* of all clients, including those with cognitive/mood/behavioral disorders that may cause them to be disruptive or very fearful and anxious in a clinical setting. Understand that behavior serves a purpose; despite sometimes self-destructive aspects, it communicates essential information about a person's history, feelings, and response to the present environment. Under the guise of creating "safety" for both clients and staff, programs frequently create rules and systems to prohibit "disruptive" behaviors. Often this is more about staff comfort level than safety. At some point, most clients have crises. Train staff in [nonviolent crisis intervention](#); educate them to distinguish dangerous behaviors from disruptive or inconvenient behaviors. Commit clients to an involuntary hold if absolutely necessary, but not often. Crisis prevention should be the priority; because emergency hospitalization is often traumatizing and may be inconsistent with therapeutic goals, devote extensive time to talking with and settling a client who is in crisis in order to avert a dangerous situation.

Tips For Dealing With Disruptive/ Anxious Clients:

- **Try to understand why the person is angry or upset.**
Use active listening and an empathic, non-judgmental approach to alleviate anxiety.
- **Try to prevent acting out behavior by being proactive.**
Approach apparently anxious clients with respect.
Address problems immediately, before they escalate.
- **Remain calm and professional; don't take acting out personally.**
Don't let your own behavior escalate.
Take a break; get help from others who have better rapport with the client.
- **In an escalating situation, isolate the difficult person.**
Separation from others often allows clients to save face and calm down.
- **Respect personal space; watch your body language.**
Remain 3-4 feet from the client — in front and slightly turned.
Avoid challenging gestures, stance and facial expressions.
- **Tone of voice is important; don't sound harsh. Be respectful.**
Don't communicate stress or negative expectations through your manner.
- **Speak clearly, slowly and simply.** Don't use jargon or large words.
Avoid jokes and arguments about what the person is seeing, feeling or experiencing.
- **Set limits that are clear, simple, reasonable and enforceable.**
Ask something the client is capable of doing. Emphasize the positive.
Be understanding of the need just to "vent."
- **After an incident, sit down with staff and debrief.**
Discuss what worked and what didn't to be better prepared next time.
- **The teachable moment is when the client has calmed down.**
Remind client how to avoid anxious situations in the future — but not in the middle of crisis.

– Eve Rubell, MPH, Homeless Health Care, Los Angeles, [Oct 2000 Healing Hands](#)

9. **Take care of staff.** *Consider the care of staff as a critical component of all programs.* Opportunities for individual and group supervision must be standardized, and other stress-reducing components added (continuing education, required vacations, communal lunches, etc.). Staff must embody flexibility and responsiveness to myriad crises and stories in any given day. Just as a harm reduction therapist prioritizes developing a therapeutic relationship, program supervisors should prioritize supporting staff as they focus their attention on the many participants in community-based programs.

- **Peer support** Peer-delivered social support services have become an integral part of behavioral health care. Peer supporters help individuals with mental and substance use disorders navigate complex service systems and advocate for underserved and vulnerable populations throughout the recovery process. Peer mentoring and peer-run mutual support groups are among the most successful examples of peer recovery support for individuals with opioid use disorders who are homeless. ([HCH Clinicians' Network, Fall 2013](#), [HCH Clinicians' Network, 2009 Jan](#))

- **Peer mentors/ peer support specialists** are individuals with lived recovery experience who have been trained and certified to help their peers gain hope and achieve specific life and recovery goals. Actively engaged in their own recovery from mental health or substance use disorders, peer specialists may be volunteers or paid employees hired to provide peer support services to others. "Recovery and healing occur within the context of supportive relationships; peers excel at building effective relationships that facilitate recovery ([HCH Clinicians' Network, Fall 2013](#))."

For example, the [Recovery Mentor Program](#) established by Central City Concern in Portland, Oregon, assigns a peer mentor to every client receiving addiction management services. Mentors check in with clients daily, making sure they maintain their commitment to a regimen of intensive outpatient medical, chemical dependency, and mental health treatment. A significant reduction in drug use and criminal activity was demonstrated among clients with addiction disorders receiving these services ([Herinckx 2008](#), [HCH Clinicians' Network, 2009 Jan](#)).

- **Peer support groups** According to formerly homeless consumer advocates, peer-run support groups are "the biggest contributing factor in helping clients avoid relapse." *Consider initiating a short-term intervention to work with clients individually and in peer-led groups.* Structure sequential sessions to gradually increase client education and involvement of paraprofessionals. Short-term interventions can become ongoing, just as recovery is. Set up a phone list so group participants can talk with each other daily. If a member isn't doing well, peers can alert a clinic staff member or paraprofessional to reach out and provide assistance to that individual.

12-Step programs, self-help groups, or mutual aid groups such as Narcotics Anonymous (NA) may provide positive peer interaction, social support, and opportunities/connections to help patients meet basic needs. Programs based on the AA/NA model of recovery are philosophically committed to abstinence. Some of these programs consider the use of medically-assisted treatment for opioid dependence as differing little from illicit drug use and are strongly critical of participants who are receiving treatment for addiction and/or comorbidities; others are more tolerant. ([White 2011](#)) Attitudes and practices of mutual support groups vary by community.

“In formulating policies and practices related to patient referrals to recovery mutual aid groups, medication-assisted treatment programs will need to consider the effects of full versus restricted participation on recovery outcomes. ... Many patients in medication-assisted treatment are greatly benefiting from NA, and ...there are NA members who were able to taper successfully from medications with the support of NA. (No study has been conducted of the experiences of these latter NA members.) But comments [from members] also raise the question of potential harm that might occur to patients from the attitudes they encounter towards medications within NA—either through the consequences of precipitously terminating their medication use or through being denied the benefits of key ingredients of the NA program.” ([White 2011](#))

For more information about peer recovery support services, see [CSAT 2009](#) and the [Resource Kit of Practical Peer Support Resources](#) prepared by the HCH Clinicians’ Network (2013).

- **Acupuncture** has been successfully used by a number of Health Care for the Homeless programs as complementary and alternative therapy to control post-acute opioid withdrawal symptoms—it helps with anxiety and provides pain relief. People with severe opioid use disorder/ dependence experience acute sensitivity to pain when withdrawing from heroin use. Acupuncture is a nonpharmacologic treatment modality that is particularly appropriate for homeless clients because of its low cost and portability as well as its effectiveness in treating the symptomatology of pain syndromes, substance abuse, and HIV ([Johnstone et al., 1994](#)). (For more information, visit the [National Acupuncture Detoxification Association](#) website.)
- **Supportive housing with employment assistance** Supported employment—particularly in combination with permanent supportive housing—has been demonstrated to be an effective model for individuals with a primary substance abuse diagnosis who experience homelessness. Employment as a treatment outcome assists in social reintegration, helps prevent relapse, and promotes economic self sufficiency.

Central City Concern (CCC) provides a comprehensive recovery oriented system of care—including addiction treatment, supportive housing, and supported employment services—to homeless and low-income individuals in Portland, OR, many of whom have addiction disorders (including opioid use disorders) with co-occurring mental and physical health problems and histories of criminal justice system involvement ([Kraybill & Zerger 2003](#), [HCH Clinicians’ Network 2009](#)). Since 1992, CCC has operated employment assistance programs that focus on the needs of chronically homeless adults, veterans, and formerly incarcerated individuals. A review of program outcomes, 2007–2009, found that 71% of all clients served by these programs achieved employment; clients who transitioned into permanent housing were employed at the highest rate (85%). ([Herinckx 2010](#))

ASSOCIATED PROBLEMS, COMPLICATIONS

Major Recommendations:

- **Carefully assess for comorbidities that can complicate or interfere with treatment of opioid use disorders. Manage co-occurring conditions simultaneously.**
- **Provide opioid safety education on the effects of opioids including the possibility of overdose to all patients with a history of substance use and to patients taking opioid medications for pain management.**
- **Institute regular monitoring of all prescribed medications taken by the patient to prevent prescription of lethal or nontherapeutic medication combinations, and to reduce risk of prescribing medications that will trigger relapse in patients with substance use disorders.**
- **If diversion/ misuse of opioid agonists is suspected, explore patient motivations; re-evaluate the plan of care; implement strategies to minimize risk of diversion/ misuse (random drug tests, alternate day dosing, prescription monitoring program, directly observed therapy). Balance overall benefits of continuing MAT with potential harms.**

Rationale: Mortality risks are significantly increased by missed diagnoses of serious medical conditions associated with opioid dependence, and by drug overdoses precipitated by reduced tolerance following a recent period of abstinence or use of drugs/ medications that cause CNS depression if combined with opioids. Diversion of opioid agonist medications used therapeutically to prevent withdrawal symptoms is common among people unable to access addiction treatment. Clinicians working with homeless patients should be cognizant of the high rates of addiction, mental illness, and extreme poverty in this population. Lack of financial resources, limited access to treatment, and barriers to affordable housing (being screened out as potentially "high risk" tenants due to chemical or mental health problems and/or criminal record) are primary reasons why people with opioid dependence experience homelessness.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, psychiatry, harm reduction therapy, and overdose prevention.

Sources: [Alford 2007](#), [Alford 2011](#), [Doe-Simkins 2013](#), [Hwang 2008](#), [Yokell 2011](#)

Problems & Complications Related to Treatment for Opioid Use Disorder

- **Drug overdose** As already discussed, opioid-dependent people experiencing homelessness are at disproportionately high risk of lethal drug overdose. Fatal overdose is less likely with buprenorphine than with use of illicit opioids or other medications prescribed for analgesia. *Be mindful of the use of medications and drugs of abuse that may cause CNS depression in the abstinent patient if used in combination with opioids.* Although these medicines can play an important role in therapy for patients with opioid use disorders, providers should monitor these patients closely and explain the risks. (See pp. 24–26 for a detailed discussion of opioid safety and overdose prevention and response education.)
- **Adverse drug-drug interactions** Consider designating one clinician with expertise in treatment of severe substance use disorders to approve and *monitor all prescribed medications and drug monitoring analyses, in order to prevent lethal or non-therapeutic medication combinations.* List all current medications, the monitoring physician, and the chemical dependence diagnosis on the front page of medical records to reduce risk of prescribing medications that will trigger relapse when patients with severe substance use disorders present to the emergency room or are seen during clinic visits. Sharing information with pharmacists about a patient's opioid use and any medically-assisted treatment received can also facilitate monitoring of potential drug interactions; but *written patient*

consent/ signed releases would be required for such disclosures, consistent with privacy protections afforded to alcohol and drug abuse patient records by 42 Code of Federal Regulations (“CFR”) Part 2. (For more information, see SAMHSA's [Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange](#).)

Before MAT is initiated, warn patients about severe side effects and risk of lethal overdose from combining heroin with other opiates, methadone, alcohol, or other drugs that potentiate overdose. Medications that may interact with common drugs of abuse are specified in Appendix D, prepared by pharmacists at Outside In, a homeless health care program in Portland, Oregon. (The pharmacodynamic interactions listed for heroin would also apply to prescription opioids.) For more information about drug-drug interactions, see [Indiana University's cytochrome -450 drug interaction table](#). Be aware of potential interactions between some antiretroviral medications and opioid agonists that may diminish the effectiveness of treatment:

Potential Interactions between Antiretrovirals and Opioid Agonists

Drug	Potential Interaction	Recommendation
ritonavir, atazanavir (protease inhibitors)	May increase concentration of buprenorphine	Initiate buprenorphine at reduced doses and titrate slowly.
ritonavir	At higher doses, may decrease concentration of methadone	Monitor for symptoms of opioid withdrawal and adjust methadone dose if necessary.
efavirenz, nevirapine (NNRTIs)	May decrease concentration of methadone	Monitor for symptoms of opioid withdrawal and adjust methadone dose if necessary.
efavirenz	May decrease concentration of buprenorphine	Monitor for symptoms of opioid withdrawal and adjust buprenorphine dose if necessary.
buprenorphine	May make tipranavir/r (NNRTI) less effective	Co-administer the combination with caution.

Sources: [Foisy & Tseng 2013](#), [Antoniou & Tseng 2012](#)

- **Diversion/ misuse of prescribed medications** Buprenorphine/naloxone obtained on the street or from others with a prescription is commonly used to prevent withdrawal or control withdrawal symptoms rather than to get high ([Alford 2011](#)). This can be more an indicator of lack of treatment access than of substance abuse *per se*. Buprenorphine/naloxone is generally ranked as the least-abused or misused opioid in the U.S., with lower rates of abuse than heroin, oxycodone, hydrocodone, methadone, morphine, or fentanyl. In some instances, patient misuse of buprenorphine by injection or inhalation may be indicative of sub-optimal clinical dosing. One study found that three quarters of injection drug users and half of non-IDUs used diverted buprenorphine because they could not afford to enter formal drug treatment. If diversion is suspected, balance overall benefits of continuing treatment with potential harms. ([Yokell 2011](#))

Strategies to minimize diversion/ misuse of buprenorphine:

- Use *random urine drug tests* to assess for diversion or misuse (e.g., whether the patient is taking some of the medication but is not adhering to the prescribed regimen).
- Consider use of *alternate day dosing* with sublingual buprenorphine to decrease diversion.
- Consult *prescription monitoring programs* to verify medication dosing and a history of controlled substances dispensed to individuals under your care. Most states now have or plan to have a prescription drug monitoring system (see <http://pmpalliance.org/>).
- Consider use of *directly observed therapy* to ensure compliance with BMT – a strategy that has been successful in promoting adherence to antiretroviral therapy for HIV infection.
- Decrease demand for illicit buprenorphine by *increasing the availability of buprenorphine and buprenorphine/naloxone*.

(See pp. 55–56 for more guidance on prevention of diversion/ misuse.)

"Discussions of diversion should be broadened beyond the risks or legal implications associated with this activity. Strong consideration should also be given to the medical, social, public health, and economic benefits that arise when opioid-dependent individuals use buprenorphine in a therapeutic manner to self-treat addiction and withdrawal symptoms or as a harm reduction approach to manage the risks associated with drug dependence. Any consideration of diversion should balance the overall benefits—both those seen in clinical patients as well as those seen in illicit users—with the potential harms." (Yokell 2011)

Problems & Complications Related to Other Factors:

- **Missed diagnoses** *Carefully assess for comorbidities that can complicate or interfere with treatment of opioid use disorders.* The diagnosis of opioid use disorder is generally straightforward. The occurrence of co-existing conditions, however, may be missed due to the overwhelming burden of living with physical dependence to an opioid and the daily struggle to obtain opioids to avoid withdrawal. Comorbidities common to homeless populations—including psychiatric illness, HIV infection, hepatitis C, and chronic substance use disorders—correlate with unsuccessful treatment of severe opioid use disorder/ dependence (Alford 2007). Management of concomitant addictions (especially to benzodiazepines) and other psychiatric comorbidities is important, whether an individual is receiving medication-assisted treatment of opioid use disorder or not. *Use multidisciplinary clinical teams to provide integrated primary and behavioral health care, including simultaneous treatment of co-occurring substance use, mental health disorders and infections associated with intravenous drug use.*

Because the common presentation of polysubstance use disorders often complicates the treatment of opioid dependence, this aspect of the diagnosis must not be missed. For example, comorbid alcoholism and benzodiazepine use disorder can interfere with MAT with buprenorphine, making it more dangerous. The occurrence of severe medical conditions resulting from opioid use disorders can be mistaken for withdrawal or self-neglect; therefore careful assessment for acute and chronic infections and other co-occurring conditions is extremely important.

For individuals seeking treatment for opioid use disorders, follow up and treat co-occurring conditions at subsequent visits. For individuals who deny substance abuse but are actively using addictive substances, treatment of comorbidities can be a way to reduce harm and engage them in ongoing care. The National Quality Forum has developed a [Multiple Chronic Conditions \(MCC\) Measurement Framework](#) that articulates a shared vision for effectively measuring the quality of care provided to individuals with chronic, co-occurring health problems. Providers dealing with the complex spectrum of comorbidities associated with opioid use disorders in homeless populations might benefit from this approach.

- **Psychiatric disorders** Mental health problems such as depression, anxiety, and PTSD should be addressed simultaneously with opioid use disorder. Uncontrolled psychosis/mania or suicidal depression should lead to a psychiatric referral. Recognize that exacerbation of mental illness and erosion of coping capacity may result from cessation of buprenorphine treatment.

Critical issues for homeless patients:

1. Can the patient follow directions and understand risks and benefits of various treatment options?
 2. Is there a safe place to store medications for the patient, provider, or visiting nurse?
 3. Is the patient suicidal?
 4. Given the high prevalence of trauma in homeless populations, does the patient have a safe environment in which to begin the recovery process?
- **Injection-related infections and bloodborne disease** Patients who are injecting substances should be counseled on proper injection techniques and given referrals to [syringe exchange programs](#) or supplied with sterile injection equipment. Injectors are at high risk for infections like endocarditis, cellulitis, necrotizing fasciitis, and abscesses along with vein damage and the transmission of HIV and viral hepatitis through the sharing of equipment.
 - **Cognitive impairment** Memory deficits, impulse control, and low intellectual functioning may interfere with treatment adherence. As many as 80% of homeless persons receiving neuropsychological testing have marked deficits in cognitive functioning ([Highley, 2008](#)). Cognitive impairments seen in homeless patients are often associated with traumatic brain injury (TBI), mental illness, chronic substance abuse, infection, strokes, tumors, poisoning, or developmental disabilities. Many of these patients were victims of assault during childhood prior to becoming homeless. Homeless people experience high rates of head injury ([Carlson 2008](#)). A study in Toronto found a lifetime prevalence of TBI in 53% of a representative sample of 904 homeless adults, with significantly increased likelihood of seizures, mental health problems, drug problems, and poorer physical and mental health status ([Hwang 2008](#)). More structured treatment settings or directly observed therapy may be preferable for these patients, whose cognitive impairments may be confused with treatment resistance/noncompliance.
 - **Acute and chronic pain** Homeless populations suffer disproportionately from health problems associated with acute and chronic pain (trauma, peripheral vascular disease, viral hepatitis, HIV/AIDS, psychiatric illness, substance use disorders) that is exacerbated by limited access to

treatment ([Wismer 2011](#)). A history of chronic pain can complicate diagnosis of opioid use disorder. Many experts would favor using buprenorphine or methadone alone in divided doses for analgesia. Other opioid analgesics can be used with methadone and rarely with buprenorphine for individuals with severe opioid use disorders and pain. (For a discussion of clinical options for treating acute pain in patients receiving opioid agonist therapy, see [Alford 2006](#).)

- **Discrimination** Consider the potential for methadone and, to a lesser extent, buprenorphine recipients to be discriminated against by employers requiring routine drug tests. Methadone may show up on employee drug screens; buprenorphine is unlikely to show up on routine drug screens. As noted, some self-help groups discriminate against participants receiving medication-assisted treatment for opioid dependence because it is mistakenly seen as equivalent to active drug use and therefore contrary to abstinence-only as a preferred recovery strategy. Employers, housing providers, and many health care providers continue to need to be educated that *methadone and buprenorphine used for treatment do not constitute active substance abuse*, and in fact are likely to result in individuals' being much more stable. It may be helpful to be proactive in providing patients with a letter describing the medicine they are taking "for a chronic condition" under your care.

FOLLOW-UP

Major Recommendations:

- **Determine frequency of follow-up based on stability of the patient and his/her living situation and risk of diversion/ misuse/ abuse of medications used for treatment of opioid use disorders or other substances.**
- **At each visit, assess for behaviors outside the treatment plan, including a psychosocial assessment. Consider causes related to homelessness — missed appointments due to competing priorities or unexpected events (e.g., in jail, delayed by another appointment), stolen medications (e.g., assault, theft in shelter).**
- **Provide medical respite care facilities where patients can convalesce when ill, recuperate following hospitalization, or receive end of life care. Facilitate entry into permanent housing with supportive services on site or in the community, to alleviate many associated problems and complications.**

Rationale: Homeless people's lives are unstable, and they have a higher prevalence of mental health and substance use problems compared to the general population. Medications prescribed for homeless patients are more often stolen, overused, traded and/or sold. Most aspects of addiction treatment are more difficult without stable housing. Substance use declines when people become housed.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, psychiatry, harm reduction therapy, and overdose prevention.

Sources: [Aidala, 2005](#), [Edgington 2011](#), [Post 2008](#), [Wisner 2011](#)

- **Frequency of follow-up for patients receiving office-based treatment for opioid use disorder**
Determine frequency of follow-up care based on stability of the patient and his/ her living situation, and risk of diversion, misuse, or abuse of medications used for treatment of opioid use disorders or other substances.

Recommended follow-up can be daily or weekly until the patient is stabilized (i.e., until the dose has been stable and urine drug screens have been clear of other opioids for a few weeks). For patients with polysubstance use disorders, more frequent visits with random urine/blood drug screens may be necessary. Drug testing should be targeted at specific goals; seek guidance on lab interpretations and plan what to do with test results. Therapeutic use of *point of care or in-office urine drug testing* can be extremely helpful for homeless patients with whom follow-up by phone is difficult. Ask patients what drugs they expect would show up on a drug screen; many patients will tell the provider what drugs they have been using in response to nonjudgmental questioning.

If the patient is not free of non-prescribed opioids, if other drugs or non-prescribed/contraindicated medications show up on drug screens (alcohol, benzodiazepines, repeated evidence of cocaine or marijuana), or if there is no buprenorphine in the urine (which could be a sign of diversion), re-evaluate the plan of care to determine the safest and most effective strategy for continuing medication-assisted treatment for opioid dependence. A special test is needed to detect buprenorphine. Many in-office urine tests only detect non-synthetic opioids such as morphine (to which heroin is metabolized) and codeine. Urine testing for the presence of buprenorphine may not be readily available or may be too expensive for many programs to implement. Benzodiazepines are hard to detect in urine screens because most tests only look for one or two metabolic products.

Between-visit pill counts can be helpful for patients who have transportation to the clinic, which can also be conducted at outreach sites. If the patient needs more medical and psychosocial support than can be provided in your health center, consider other treatment alternatives/settings (detox center, inpatient care, intensive outpatient treatment program, supported housing) and make appropriate referrals.

If prescribing an opioid agonist, make sure that follow-up occurs before the prescribed medication runs out. Coordinating prescription refills with medical appointments helps encourage patients to come to the clinic for follow-up of comorbid medical conditions.

- **Medication refills** In general, prescriptions should be of shorter duration to help reduce misuse/ diversion, overdose, or loss of medications. Depending on the patient's needs, one can gradually increase the frequency of prescriptions from daily, to every 3–5 days, to bi-weekly. Extend or decrease prescription duration consistent with appropriate use of the medications and patient ability to store them securely. Designate an authorized physician to refill opioid and other medications if the prescriber is unavailable to do so. The clinician's responsibility to the patient lies in providing the medications on an agreed-upon basis.
- **Progress review** At every visit, review progress toward completion of the diagnostic work up, behavioral interventions, medication adherence, receipt of/ adherence to other treatments, and progress toward patient goals. Assess the patient's response to treatment (each visit), functional improvement (each visit), and mental health and substance use (at regular intervals, depending on original assessment results). Assess medication side effects. Change medications/ treatments/ treatment goals as needed. Keep expectations clear.
- **Medication storage evaluation** Medications prescribed for homeless patients are frequently stolen, overused, shared, traded, or sold. Medications may be lost as people travel from place to place, or confiscated by police if arrested/ questioned for loitering (sitting on a bench or on the ground), trespassing (camping somewhere), and/or addressing other basic human needs. Follow-up should include a re-evaluation of the patient's ability to manage a certain quantity of medications and strategies to keep medications safe.
- **Medical respite care/ permanent housing** Research has shown that substance use declines when people become stably housed ([Aidala, 2005](#)). Housing should be a component of any treatment strategy to manage opioid use disorder. Provide or refer to medical respite care facilities where homeless patients can convalesce when ill, recuperate following hospitalization, and receive harm reduction informed addiction treatment ([Ciambrone & Edgington, 2009](#), [Edgington 2011](#)). Facilitate entry into affordable permanent housing with supportive services in the community and/or available on site—an integrated package of care management with coordinated primary and behavioral health care—to reduce problems and complications associated with treatment ([Post 2008](#)).
- **Case management** Assess the patient's need for social work/ case management/ legal services at every visit. (“Has anything changed? Lost Medicaid? Problems in living situation? ER visit? Family problems?”)

Model of Care

SERVICE DELIVERY DESIGN

Major Recommendations:

- **Design service delivery systems based on meeting patient needs, promoting consistency in practice, and supporting staff that work with challenging patients.**
- **Consider use of unconventional treatment sites (e.g., mobile methadone vans), addiction counseling on a drop-in basis, flexible treatment goals and desired outcomes, and creative strategies for recruiting patients into treatment.**
- **Establish collaborative relationships with methadone maintenance providers, detoxification programs, and other inpatient and outpatient addiction treatment programs for cross referral and coordinated care.**
- **Integrate primary and behavioral health care and use a harm reduction approach to the management of opioid use disorders. Use multidisciplinary clinical teams working at the same location. Locate treatment activities in places where homeless individuals with substance use disorders congregate. Provide recovery-oriented support services (e.g., peer mentoring, group therapy, employment assistance).**

Rationale: It is important to develop a system of care that supports the patient-provider relationship, given the barriers that homeless patients face in obtaining treatment for opioid use disorder and the challenges that providers face in providing an appropriate combination of treatments in a safe and effective manner. Also important is developing a system of care that addresses the myriad needs of many homeless patients (e.g., medical, behavioral health, and social services) in a coordinated way.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, psychiatry, and harm reduction therapy.

Sources: [Alford 2011](#), [Altice 1999](#), [Denning & Little 2011](#), [Goyer 2011](#), [Meinbresse 2013](#), [SAMHSA 2013 \(TIP 55\)](#).

- **Goals of optimal service delivery** *Design service delivery systems based on meeting patient needs, promoting consistency in practice, and supporting staff that work with challenging patients.* Recognize that people with opioid use disorders who are experiencing homelessness need a broad array of services and resources to meet basic needs, maintain/ improve health, and mitigate conditions inherent to homelessness that limit health care access and complicate treatment adherence:
 1. Decent, safe, and affordable housing with supportive services, on site or in the community;
 2. A livable income/ resources – to pay for food, clothing, shelter, and health care; and to meet requirements of the correctional system (e.g., for regular drug testing);
 3. Access to overdose prevention supplies, syringes, and education on reducing drug-related harm;
 4. Access to comprehensive health care, including inpatient and outpatient care, and ongoing aftercare through case management and/or peer mentoring;
 5. An approach to care that takes into consideration the patient's personal strengths, aspirations, and cultural/ religious/ spiritual preferences;
 6. Monitoring and coordination of all medical prescriptions for every patient with a known substance use disorder, in emergency departments, clinics, and pharmacies;
 7. Physical exercise and recreational activities;
 8. Peer support/ community connections (group meetings, volunteer opportunities, advocacy activities to address the structural causes of homelessness);
 9. Access to affordable transportation; and
 10. Education and employment/ training opportunities.

■ **Service delivery adaptations recommended for patients experiencing homelessness:**

1. **Sites of treatment and other service delivery may be unconventional.**

Examples:

- Mobile methadone vans in [Seattle](#), [San Francisco](#), [Vermont](#), [Omaha](#)
- [San Francisco Drug Users Union](#) – represents political interests and practical needs of chronic drug users (e.g., provides clean needles, harm reduction support group).
- [Harm Reduction Coalition](#), New York City – policy and advocacy for drug users; skills-building training, community consultation and other technical assistance; overdose prevention education and advocacy; sponsoring and organizing regional and national conferences.

2. **Counseling may need to be on a drop-in basis or require more outreach to bring patients in.**

Examples:

- [Office-based opiate treatment \(OBOT\)](#) experience in San Francisco
- Individual and group counseling at [Harm Reduction Therapy Center](#) in San Francisco Tenderloin district

3. **Goals and desired outcomes of treatment may need to be flexible.**

Example:

- As in other drug using populations, the only social connections and support that homeless patients have may be with drug-using friends or those with whom they share encampment. New social networks and support may need to be established for patients who are estranged from their families and from conventional social supports (e.g., the [Recovery Mentor Program](#) in Portland, Oregon).

4. **Recruitment into treatment may need to be creative and visible to people on the margins.**

Examples:

- Heroin users encamped in alley adjacent to clinic with no effective outreach to get them into treatment
- Success of project [Homeless Connect](#) model of having intake and health screening on site at large homeless services events
- Special funding for treatment of homeless people may need to be developed. (This can be quite politically touchy and can elicit issues of discrimination, racism, etc.)
- Many homeless women in need of treatment for opioid use disorders are connected to men also in need. Program flexibility is needed to accommodate treatment of couples.

- **Integrated services & collaborative care** Because of the high prevalence of co-occurring mental/behavioral health conditions and other chronic illnesses in homeless populations, opioid-dependent persons experiencing homelessness can greatly benefit from the integration of primary and behavioral health care with MAT. Integrated care exists when all staff work together collaboratively as a team, using the same clinical record in the same physical space with ongoing communication, and are rapidly accessible to intervene with patients when needed.

Examples:

- ***Integrated primary/ HIV/ HCV care*** for patients in MMT or BMT: Patients prioritize getting their daily methadone dose or office-based therapy with buprenorphine/naloxone, which makes these treatment settings ideal for integrated care – e.g., provision of [primary care](#) (flu shots and other immunizations), [HIV](#) care, [HCV](#) care, etc., in the same location. ([Altice 1999](#), [Harris 2010](#)), [Dilonardo 2011](#), [HAB 2012](#))
- ***Integration of primary and behavioral health care*** with MAT for opioid-dependent patients with co-occurring psychiatric disorders: Patients in BMT with active psychiatric diagnoses co-managed with a psychiatrist. ([Alford 2011](#))
- ***Collaborative, coordinated care with nurse care managers*** can foster successful outcomes of BMT for opioid-dependent patients with complex psychosocial needs ([Ibid.](#)).

Resources:

- Integrated Care Quick Guide: Integrating Behavioral Health & Primary Care in the HCH Setting ([Meinbresse 2013](#))
 - Key Elements of Integrated Care for Persons Experiencing Homelessness ([Goyer 2011](#))
 - National Health Care for the Homeless Council's Webinar on [Integrating Behavioral Health & Primary Care for People Experiencing Homelessness](#), February 19, 2013.
- **Recovery support services** are especially important for homeless people with opioid use disorders. These may include peer mentoring, alcohol- and drug-free community (ADFC) housing, and peer-to-peer support services.

Recommendations for homeless patients:

1. **Provide peer-to-peer services** in a modified program that doesn't necessarily require detox or treatment. This is a cost-effective strategy that can result in better outcomes due to increased client comfort level with peers compared to professional staff.
Example: Central City Concern's [Recovery Mentor Program](#) in Portland, Oregon increases the number of successful outcomes for non medication-assisted treatment models and enables more opioid-dependent people to qualify for and maintain ADFC housing.
 2. **Improve access to detox and opioid agonist treatment** – especially for uninsured people and Medicaid recipients in jurisdictions where behavioral health services are limited.
 3. **Promote comprehensive models of care** that include *both* medication-assisted and non-medication-assisted treatment options.
 4. **Foster access to decent, safe and affordable housing**, including medical respite care, subsidized transitional housing, and permanent housing with supportive services. Housing is often the most stabilizing health intervention.
- **Advocacy** *Involve both service providers and clients in policy advocacy to protect successful recovery models of care.* *Example:* Oregon Health Authority's [Addictions and Mental Health Planning and Advisory Council](#)

OUTREACH AND ENGAGEMENT

Major Recommendations:

- **Use outreach workers in the community to facilitate initial engagement with and provide support to people at risk for opioid overdose. Do outreach in partnership with a consumer/ peer counselor as much as possible.**
- **Provide ongoing opportunities for group therapy to patients with opioid use disorder.**
- **If possible, provide medication-assisted treatment where homeless people live (e.g., shelter-based treatment with buprenorphine).**
- **Use a team approach in care planning and coordination to facilitate engagement.**

Rationale: Homeless patients often work with counselors, case managers, and/ or outreach workers who may explore opioid use issues when engaging the patient. These members of the care team often have more access to patients and are more accessible than medical providers. Caring for homeless patients is as much about building relationships as about clinical expertise.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, psychiatry, outreach/ case management, and harm reduction therapy.

Sources: [Bonin 2010](#), [Booth 2004](#), [Kraybill 2005](#), [Palepu 2011](#)

Outreach

“Outreach and engagement is the process of coming alongside of someone who is struggling with homelessness and related health and social concerns, and sharing the journey in a way that leads to healing, wholeness and stability in community. Outreach and engagement activities can be seen as a movement through four phases of relationship: approach, companionship, partnership, and mutuality.” – Craig Rennebohm, D.Min. ([Kraybill 2005](#))

- **Outreach workers** Recognize that social support is essential to successful treatment of opioid use disorders. *Use outreach workers in the community to facilitate initial engagement with and provide support to people at risk for opioid overdose.* Community health workers and case managers can facilitate treatment entry and retention of individuals who have not contemplated treatment before ([Booth 2004](#), [Palepu 2011](#)), stay in touch with clients by phone (if possible), meet with them in community shelters and transitional/permanent housing, and make sure they return for follow-up. Lack of engagement in treatment should not end outreach contacts; continue frequent contacts, which in themselves can be beneficial.
- **Outreach sites** *Consider all client interactions, inside or outside the clinic, as outreach opportunities to engage people experiencing homelessness* ([Bonin 2010](#)). Conduct outreach in locations where injection drug users are known to congregate – on the streets, in soup kitchens, shelters, transitional/ permanent supportive housing, and other places where homeless people receive services.
- **Group therapy** *Provide ongoing opportunities for group therapy to patients with opioid use disorders.*
12-Step groups (based on the AA/NA model): Participants are likely to focus on abstinence support and goals and longer-term recovery issues.

Harm reduction groups: Participants talk about the benefits of opiate replacement therapy, overdose risk, safer or reduced use of non-opiate drugs, and any non-drug related issues. (See pp. 45–48 and Appendix A for detailed information about harm reduction therapy.) Convening groups several times a week can provide an open forum for to discuss issues such as overdose risk. Encourage groups to continue discussions in shelter settings as well. (See pp. 48–49 for more information about peer support groups.)

- **Consumer involvement** *Do outreach in partnership with a consumer as much as possible.* Use of formerly homeless clients to join staff in outreach efforts can foster rapport with clients by reaching out to friends and sharing their own experience with treatment and recovery. Consumers should be paid or provided stipends for their service and should be included as members of the care planning team. There is very well-organized methadone advocacy training and peer recovery support available from the Medicated Assisted Recovery Services ([MARS](#)) Project.
- **Shelter-based treatment** *Provide buprenorphine maintenance treatment where patients live.* People residing in homeless shelters who are actively using opioids are at high risk for overdose. To help reduce alarmingly high mortality rates from opioid toxicity, the Boston Health Care for the Homeless Program (BHCHP) pioneered office-based buprenorphine/naloxone (Suboxone®) treatment in a shelter setting—the first such program in the country. DEA regulations made it difficult to get approval from the Boston Department of Public Health to initiate shelter-based Suboxone treatment. Eventually, BHCHP succeeded in obtaining a waiver from the DPH to administer Suboxone in a shelter clinic, with strict adherence to DEA regulations. The homeless clinic now gets referrals from shelter staff, and BHCHP staff report that mortality rates secondary to opioid overdose have decreased among their clients. Work with medical boards and public health departments to obtain approval to administer buprenorphine (Suboxone) treatment in shelter settings consistent with DEA regulations. Be aware that it is essential to go through appropriate government channels in instituting treatment programs at unconventional sites to avoid losing prescribing authorization/medical licensure.

OUTREACH STRATEGIES

- **Connect with people experiencing homelessness:** Go with a person who is known in the area; utilize active/reflective listening; make eye contact; look for indications of drug use. Provide basic hygiene items, mittens, hats, backpack, information about where services are available. Keep coming back; trust is developed through consistency and respect.
- **Work with other agencies** including harm reduction centers. Provide space for 12-Step and other peer support programs.
- **Dos & Don'ts:** Wear casual clothing, not suits. Take cell phone for safety. Don't take calls, text, or use PDA/ computer while listening to people experiencing homelessness, who may already feel intimidated and ignored.

Engagement

- **Clinical team** *Involve all members of the clinical team in care planning and coordination to facilitate engagement.* Use outreach workers and case managers to promote initial engagement with the patient. The clinical team should include people who have experienced homelessness. Hire culturally competent staff who look and talk like the populations served or use an interpreter. ([Bonin 2010](#))
- **Therapeutic relationship** Nonjudgmental and supportive patient interactions with members of the clinical team are essential for successful engagement in a therapeutic relationship. *Recognize that caring for homeless patients is as much about building relationships as about clinical expertise.* Essential to building and maintaining trusting relationships with individuals who are homeless is person-centered, trauma-informed, recovery-oriented care ([Morrison 2007](#)).⁶ *Recognize that recovery is not a linear process, and that relapse is part of the cycle of behavioral change.* ([Bonin 2010](#))
- **Incentives** *Use incentives to promote engagement and treatment entry.* ([Bonin 2010](#), [Booth 2004](#), [SAMHSA 2013 TIP 55](#))
Examples:
 1. Provide food and drink/ meal vouchers, hygiene products (toothbrush, toothpaste, soap, shampoo)/ clothing appropriate to the weather (socks, sneakers, hat, gloves).
 2. Providing condoms, safe sex literature, and safe drug use materials is a key step in engaging drug users in a conversation while meeting their basic needs. Syringes and other injection equipment, safer crack-smoking kits, condoms and other harm reduction supplies are highly desired by people who are using, and convey to the person that you are able to discuss drug use with them.
 3. Use foot baths to alleviate anxiety and increase comfort level.
 4. Hand out subway/bus cards or tokens to facilitate transportation to and from the clinic.
 5. Provide peer mentoring and linkage to housing opportunities and other resources.

⁶ **Person-centered care** emphasizes a partnership between care providers and recipients that encourages full participation of the patient, drawing on his/her strengths and inner resources, and promotes patient choice and self-determination. The care recipient determines the focus and pace of treatment, and defines outcomes based on his/her capacities and available supports.

Trauma-informed care assumes that homelessness is a traumatic experience, which for many homeless people is compounded by serious medical and behavioral health problems and/or histories of abuse and neglect from which they still suffer.

Recovery-oriented care fosters the process of recovery — healing and recuperation from illness or a medical procedure; restoration or retention of functioning; progress toward gaining or maintaining abstinence from the use of addictive substances; regaining a sense of safety, control, connection, and meaning following trauma; becoming stably housed and restoring one's sense of purpose and a meaningful place in the community.

STANDARDS OF CARE

Major Recommendations:

- **Adapt clinical practices to optimize care for patients who are homeless or at risk of becoming homeless considering the recommendations contained in this guide.**
- **Offer medication-assisted treatment to any patient with an opioid use disorder.**
- **Address acute and chronic medical problems related to drug use.**
- **Offer naloxone to patients with an opioid use disorder and offer needle exchange to injecting drug users, to the extent permitted by law and available resources.**
- **Advocate for improved access for homeless and other underserved populations to a broader range of interventions for the management of opioid use disorders.**

Rationale: Employ the same standards of care for patients who are homeless as for those with more resources – based on scientific evidence, expert opinion, and recommendations of practitioners with extensive experience working with homeless people. Involving direct service providers and patients in advocacy adds credibility to the positions presented, helps counteract staff burn-out, and can facilitate the recovery process.

Evidence: Recommendations are based on expert consensus of practitioners experienced in homeless health care with expertise in primary care, addiction medicine, psychiatry, and harm reduction therapy.

Sources: [FSMB 2013](#), [Baggett 2013](#), [Wismer 2011](#)

- **Clinical standards** *Employ the same standards of care for patients who are homeless as for other patients* – based on scientific evidence, expert opinion, and recommendations of health care professionals. *Adapt clinical practices to optimize care for patients who are homeless or at risk of becoming homeless, considering the recommendations contained in this guide.*
- **Consumer involvement** Active involvement of patients in their own care is warranted as a basic principle of human rights – people should be involved in making decisions that affect their lives.
- **Prescription of controlled substances** DEA regulates the prescription of controlled substances. States differ in medical and pharmacy laws. Many states require second opinions, patient-provider agreements, urine drug tests, etc., of clinical practices that prescribe buprenorphine for treatment of severe opioid use disorder. Check with your state medical, nursing, and pharmacy boards; refer to the [Model Policy for Use of Controlled Substances in the Treatment of Opioid Addiction](#) in the medical office by the Federation of State Medical Board: Note: Treatment provided by office-based physicians is included in state prescription databases; however, due to federal substance abuse confidentiality laws (42 CFR Part 2), drugs prescribed at an OTP/NTP are not.
- **Licensure** Many states license acupuncturists, and those that do not may have rules or regulations. State certification requirements are available at: www.acupuncture.com/statelaws/statelaw.htm. To learn about training opportunities, consult the [National Acupuncture Detoxification Association](#).
- **Advocacy** *Integrate service with advocacy to improve access for homeless people to a broader range of interventions for the management of opioid use disorders and address the structural causes of homelessness.* Advocacy is the educational process through which data, experiences, and insight are shared with those who craft public policy so that they may make informed decisions. Its aim is to educate policymakers about homelessness so that myths and stereotypes can give way to better-informed

decision-making and resource allocation. Involving direct service providers and recipients in advocacy adds credibility to the positions presented, helps counteract staff burn-out, and can facilitate patients' recovery process. Encourage involvement in homeless advocacy groups at the national, state, and local levels.

Consider advocating for:

- Increased resources for provider licensure, licensing/approval of unconventional sites, and greater patient access to licensed prescribers for office-based treatment of opioid dependence.
- Standardized Medicare and Medicaid coverage for medication-assisted treatment in every state.
- Criminal justice diversion to treatment for opioid-dependent offenders and approval of treatment models that employ a Harm Reduction approach to care.
- Progressive state medical and pharmacy laws/regulations that are more consistent nationally.

CASE STUDY: TREATMENT SELECTION FOR PATIENTS WITH OPIOID USE DISORDER

History: Mr. K is a 30 y/o man who presents stating "I will die soon the way things are going." He reports he has been using heroin for over 10 years and now injects in his jugular vein because his other veins are "trashed." He has been told he has hepatitis C but does not know what stage. He was involved in a serious MVA 7 yrs ago with neck fracture requiring neurosurgery. He reports some neck stiffness and loss of range of motion. His family history is significant for "many functioning alcoholics." At one time he was very successful as a heroin dealer but now he fears the violence on the streets is so severe that he is at risk of being killed. He lives with his girlfriend who also uses heroin and rents an SRO room when he can afford it. Otherwise he couch surfs or stays on the streets. He has tried methadone and states "it worked, it could have worked better but I wasn't done, I was dealing heroin at the same time and using on top of it." His usual dose was 70mg or less and this did prevent feelings of withdrawal and craving. He drinks "2-3 beers per week" but usually only when he is waiting to get heroin and states alcohol "is never a problem." He does not use other drugs. He recently had 7 mo clean living with a relative in a rural area but states "I always seem to want to mess up when things are going good."

Physical exam: Many old tracks and scars, Recent tracks in neck with some redness, Alert and oriented, Full PE deferred

Patients stated goals: "I want to get my s--t together for real for real," take better care of self, take care of hep C, better diet - eat good foods, exercise, individual counseling, couples counseling, stop using heroin, get my own place, get a normal job

Decisions for Mr. K:

Would he benefit from treatment?

Does he require Medication Assisted Treatment?

Does he require "detox" or maintenance treatment?

What are the possible benefits buprenorphine maintenance?

What are the possible harms of buprenorphine maintenance?

What are the possible benefits of methadone maintenance?

What are the possible harms of methadone maintenance?

What are the possible benefits of non medication assisted treatment?

What are the possible harms of non-medication assisted treatment?

What are the likely challenges to success?

Does he have any contraindications to buprenorphine or methadone treatment?

Can we treat him in an outpatient setting with limited resources?

Can we treat him in a healthcare for the homeless setting?

Treatment & Outcome: Mr. K and his girl friend were simultaneously started on Suboxone. They have both abstained from opioids for over 5 years. Mr. K struggles with anxiety and panic and binge drinks when these feelings are overwhelming. He has successfully apprenticed in a trade and is working. He is housed with his girl friend who became pregnant 18 mos after starting buprenorphine. She chose to continue Subutex throughout the pregnancy and she had a normal labor and delivery. Their son was discharged on hospital day #3 and is doing well.

Barry Zevin, MD, Tom Waddell Health Center,
San Francisco Department of Public Health, San Francisco, California (2013)

CASE STUDY: COUNTERING MYTHS ABOUT METHADONE MAINTENANCE TREATMENT

A 50 year old man presents to the HCH drop-in urgent care clinic requesting a refill of blood pressure medication. He reports he has recently gotten out of prison and ran out of medication he had been prescribed. He gives a history of hypertension. He complains of a chronic cough that he attributes to smoking cigarettes.

He is dressed in long sleeves and appears hesitant to take off his shirt to be examined. Overall he appears to be anxious and somewhat hypervigilant. When asked directly about his mental health he reports he has "psychotic reactions" from using cocaine and speed at times. When asked about his current drug use he states he is muscling about a gram of heroin a day and occasionally smoking crack. He reports using clonazepam when he can't get heroin or when he starts to feel "overamped."

You refill his blood pressure medication (avoiding clonidine or beta blockers which could be problems considering his substance use.) You ask him if it would be okay to talk more about his drug use and possible treatment. He reports he was on methadone in the past and this kept him from using heroin. He stopped when he was incarcerated and had severe withdrawal because they did not give methadone or treat drug withdrawal in prison. He would like to stop heroin before his habit gets bigger and he lands back in prison or overdoses like a buddy of his recently did. He does not want to start methadone again because he sees the old timers in the methadone clinic are usually "bent over, limping and broken down."

You explain that it is true that many people on methadone maintenance have had a lifetime of injuries and often didn't get proper medical care that has resulted in their conditions. He easily relates to this. You also explain that there is no direct effect of methadone on bones and that it is a common myth that methadone eats up your bones. You explain that heroin and methadone have been associated with low testosterone and low vitamin D (explaining that vitamin D depends on plenty of exposure to the sun on exposed skin, which is something that many heroin users don't get). You tell him that you monitor testosterone and vitamin D levels for your patients on methadone to prevent these problems. He appears grateful for this information and states he knows the locations of the local methadone programs that accept Medi-Cal. He knows the location of the local syringe exchange and has gotten overdose prevention education and naloxone there. As the patient leaves you feel very uncertain whether you have helped him. You wonder if you should have raised the issue of buprenorphine but you know bupe prescribers in your community are very hesitant to prescribe to polysubstance users, especially if they use benzodiazepines.

He returns to urgent care 3 months later with cold symptoms. He is profusely grateful to you for your advice and states he has been on methadone for about 3 months. His dose is now 110 mg which he feels holds him. He appears less anxious. He is considering entering a residential program for his other drug use. He is clear that when he has gotten clean in the past he always craved heroin first and then the other drugs followed. He thinks things might be different if he does a program and stays on methadone maintenance. He also reports he has told all his friends about the testosterone and vitamin D thing. He is amenable to seeing you in primary care because "you're cool."

Barry Zevin, MD, Tom Waddell Health Center,
San Francisco Department of Public Health, San Francisco, California (2014)

Sources & Resources

PRIMARY SOURCES

Accessed 2/2/2014

- Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). TIP 55: *Behavioral Health Services for People Who Are Homeless*. <http://store.samhsa.gov/shin/content//SMA13-4734/SMA13-4734.pdf>; TIP 55 Literature Review: http://store.samhsa.gov/shin/content//SMA13-4734/SMA13-4734_Literature.pdf
- Department of Veterans Affairs, Department of Defense (VA/DoD). (2009). Clinical Practice Guidelines for the Management of Substance Use Disorders (SUD). www.healthquality.va.gov/sud/sud_full_601f.pdf
- Handford C, Kahan M, Srivastava A, Cirone S, Sanghera S, Palda V, Lester MD, Janeczek E, Franklyn M, Cord M, Selby P, Ordean A. (2011). Buprenorphine/naloxone for opioid dependence: Clinical practice guideline. Toronto (ON): Centre for Addiction and Mental Health (CAMH). 145 p. NGC:009542 www.guideline.gov/content.aspx?id=39351; knowledgex.camh.net/primary_care/guidelines_materials/Documents/buprenorphine_naloxone_gdlns2012.pdf
- Wisner B, Amann T, Diaz R, Eisen D, Elder N, Ho C, Hwang S, Johnston M, Joslyn M, Kertesz S, Kushel M, Preston C, Solotoroff R, Thompson L, Silva F, Smith S, Zevin B, Meinbresse M, Post P, editor(s). (2011). *Adapting your Practice: Recommendations for the Care of Homeless Adults with Chronic Non-malignant Pain*. Nashville (TN): Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. 119 p. www.guideline.gov/content.aspx?id=34273; www.nhchc.org/wp-content/uploads/2011/09/ChronicPainManagement.pdf

REFERENCES ON HOMELESS/ UNDERSERVED POPULATIONS

Accessed 2/2/2014

- Alford DP, LaBelle CT, Richardson JM, O'Connell JJ, Hohl CA, Cheng DM, Samet JH. (2007 Feb). Treating homeless opioid dependent patients with buprenorphine in an office-based setting; *J Gen Intern Med*. 22(2): 171–176. www.ncbi.nlm.nih.gov/pmc/articles/PMC1824722/
- Altice FL, Bruce RD, Lucas GM, Lum PJ, Korthuis PT, Flanigan TP, Cunningham CO, Sullivan LE, Vergara-Rodriguez P, Fiellin DA, Cajina A, Botsko M, Nandi V, Gourevitch MN, Finkelstein R; BHIVES Collaborative. (2011, Mar). HIV treatment outcomes among HIV-infected, opioid-dependent patients receiving buprenorphine/naloxone treatment within HIV clinical care settings: results from a multisite study. *J Acquir Immune Defic Syndr*; 1(56) Suppl 1:S22–32. www.ncbi.nlm.nih.gov/pmc/articles/PMC3263431/
- Appel PW, Tsemberis S, Joseph H, Stefancic A, Lambert-Wacey D. (2012). Housing First for severely mentally ill homeless methadone patients. *J Addict Dis*. 2012;31(3):270–7. www.ncbi.nlm.nih.gov/pubmed/22873188
- Baggett TP, Hwang SW, O'Connell JJ, Porneala BC, Stringfellow EJ, Orav EJ, Singer DE, MD; Rigotti NA. (2013 Mar). Mortality among homeless adults in Boston: Shifts in causes of death over a 15-year period. *JAMA Intern Med*. 2013;173(3):189–195. <http://archinte.jamanetwork.com/article.aspx?articleid=1556797>

- Bonin E, Brehove T, Carlson C, Downing M, Hoeft J, Kalinowski A, Solomon-Bame J, Post P. (2010). *Adapting Your Practice: General Recommendations for the Care of Homeless Patients*, 50 p. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. www.nhchc.org/wp-content/uploads/2011/09/GenRecsHomeless2010.pdf
- Booth RE, Corsi KF, Mikulich-Gilbertson SK. (2004). Factors associated with methadone maintenance treatment retention among street-recruited injection drug users. *Drug and Alcohol Dependence* 74: 177–185. www.oatc.ca/wp-content/uploads/2013/04/Factors.associated.with_.methadone.maintenance.treatment.retention.pdf
- Carlson T, Thompson L, Waldmann C, Post P. (2008). Traumatic brain injury in a homeless male. HCH Clinicians' Network. *Homeless Health Care Case Report*, 4(1): 1–10. www.nhchc.org/wp-content/uploads/2011/10/TBICaseRpt031008.pdf
- Corsi KF, Kwiatkowski CF, Booth RE. (2007 Jan). Treatment entry and predictors among opiate-using injection drug users. *Am J Drug Alcohol Abuse*;33(1):121–7. www.ncbi.nlm.nih.gov/pubmed/17366252
- Dasgupta N, Sanford C, Albert S, Brason F. (2009 Oct). Opioid Drug Overdoses: A Prescription for Harm and Potential for Prevention. *American Journal of Lifestyle Medicine*; 4(1):32–37. <http://prescribetoprevent.org/wp-content/uploads/2012/11/amjlm2009dasgupta.pdf>
- Doe-Simkins M, Walley AY, Epstein A, Peter Moyer P. (2009 May). Saved by the nose: Bystander-administered intranasal naloxone hydrochloride for opioid overdose. *Am J Public Health*; 99(5): 788–791. www.ncbi.nlm.nih.gov/pmc/articles/PMC2667836/#_ffn_sectitle
- Doe-Simkins M. (2013 Jul). Opportunities for opioid safety and community-based overdose management. Presentation, National Health Care for the Homeless Council Midwest Regional Training, Chicago, IL - July, 2013. www.youtube.com/watch%3Fv%3DgfXBM1Gim6Y
- Friedmann PD, Mello D, Lonergan S, Bourgault C, O'Toole TP. (2013 Apr-Jun). Aversion to injection limits acceptability of extended-release naltrexone among homeless, alcohol-dependent patients. *Subst Abuse*;34(2):94–6. www.ncbi.nlm.nih.gov/pubmed/23577900
- Goyer CF. (2011). *Key Elements of Integrated Care for Persons Experiencing Homelessness: A Guide for Health Care for the Homeless Providers*. National Health Care for the Homeless Council. www.nhchc.org/wp-content/uploads/2011/10/Key-Elements-of-Integrated-Care.pdf
- Health Care for the Homeless (HCH) Clinicians' Network. (2000 Jun). Eliciting behavioral change: Tools for HCH clinicians; *Healing Hands*; 4(3):1–4. www.nhchc.org/wp-content/uploads/2012/02/hh.06_00.pdf
- HCH Clinicians' Network. (2006 Oct). Addiction on the streets: Clinical interventions; *Healing Hands* 10(4):1–6. www.nhchc.org/wp-content/uploads/2012/02/Oct2006HealingHands.pdf
- HCH Clinicians' Network. (2009 Jan). Meeting the challenges of co-morbid mental illness & substance-related disorders; *Healing Hands* 13(1):1–6. www.nhchc.org/wp-content/uploads/2011/09/Feb09HealingHands.pdf
- HCH Clinicians' Network. (2014 Winter). Tuberculosis: A persistent threat to public health. *Healing Hands*;18(1):1–8. www.nhchc.org/wpcontent/uploads/2014/01/winter2014healinghands.pdf

- Herinckx H. (2008). *Criminal Activity and Substance Abuse Study, Central City Concern: Mentor and ADFC Housing Programs*. Regional Research Institute for Human Services, Portland State University, in collaborations with Central City Concern, Portland, OR.
https://www.rri.pdx.edu/files/585/ccc_criminalactivity_substanceabuse_2008.pdf
- Herinckx H. (2010). Central City Concerned Supported Employment Programs. Regional Research Institute for Human Services, Portland State University.
<http://www.centralcityconcern.org/LiteratureRetrieve.aspx?ID=89434>
- Henwood BF, Padgett DK, Tiderington E. (2013 Feb). Provider views of harm reduction versus abstinence policies within homeless services for dually diagnosed adults. *J Behav Health Serv Res*. 2013 Feb 13. [Epub ahead of print] www.ncbi.nlm.nih.gov/pubmed/23404076
- Hersh D, Little SL, Gleghorn A. (2011 Apr-Jun). Integrating buprenorphine treatment into a public healthcare system: The San Francisco Department of Public Health's office-based Buprenorphine Pilot Program. *J Psychoactive Drugs*; 43(2):136–45.
www.ncbi.nlm.nih.gov/pubmed/21858959
- Hickerta AO & Taylor MJ. (2011 Feb). Supportive housing for addicted, incarcerated homeless adults. *Journal of Social Service Research*; 37(2), 136–151.
www.tandfonline.com/doi/abs/10.1080/01488376.2011.547449#.UexJ6m3ByOx
- Highley JL. (2008). *Traumatic Brain Injury among Homeless Persons: Etiology, Prevalence and Severity* (B.J. Proffitt, Ed.). Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. http://www.nhchc.org/wp-content/uploads/2011/12/TBIAmongHomelessPersons_2008.pdf
- Hwang SW, Kirst MJ, Chiu S, Tolomiczenko G, Kiss A, Cowan L, Levinson W. (2009 Sep). Multidimensional social support and the health of homeless individuals. *J Urban Health*; 86(5): 791–803. www.ncbi.nlm.nih.gov/pmc/articles/PMC2729873/
- Hwang SW, Colatonia A, Chiu S, Tolomiczenko G, Kiss A, Cowan L, Redelmeier DA, Levinson W. (2008). The effect of traumatic brain injury on the health of homeless people. *CMAJ* 2008; 179(8): 779–84. www.cmaj.ca/content/179/8/779.full.pdf
- Johnstone H, Marcinak J, Luckett M, Scott J. (1994). An evaluation of the treatment effectiveness of the Chicago Health Outreach Acupuncture Clinic. *Journal of Holistic Nursing*, 12(2):171–83. Abstract: www.ncbi.nlm.nih.gov/pubmed/8195574
- Kertesz SG, Crouch K, Milby JB, Cusimano RE, Schumacher JE. Housing First for homeless persons with active addiction: Are we overreaching? (2009 Feb). *Journal of Behavioral Health Services and Research*; 87(2):495–534.
www.ncbi.nlm.nih.gov/pmc/articles/PMC2881444/
- Kertesz SG, Horton NJ, Friedmann PD, Saitz R, Samet JH. (2003). Slowing the revolving door: Stabilization programs reduce homeless persons' substance use after detoxification. *J Subst Abuse Treat*; 24:197–207. www.ncbi.nlm.nih.gov/pubmed/12810140
- Khoury L, Tang YL, Bradley B, Cubells JF, Ressler KJ. (2010 Dec). Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depress Anxiety*; 27(12):1077–86.

- Kraybill K & Zerger S. (2003). *Providing Treatment for Homeless People with Substance Use Disorders: Case Studies of Six Programs*. National Health Care for the Homeless Council. 46 p.
www.nhchc.org/wp-content/uploads/2012/02/CA05RCasestudies-FINAL5.pdf
- Krull I, Lundgren L, Zerden Lde S. (2011 Oct). Attitudes toward evidence-based pharmacological treatments among community-based addiction treatment programs targeting vulnerable patient groups. *J Addict Dis*;30(4):323–33. www.ncbi.nlm.nih.gov/pubmed/22026524
- Kushel MB, Evans JL, Perry S, Robertson MJ, Moss AR. (2003 Nov). No door to lock: Victimization among homeless and marginally housed persons. *Arch Intern Med*;163(20):2492–99.
<http://archinte.jamanetwork.com/article.aspx?articleid=216287>
- Lundgren LM, Sullivan LM, Maina AW, Schilling RF. (2007 Mar). Client factors associated with length of stay in methadone treatment among heroin users who inject drugs: quantitative analysis of state-level substance abuse treatment utilization data. *J Addict Med*;1(1):26–32.
www.ncbi.nlm.nih.gov/pubmed/21768929
- Malone S. (2013 Jan). Drug overdoses top AIDS as main cause of death in US homeless; *Reuters Health Information*; January 14, 2013.
www.reuters.com/article/2013/01/14/us-usa-health-homeless-idUSBRE90D14C20130114
- Morrison S. (2007). *Self Management Support: Helping Clients Set Goals To Improve Their Health*. National Health Care for the Homeless Council.
www.nhchc.org/wp-content/uploads/2011/09/SelfManagementSupport052907.pdf
- National Center on Addiction and Substance Abuse at Columbia University [CASA Columbia Study]. (2012). *Addiction Medicine: Closing the Gap between Science and Practice*. 586 p.
www.casacolumbia.org/addiction-research/reports/addiction-medicine
- National Health Care for the Homeless Council. (2010). Fact Sheet: Harm Reduction: Preparing People for Change. http://nhchc-old.parthenonpub.com/harmreductionfactsheet_Apr10.pdf
- National Institute on Drug Abuse. (2013 Jan). *Overdose Deaths Among Homeless Persons*.
www.drugabuse.gov/about-nida/directors-page/messages-director/2013/01/overdose-deaths-among-homeless-persons#messagesfromdirector-block_3-2
- Palepu A, Milloy MJ, Kerr T, Zhang R, Wood E. (2011 Jun). Homelessness and adherence to antiretroviral therapy among a cohort of HIV-infected injection drug users. *J Urban Health*;88(3):545–55.
www.ncbi.nlm.nih.gov/pmc/articles/PMC3126933/pdf/11524_2011_Article_9562.pdf
- Palepu A, Marshall BD, Lai C, Wood E, Kerr T. (2010 Jul). Addiction treatment and stable housing among a cohort of injection drug users. *PLoS One*. 2010; 5(7): e11697.
www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0011697
- Perlman J & Parvensky J. (2006). *Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report*. Colorado Coalition for the Homeless, December 11, 2006.
www.mhtrust.org/layouts/mhtrust/files/documents/focus_affordablehousing/HousingFirst-DenverCostStudy.pdf

- Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. (2009 May). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. *JAMA*;301(17):1771-8.
<http://www.ncbi.nlm.nih.gov/pubmed/19417194>
- Stancliff S, Joseph H, Fong C, Furst T, Comer SD, Roux P. (2012 Mar). Opioid maintenance treatment as a harm reduction tool for opioid-dependent individuals in New York City: the need to expand access to buprenorphine/naloxone in marginalized populations. *J Addict Dis*; 31(3):278-87. Free PMC Article <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3620719/>
- SAMHSA, Center for Behavioral Health Statistics and Quality. (2012 Jul 31). *The TEDS Report: A Comparison of Rural and Urban Substance Abuse Treatment Admissions*. Rockville, MD.
www.samhsa.gov/data/2k12/TEDS_043/TEDSShortReport043UrbanRuralAdmissions2012.htm
- SAMHSA. (2011). Treatment Episode Data Set (TEDS). 1999 - 2009. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-56, HHS Publication No. (SMA) 11-4646, Rockville, MD www.samhsa.gov/data/DASIS/teds09/teds2k9nweb.pdf
- Tidderington E, Stanhope V, Henwood BF. (2013 Jan). A qualitative analysis of case managers' use of harm reduction in practice. *J Subst Abuse Treat*;44(1):71-7.
www.ncbi.nlm.nih.gov/pubmed/22520277
- Walley AY, Doe-Simkins M, Quinn E, Pierce C, Xuan Z. (2013 Feb). Opioid overdose prevention with intranasal naloxone among people who take methadone. *J Subst Abuse Treat*;44(2):241-47.
www.journalofsubstanceabusetreatment.com/article/S0740-5472%2812%2900121-3/abstract
- Westermeyer J, Lee K. (2013 Jul). Residential placement for veterans with addiction: American Society of Addiction Medicine criteria vs. a veterans homeless program. *J Nerv Ment Dis*;201(7):567-71.
www.ncbi.nlm.nih.gov/pubmed/23817153
- Wright NM, Tompkins CN. (2006 Apr). How can health services effectively meet the health needs of homeless people? *The British Journal of General Practice*; 56(525):286-293.
www.ncbi.nlm.nih.gov/pmc/articles/PMC1832238/
- Zerger S. (2002). *Substance Abuse Treatment: What Works for Homeless Individuals? A Review of the Literature*. National Health Care for the Homeless Council, Inc. 62 p.
www.nhchc.org/wp-content/uploads/2012/02/SubstanceAbuseTreatmentLitReview.pdf

OTHER REFERENCES (organized by topic)

Diagnostic Criteria

- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing. <http://www.dsm5.org/Pages/Default.aspx>
- Weissman DE & Haddox JD. (1989 Mar). Opioid pseudoaddiction—an iatrogenic syndrome. *Pain*;36(3):363–6. www.ncbi.nlm.nih.gov/pubmed/2710565

Practice Guidelines

- American College of Obstetricians and Gynecologists (ACOG). (2012 May). Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion Number 524. www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Opioid_Abuse_Dependence_and_Addiction_in_Pregnancy
- Center for Substance Abuse Treatment (CSAT). (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders*. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration. www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf
- CSAT. (2004). Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration. http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf
- World Health Organization (WHO). (2009). *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*. www.ncbi.nlm.nih.gov/books/NBK143185/

Epidemiological data

- SAMHSA. (2012 Sep). *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. www.samhsa.gov/data/nsduh/2k11results/nsduhresults2011.htm#1.1

Medication-Assisted Treatment of Opioid Use Disorder

- Alford DP, LaBelle CT, Kretsch N, Bergeron A, Winter M, Botticelli M, Samet JH. (2011 Mar). Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. *Arch Intern Med*;171(5):425–31. www.ncbi.nlm.nih.gov/pmc/articles/PMC3059544/
- American Society of Addiction Medicine (ASAM). (2013). *Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment*. www.asam.org/docs/advocacy/implications-for-opioid-addiction-treatment
- Antoniou T & Tseng A. (2012 Aug). Antiretroviral-Methadone Interactions (table). www.hivclinic.ca/main/drugs_interact_files/methadone-int.pdf
- Ball JC, Ross A. (1991). *The Effectiveness of Methadone Maintenance Treatment*. New York: Springer-Verlag. http://books.google.com/books/about/The_Effectiveness_of_Methadone_Maintenan.html?id=zCZsAA_AAMAAJ

- Bart G. (2012 Jul). Maintenance medication for opiate addiction: The foundation of recovery. *J Addict Dis*; 31(3): 207–225. www.ncbi.nlm.nih.gov/pmc/articles/PMC3411273/
- Buckley DI, Calvert JF, Lapidus JA, Morris CD. (2010 May-Jun). Chronic opioid therapy and preventive services in rural primary care: An Oregon rural practice-based research network study. *Ann Fam Med*;8(3):237–44. www.ncbi.nlm.nih.gov/pubmed/20458107
- Carroll KM, Ball SA, Nich C, O'Connor PG, Eagan DA, Frankforter TL, Triffleman EG, Shi J, Rounsaville BJ. (2001 Aug). Targeting behavioral therapies to enhance naltrexone treatment of opioid dependence: Efficacy of contingency management and significant other involvement. *Arch Gen Psychiatry*;58(8):755–61. www.ncbi.nlm.nih.gov/pmc/articles/PMC3651594/
- Chalk M, Alanis-Hirsch K, Woodworth A, Kemp J, McLellan AT. (2013). Report III: FDA approved medications for the treatment of opiate dependence: Literature reviews on effectiveness & cost-effectiveness. Treatment Research Institute (TRI). In: American Society of Addiction Medicine (ASAM). (2013). *Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment*, 115–221. www.asam.org/docs/advocacy/implications-for-opioid-addiction-treatment
- DeFulio A, Everly JJ, Leoutsakos JS, Umbricht A, Fingerhood M, Bigelow GE, Silverman K. Employment-based reinforcement of adherence to an FDA approved extended release formulation of naltrexone in opioid-dependent adults: A randomized controlled trial. *Drug Alcohol Depend*;120(1–3):48–54. www.ncbi.nlm.nih.gov/pubmed/21782353
- Everly JJ, DeFulio A, Koffarnus MN, Leoutsakos JM, Donlin WD, Aklin WM, Umbricht A, Fingerhood M, Bigelow GE, Silverman K.. (2011 Jul). Employment-based reinforcement of adherence to depot naltrexone in unemployed opioid-dependent adults: a randomized controlled trial. *Addiction*;106(7):1309–18. www.ncbi.nlm.nih.gov/pubmed/21320227
- Federation of State Medical Boards. (2013 Aug). *Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office*. www.fsmb.org/pdf/2013_model_policy_treatment_opioid_addiction.pdf
- Fiellin DA, Barry DT, Sullivan LE, Cutter CJ, Moore BA, O'Connor PG, Schottenfeld RS. (2013 Jan). A randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. *Am J Med*;126(1):74.e11–7. www.ncbi.nlm.nih.gov/pubmed/23260506
- Fiellin DA, O'Connor PG, Chawarski M, Pakes JP, Pantalon MV, Schottenfeld RS. (2001 Oct). Methadone maintenance in primary care: a randomized controlled trial. *JAMA*;286(14):1724–31. www.ncbi.nlm.nih.gov/pubmed/11594897
- Foisy M & Tseng A. (2013 Aug). Interactions Between Opioids and Antiretrovirals (table). www.hivclinic.ca/main/drugs_interact_files/narc-int.pdf
- Gjersing L & Bretteville-Jensen AL. (2013). Is opioid substitution treatment beneficial if injecting behaviour continues? *Drug Alcohol Depend* [in press] www.ncbi.nlm.nih.gov/pubmed/23773951
- Health Resources and Services Administration (HRSA). (2004). Use of Buprenorphine in Health Center Substance Abuse Treatment Programs. *Program Assistance Letter (PAL) 2004-01*. [ftp://ftp.hrsa.gov/bphc/docs/2004pals/2004-01.PDF](http://ftp.hrsa.gov/bphc/docs/2004pals/2004-01.PDF)

- Jerry JM & Collins GB. (2013 Jun). Medication-assisted treatment of opiate dependence is gaining favor. *Cleveland Clinic Journal of Medicine*; 80(6): 345–349.
www.ccm.org/content/80/6/345.full.pdf
- Kakko J, Svanborg KD, Kreek MJ, Heilig M. (2003 Feb 22). 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. *Lancet*; 361(9358):662–8.
www.ncbi.nlm.nih.gov/pubmed/?term=Kakko%2C+buprenorphine+versus+placebo#
- Kidorf M, Brooner RK, Gandotra N, Antoine D, King VL, Peirce J, Ghazarian S. (2013 Jul 15). Reinforcing integrated psychiatric service attendance in an opioid-agonist program: A randomized and controlled trial. doi:pii: S0376-8716(13)00224-X. 10.1016/j.drugalcdep.2013.06.005. [Epub ahead of print]
www.ncbi.nlm.nih.gov/pubmed/23866988
- Kleber HD. (2007 Dec). Pharmacologic treatments for opioid dependence: detoxification and maintenance options. *Dialogues Clin Neurosci*; 9(4): 455–470.
www.ncbi.nlm.nih.gov/pmc/articles/PMC3202507/
- Krupitsky E, Nunes EV, Ling W, Illeperuma A, Gastfriend DR, Silverman BL. (2011 Apr). Injectable extended-release naltrexone for opioid dependence: A double-blind, placebo-controlled, multicentre randomised trial. *The Lancet*; 377:1506–13.
www.diakonie-rlw.de/materialien/suchtfinfo/7.2011/NaltrexonDepotinjektion.pdf
- Marsden J, Eastwood B, Bradbury C, Dale-Perera A, Farrell M, et al. (2009). Effectiveness of community treatments for heroin and crack cocaine addiction in England: A prospective, in-treatment cohort study. *Lancet*; 374:1262–70. www.ncbi.nlm.nih.gov/pubmed/19800681
- Mattick RP, Breen C, Kimber J, Davoli M. (2009). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database Syst Rev*. 2009;(2):CD002209.
www.ncbi.nlm.nih.gov/pubmed/12804430
- McCarty D, Rieckmann T, Green C, Gallon S, Knudsen J. (2004 Apr). Training rural practitioners to use buprenorphine: Using The Change Book to facilitate technology transfer. *J Subst Abuse Treat*; 26(3):203–8. www.ncbi.nlm.nih.gov/pubmed/15063914
- McLellan AT, Arndt IO, Metzger DS, Woody GE, O'Brien CP. (1993 Apr). The effects of psychosocial services in substance abuse treatment. *JAMA*; 269(15):1953–9.
www.ncbi.nlm.nih.gov/pubmed/8385230
- Minozzi S, Amato L, Vecchi S, Davoli M, Kirchmayer U, Verster A. (2011). Oral naltrexone maintenance treatment for opioid dependence (Review). The Cochrane Library 2011, Issue 4.
<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001333.pub4/pdf/abstract>
- Murphy SM, Fishman PA, McPherson S, Dyck DG, Roll JR. (2014 Mar). Determinants of buprenorphine treatment for opioid dependence. *Journal of Substance Abuse Treatment*; 46(3): 315–319. www.ncbi.nlm.nih.gov/pubmed/24209382
- National Institute on Drug Abuse (NIDA). (2012 Apr). Topics in Brief: Medication-Assisted Treatment for Opioid Addiction. www.drugabuse.gov/publications/topics-in-brief/medication-assisted-treatment-opioid-addiction

- Nava F, Manzato E, Leonardi C, Lucchini A. (2008 Dec). Opioid maintenance therapy suppresses alcohol intake in heroin addicts with alcohol dependence: Preliminary results of an open randomized study. *Prog Neuropsychopharmacol Biol Psychiatry*;32(8):1867–72. www.ncbi.nlm.nih.gov/pubmed/18801404
- Nunn A, Zaller N, Dickman S, Nijhawan A, Rich JD. (2010 Jul). Improving access to opiate addiction treatment for prisoners. *Addiction*; 105(7): 1312–1313. www.ncbi.nlm.nih.gov/pmc/articles/PMC3081614/
- Office of National Drug Control Policy (ONDCP), Executive Office of the President. (2012 Sep). Medication-Assisted Treatment for Opioid Addiction: Healthcare Brief www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf
- Parran TV, Adelman CA, Merkin B, Pagano ME, Defranco R, Ionescu RA, Mace AG. (2010 Jan 1). Long-term outcomes of office-based buprenorphine/naloxone maintenance therapy. *Drug Alcohol Depend*;106(1):56–60. www.ncbi.nlm.nih.gov/pubmed/19717249
- Preda E & Dunayevich E (Eds). (2013 Sep). *Opioid Abuse Treatment & Management*; Medscape (Medline). <http://emedicine.medscape.com/article/287790-treatment>
- Quest TL, Merrill JO, Roll J, Saxon AJ, Rosenblatt RA. (2012 Jan-Feb). Buprenorphine therapy for opioid addiction in rural Washington: the experience of the early adopters. *J Opioid Manag*;8(1):29–38. www.ncbi.nlm.nih.gov/pubmed/22479882
- Rieckmann TR, Kovas AE, McFarland BH, Abraham AJ. (2011 Dec). Counselor attitudes toward the use of buprenorphine in substance abuse treatment: A multi-level modeling approach. *J Subst Abuse Treat*; 41(4): 374–385. www.ncbi.nlm.nih.gov/pmc/articles/PMC3486698/
- Rinaldo SG & Rinaldo DW, The Avisa Group. (2013). Report I: Availability Without Accessibility? State Medicaid Coverage and Authorization Requirements for Opioid Dependence Medications, pp. 9–60. In: American Society of Addiction Medicine (ASAM). (2013). *Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment*. <http://www.asam.org/docs/advocacy/implications-for-opioid-addiction-treatment>
- Schwartz RP, Kelly SM, O'Grady KE, Gandhi D, Jaffe JH. (2012 May). Randomized trial of standard methadone treatment compared to initiating methadone without counseling:12-month findings. *Addiction*;107(5): 943–52. www.ncbi.nlm.nih.gov/pubmed/22029398
- Sees KL, Delucchi KL, Masson C, Rosen A, Clark HW, Robillard H, Banys P, Hall SM. (2000 Mar 8). Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence: a randomized controlled trial. *JAMA*;283(10):1303–10. www.ncbi.nlm.nih.gov/pubmed/10714729#
- Weinrich M, Stuart M. (2000 Mar). Provision of methadone treatment in primary care medical practices: Review of the Scottish experience and implications for US policy. *JAMA*;283(10):1343–8. www.ncbi.nlm.nih.gov/pubmed/10714738
- Weiss RD, Potter JS, Fiellin DA, Byrne M, Connery HS, Dickinson W, et al. (2011 Dec). Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: a 2-phase randomized controlled trial. *Arch Gen Psychiatry*;68(12):1238–46. www.ncbi.nlm.nih.gov/pubmed/22065255

White WL & Mojer-Torres L. (2010). *Recovery-Oriented Methadone Maintenance*. Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center. 168 p.
www.williamwhitepapers.com/pr/books/full_texts/file_download.php?fn=2010Recovery_orientedMethadoneMaintenance&ext=pdf

Yokell MA, Zaller ND, Green TC, Rich JD. (2011 Mar). Buprenorphine and buprenorphine/naloxone diversion, misuse, and illicit use: An international review. *Curr Drug Abuse Rev*;4(1): 28–41.
www.ncbi.nlm.nih.gov/pmc/articles/PMC3154701/pdf/nihms314965.pdf

Non-Medication-Assisted Treatment of Opioid Use Disorder

Amato L, Minozzi S, Davoli M, Vecchi S, Ferri MM, Mayet S. (2008 Jul 16). Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. *Cochrane Database Syst Rev*; (3):CD005031. Update in *Cochrane Database Syst Rev*. 2008;(4):CD005031. www.ncbi.nlm.nih.gov/pubmed/18646118

Center for Substance Abuse Treatment (CSAT). (2009). *What are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.
<http://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf>

Currie SR, Hodgins DC, Crabtree A, Jacobi J, Armstrong S. (2003). Outcome from integrated pain management treatment for recovering substance abusers. *Journal of Pain*;4(2), 91–100.
www.ncbi.nlm.nih.gov/pubmed/14622720

White WL. (2011). *Narcotics Anonymous and the Pharmacotherapeutic Treatment of Opioid Addiction in the United States*. Published by the Philadelphia Dept. of Behavioral Health and Intellectual disability Services and the Great Lakes Addiction Technology Transfer Center.
<http://atforum.com/addiction-resources/documents/2011NAandMedication-assistedTreatment.pdf>

Harm Reduction/ Overdose Prevention & Response

Albert S, Brason FW, Sanford CK, Dasgupta N, Graham J, Lovette B. (2011). Project Lazarus: Community-based overdose prevention in rural North Carolina. *Pain Medicine*; 12: S77–S85.
<https://www.ncha.org/doc/266>

Centers for Disease Control and Prevention (CDC). (2012 Feb). Community-based opioid overdose prevention programs providing naloxone – United States, 2010. *MMWR*;61(6), 1–5.
www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm

CDC. (2011 Nov). Vital signs: Overdoses of prescription opioid pain relievers—United States, 1999–2008. *MMWR*; 60(43):1487–92. www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm

CDC. (2002 Feb). IDU HIV Prevention: Methadone Maintenance Treatment.
www.cdc.gov/idu/facts/methadonefin.pdf

Coffin PO, Sullivan SD. (2013). Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intern Med*;158(1):1–9. <http://annals.org/article.aspx?articleid=1487798>

Denning P & Little J. (2011 Nov). *Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions*, Second Edition. Guilford Press, ISBN 978-1-4625-0233-2. www.guilford.com/cgi-bin/cartscript.cgi?page=pr/denning.htm&sec=toc&dir=pp/addictions

- Leavitt S. (2010 Oct). Intranasal Naloxone for At-Home Opioid Rescue. *Practical Pain Management*; 10(8):42–46. <http://prescribtoprevent.org/wp-content/uploads/2012/11/ppm2010leavitt.pdf>
- Scavone JL, Sterling RC, Van Bockstaele EJ. (2013 Sep). Cannabinoid and opioid interactions: implications for opiate dependence and withdrawal. *Neuroscience*;248: 637–54. www.ncbi.nlm.nih.gov/pubmed/23624062
- Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, Ruiz S, Ozonoff A. (2013 Jan). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. www.bmc.org/Documents/Alexander-Walley-2013.pdf
- Wermeling D. (2010 Jul). Opioid harm reduction strategies: Focus on expanded access to intranasal naloxone. *Pharmacotherapy*; 30(7):627–63. <http://prescribtoprevent.org/wp-content/uploads/2012/11/pharma2010wermerling.pdf>
- Wheeler E, Burk K, McQuie H, Stancliff S. (2012). *Guide To Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*. Harm Reduction Coalition. <http://harmreduction.org/wp-content/uploads/2012/11/od-manual-final-links.pdf>
- World Health Organization (WHO). (2013). Opioid overdose: Preventing and reducing opioid overdose mortality. UNODC/WHO discussion paper. www.unodc.org/docs/treatment/overdose.pdf
- Zevin B. (2011). *Co-Occurring Disorders: Prescribing Medicines to People Who Use Drugs*. Harm Reduction Therapy Center, San Francisco, CA. www.harmreductiontherapy.org/sites/default/files/Addiction%20Medicine%202011%20Zevin.pdf

Pain Management

- Alford DP, Compton P, Samet JH. (2006 Jan). Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Ann Intern Med*. 2006 January 17; 144(2): 127–134. www.ncbi.nlm.nih.gov/pmc/articles/PMC1892816/
- American Academy of Pain Medicine (AAPM), American Pain Society (APS), and American Society of Addiction Medicine (ASAM). (2001). Definitions related to the use of opioids for the treatment of pain: Consensus statement of the AAPM, APS, & ASAM. https://www.erowid.org/psychoactives/addiction/addiction_definitions1.pdf
- Belgrade MJ, Schamber CD, Lindgren BR. (2006). The DIRE Score: Predicting outcomes of opioid prescribing for chronic pain. *Journal of Pain* 7(9): 671–81. www.ncbi.nlm.nih.gov/pubmed/16942953
- Chou R, Fanciullo GJ, Fine PG, Adler JA, Ballantyne PD, et al. (2009). Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *Journal of Pain*;10(2): 113–30. www.jpain.org/article/S1526-5900%2808%2900831-6/fulltext
- Gersh E, Arnold C, Gibson SJ. (2011 Jan). The relationship between the readiness for change and clinical outcomes in response to multidisciplinary pain management. *Pain Med*;12(1):165–72. www.ncbi.nlm.nih.gov/pubmed/21223494
- Hwang SW, Wilkins E, Chambers C, Estrabillo E, Berends J, MacDonald A. (2011 Jul). *BMC Fam Pract*;12:73. www.biomedcentral.com/1471-2296/12/73

- Martin J. (2013). Opioids and the pain/addiction interface. Western Occupational and Environmental Medical Association CME Webinar, April 17, 2013.
www.woema.org/files/Webinar/OpioidandthePain_JMartin.pdf
- Martin JA, Campbell A, Killip T, Kotz M, Krantz MJ, Kreek MJ, McCarroll BA, Mehta D, Payte JT, Stimmel B, Taylor T, Haigney MCP, Wilford BB. (2011). QT interval screening in methadone maintenance treatment: Report of a SAMHSA expert panel. *Journal of Addictive Diseases*;30(4):283–306. www.tandfonline.com/doi/pdf/10.1080/10550887.2011.610710
- Savage SR, Kirsh KL, Passik SD. (2008 Jun). Challenges in using opioids to treat pain in persons with substance use disorders. *Addict Sci Clin Pract*; 4(2), 4–25.
www.ncbi.nlm.nih.gov/pmc/articles/PMC2797112/
- Tsao JCI, Plankey MW, Young MA. (2012, Apr-Jun). Pain, psychological symptoms and prescription drug misuse in HIV: A literature review. *J Pain Mgt*; 5(2): 111–118.
www.ncbi.nlm.nih.gov/pmc/articles/PMC3697768/

Service Integration

- Alford DP, LaBelle CT, Kretsch N, Bergeron A, Winter M, Botticelli M, Samet JH. (2011 Mar). Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. *Arch Intern Med*;171(5):425–31. www.ncbi.nlm.nih.gov/pmc/articles/PMC3059544/
- Dilonardo J. (2011 Aug). Workforce Issues Related to Physical and Behavioral Healthcare Integration: Substance Use Disorders and Primary Care – developed for joint ONDCP/SAMHSA/HRSA meeting re: integration of services for Primary Care and Substance Use Disorders, August 10, 2011. www.integration.samhsa.gov/clinical-practice/ONDCP_Framework_Paper.pdf
- Harris KA Jr, Arnsten JH, Litwin AH. (2010 Mar). Successful integration of hepatitis C evaluation and treatment services with methadone maintenance. *J Addict Med*;4(1):20–6.
www.ncbi.nlm.nih.gov/pmc/articles/PMC2872238/
- HIV/AIDS Bureau (HAB), Special Projects of National Significance Program. (2011). Integrating buprenorphine therapy into HIV primary care settings. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration.
http://hab.hrsa.gov/about/hab/files/hab_spns_buprenorphine_monograph.pdf

SUGGESTED RESOURCES

- Bascelli I & Colangelo B. (2013). Mental health services in primary care. Presentation: Pre-HCH Conference Institute on Behavioral Health Integration, March 13, 2013. www.nhchc.org/wp-content/uploads/2012/11/Behavioral-Health-Integration-Bascelli-Colangelo.pdf
- Ciambrone S & Edgington S. (2009). *Medical Respite Services for Homeless People: Practical Planning*. Nashville: Respite Care Providers Network, National Health Care for the Homeless Council, Inc. www.nhchc.org/wp-content/uploads/2011/09/FINALRespiteMonograph1.pdf
- Clary LF & Gallon S. (2003 Nov). *Treating Opiate Dependence in Rural Communities: A Guide for Developing Community Resources*. <http://files.ireta.org/opiates2005/10.pdf>
- Edgington S (Ed.). (2011). *Clinical Recommendations for the Medical Respite Setting*. National Health Care for the Homeless Council. www.nhchc.org/wp-content/uploads/2011/11/ClinicalRecsMedRespite.pdf
- HCH Clinicians' Network. (2013 Fall). Speaking from Experience: The Power of Peer Specialists. *Healing Hands*;17(3): 1-8. www.nhchc.org/wp-content/uploads/2013/11/healinghandsfall2013.pdf
- Kraybill K. (2005). *Outreach to People Experiencing Homelessness: A Curriculum for Training Health Care for the Homeless Outreach Workers*, National Health Care for the Homeless Council. www.nhchc.org/wp-content/uploads/2012/02/OutreachCurriculum2005.pdf
- Meinbresse M. (2013). *Integrated Care Quick Guide: Integrating Behavioral Health & Primary Care in the HCH Setting*. National Health Care for the Homeless Council. www.nhchc.org/wp-content/uploads/2013/10/integrated-care-quick-guide-sept-2013.pdf
- National Center on Addiction and Substance Abuse at Columbia University. (2012). *Addiction Medicine: Closing the gap between science and practice*. www.casacolumbia.org/upload/2012/20120626addictionmed.pdf
- National Quality Forum. (2012 May). *Multiple Chronic Conditions (MCC) Measurement Framework*. U.S. Department of Health and Human Services. www.qualityforum.org/Projects/Multiple_Chronic_Conditions_Measurement_Framework.aspx
- O'Connell JJ, Zevin BD, Quick PD, Anderson S, Perret YM, Dalton M, Post PA (Ed.). (2007). *Documenting Disability: Simple Strategies for Medical Providers*. Nashville: Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. 82 p. www.nhchc.org/wp-content/uploads/courses/dd101/mod1/doc/DocumentingDisability2007.pdf
- Post PA. (2008). *Defining and Funding the Support in Permanent Supportive Housing: Recommendations of Health Centers Serving Homeless People*. Prepared by the National Health Care for the Homeless Council for the Corporation for Supportive Housing. www.csh.org/wp-content/uploads/2011/12/Report_HealthCentersRcs2.pdf
- Substance Abuse and Mental Health Services Administration. (2013). *SAMHSA Opioid Overdose Prevention Toolkit*. HHS Publication No. (SMA) 13-4742. Rockville, MD. <http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742>

WEBSITES

American Academy of Pain Medicine	www.painmed.org/
American Association for the Treatment of Opioid Dependence	www.aatod.org
American Society of Addiction Medicine	www.asam.org/
Harm Reduction Coalition	http://harmreduction.org/
National Acupuncture Detoxification Association	www.acudetox.com/
National Health Care for the Homeless Council	www.nhchc.org/
National Institute on Drug Abuse	www.nida.nih.gov/
PrescribeToPrevent.org	http://prescribetoprevent.org/
Substance Abuse & Mental Health Administration	www.samhsa.gov/

ABOUT THE HCH CLINICIANS' NETWORK

Founded in 1994, the Health Care for the Homeless Clinicians' Network is a national membership association that unites care providers from many disciplines who are committed to improving the health and quality of life of homeless people. Operated by the National Health Care for the Homeless Council, the HCH Clinicians' Network is engaged in a broad range of activities including publications, training, research and peer support. The Network is governed by a Steering Committee representing diverse community and professional interests.

Please visit our website at www.nhchc.org/resources/clinical/hch-clinicians-network/.

Harm Reduction Practice Guidelines for Working with Homeless Opiate Users

by Patt Denning, PhD and Jeannie Little, LCSW

BACKGROUND AND HISTORY

In response to an increase in hepatitis B among people injecting drugs in Rotterdam, the Netherlands in the mid – 1980s, drug users organized themselves into “junkie unions” to petition the Health Department for injection equipment. Syringe exchange as a public health intervention was born.

In mid – late 1980s in UK and Australia, partly in response to the emerging HIV epidemic, syringe exchange and drug programs, often funded by government, experimented with a range of services designed to attract users by responding to their real needs, which come to be collectively termed “Harm Reduction” services. The model of Harm Reduction developed in Merseyside, UK included safe injecting education, drug substitution maintenance other than methadone, methadone maintenance options (by dose and mode of injection) and non-drug related interventions.

WHAT IS HARM REDUCTION?

Harm reduction is an approach to working with drug users that aims to reduce drug-related harm to individuals, their families, and communities without necessarily reducing the consumption of drugs and alcohol. The damage done by drug and alcohol use, not *necessarily* the drug use itself, is the focus of attention. Harm reduction doesn’t get caught up in arguments about whether people *should* or *should not* use drugs.

The term harm reduction was coined in the 1980’s to describe public health approaches to working with drug use. At that time, the goal of harm reduction was to reduce the transmission of blood-borne diseases, specifically Hepatitis B and HIV. It was based on the reality that all behavior change (leaving a relationship, changing sexual habits, changing diet, getting psychiatric treatment, deciding to take meds for HIV, deciding to reduce or quit drugs or alcohol...) requires a process of decision-making for successful implementation of a plan of change. Ambivalence and resistance are normal and expected parts of the change process. It was far too important to save lives by offering immediate practical interventions than to get involved in whether or not people should or should not be using drugs.

Harm reduction includes a range of evidence-based approaches that recognize that people unable or unwilling to abstain from drug and harmful alcohol use can still make positive choices to protect their health, and the health of their families and communities.

Currently in the United States, harm reduction is practiced in three broad arenas:

- Public health approaches include needle exchange, non-discriminatory healthcare, overdose prevention, and pill testing in clubs to reduce physical harm (e.g., HIV/HCV transmission) related to drug use. Under the public health umbrella, harm reduction services include low-threshold housing that does not discriminate against drug users and that provides adequate and relevant supportive services. They also include interventions such as drug substitution therapies (e.g., methadone and buprenorphine). The most recent innovation in public health

for drug users is the creation of safe injection facilities to ensure clean, safe drug use for people who do not have sanitary conditions for drug consumption. While there are no facilities in the U.S., Canada has a safe injection facility and has embraced harm reduction as part of its public health philosophy, as have many countries around the world.

- Advocacy for the decriminalization of drug use, fair sentencing laws, medical marijuana to reduce harm done by the War on Drugs, and other sane drug policies. The drug war is wholly responsible for the explosion of the U.S. prison population since the mid-1980's. The vast majority of people imprisoned for drug offences are people of color. More harm has been done by the War on Drugs than by drug use itself.
- Harm Reduction Therapy, a clinical approach to facilitate change in harmful drug using behaviors. The approach is unique in that treatment is offered to active drug users and it is entirely client-centered. The goals and the pace of treatment are determined by the client, not the therapist or counselor.

The principles of harm reduction are sufficiently broad that they have been applied to any low-threshold, inclusive and non-discriminatory approach to working with other issues, from domestic violence to severe mental illness to chronic homelessness.

Bringing harm reduction principles to addiction treatment could mean that more individuals begin to engage in the harm reduction-addiction treatment continuum, further increasing the cost-efficiency and –effectiveness of public investments.

Harm reduction is an empowerment model that turns control over to consumers who choose their own goals for and pace of change. There is no requirement that substance users embrace abstinence or any other particular change goal. This opens the doors to anyone who uses substances in a way that might be unsafe or problematic. Many harm-reducing and change strategies belong under the harm reduction umbrella -- low threshold health interventions such as syringe access, overdose prevention, and supervised injection that bring active users who may have no interest in changing their drug use into a healthcare environment that meets their needs; harm reduction therapy that uses strategies such as motivational interviewing to motivate change and safer substance use education such as moderation or substance use management, all within a relational approach that respects client autonomy and choice. These programs reach people who would not enter a traditional treatment program. Strategies include 1) offering a full array of services needed by drug users to engage them in a service relationship, 2) creating a continuum of treatment options that offer substance users a full array of options for change and 3) integrating mental health and substance use treatment models and funding streams.

HARM REDUCTION PRINCIPLES

Not all drug use is abuse.

- Intoxication has been a normal part of human experience forever, a part of sacred or social ritual in every part of the world.
- Most people in the U.S. use some type of drug, and most do not have problems. Moreover, most can and do make rational choices about, and while, using drugs.

- Drug *use* occurs on a continuum from benign to chaotic, and people move back and forth between those poles throughout their drug-using lifespan, most never reaching the point of chaos.
- Drug *abuse* is a health, not a legal or moral concern – There should be no punitive sanctions for what a person chooses to, or refuses to, put into her/his body.

People use drugs for reasons.

- New learning in *neurobiology* supports the fact that people, especially those with physical, mental or emotional illness, get significant relief from street drugs.
- People don't usually have the disease of addiction, they have a *relationship with drugs*.
- Harm is relative – depending on one's reason for using, drugs may be preferable to one's experience without them.

Incremental change is normal and motivation is fluid.

- The *Stage Model of Change*, based on research, explains the process that we go through to make major behavior change and asserts that change is *most* effective if we work through the stages one at a time, thoroughly, in order, and preferably with support.

Harm Reduction is a collaborative process model, not an outcome, model.

- Harm reduction requires that the drug user and the treatment provider work *together* to identify the problems and to plan solutions. A combination of Drug, Set, Setting and the Stage Model of Change help to establish each drug user's *Hierarchy of Needs* (treatment goals).
- *Self-Determination Theory* informs us that client-driven, not externally-driven, goals are most highly correlated with intrinsic motivation and therefore with successful change.
- *Motivational Interviewing* is the most useful model for facilitating motivation and change.
- Fundamental to harm reduction is to start where the client is and treat drug users with respect – people have the right to make their own choices, including “bad” ones.

Outcomes are as varied as the people seeking change; this is not only real, it is desirable!

- Abstinence *is* one of many harm reduction goals, it just isn't the only one.
- At any point in time, most people in the United States with drug problems are not abstinent.
- To date, treatment has abysmal abstinence outcomes, but much better harm reduction outcomes.

Harm reduction requires of practitioners ---

- A recognition that people will drink and use drugs, sometimes with harmful consequences to themselves and others
- Belief that what we call “addiction” is actually a complex phenomena encompassing biological, psychological, and social-cultural factors, rather than simply a brain disease.
- Commitment to working with people “As they are” and setting no goals or outcomes that are not freely chosen by the person. The continuum of drug use is mirrored in a continuum of care and goals.
- Affirmation that drug users should have an active voice in their treatment, and that they are the main agents of change

HARM REDUCTION THERAPY

Harm reduction therapy developed first as a non-abstinence-based clinic and therapy office-based method of treating people with drug and alcohol problems.

This section describes the application of the principles and practices of harm reduction therapy in community settings with complex, often opiate dependent people. Low-threshold welcoming and flexible session arrangements are defining characteristics of this community-based approach. Much effort goes into engaging people who have been shunned by mental health programs or have failed in substance abuse treatment programs.

Developed during the 1990's by several practitioners (Springer, 1991, Denning, 1998, Denning & Little 2012, Tatarsky, 1998 & 2002, Little, 2001 & 2002) and a researcher (Marlatt (2013), harm reduction therapy has grown over the last 18 years as an alternative approach to treating people with drug and alcohol problems. Harm reduction therapy (HRT) is based on the understanding that drug and alcohol problems are multi-determined, and that each individual has a unique and idiosyncratic relationship with his or her drugs. Any resulting treatment should be entirely individualized, with a different course and different outcomes for each person. Harm reduction and harm reduction therapy principles of respect, collaboration, incremental client-driven change, and offering a menu of options for behavior change all support an individualized approach and especially support an approach that encourages clients to make their own decisions about whether to come or not come to treatment.

A unifying principle of HRT is that drug users do not have to quit in order to reduce harm or to resolve their problems with drugs. While it recognizes and supports abstinence as a worthy goal of treatment, it is not by any means the only goal, and it is only a legitimate goal if proposed by the client. The ultimate goal of harm reduction is *not* abstinence. At the risk of stating a redundancy, the goal of harm reduction is harm reduction!

We think of these individuals as exquisitely complex, as they present a multiplicity of priorities, both for themselves and for the therapists working with them. Our attempts to refer clients to other mental health or substance abuse programs, and the clients' previous attempts at treatment, have been largely unsuccessful. Many of these individuals are unable to meet the high threshold requirements of other clinics, such as sitting quietly in a clinic waiting room, having the attention span or comprehension skills to fill out intake paperwork, or possessing the trust to enter an office with a staff person with the door closed. HRTC requires none of these things; HRTC expressly developed its community-based programs to enable people to receive mental health and substance abuse treatment without having to satisfy any program criteria.

Key elements of harm reduction practice

Low threshold

Locate treatment activities in places where people congregate for non-therapeutic reasons – street corners, community drop-in centers, needle exchanges, and primary care clinics.

A fundamental characteristic of community-based treatment is that the frame of the treatment is informed by the needs of the members of the community in which the program is located. In a community whose members are dealing with survival needs, such as finding a place to sleep for

the night or getting something to eat, a program that required appointments in order to access its resources would not be an example of community-based treatment. Such a program might fit in a community whose members have access to instrumental needs such as food, clothing, and shelter, but its high threshold would be a barrier in a community whose members struggle to meet those needs on a daily basis.

Integrated

HR-informed treatment is integrated. We pay equal attention to drug problems, mental illness, and other psychosocial problems. It is the client's hierarchy of needs that determines the focus of therapy on any given day.

HRP integrates several therapeutic approaches: motivational interviewing (Miller & Rollnick, 2003); cognitive-behavioral skills training (Moderation Management (Kern, et al, 20...) stress reduction, mindfulness, substance use management (Bigg, 2001), life coaching (money management, nutrition, other life skills); and nonverbal approaches such as drumming (Schultz, 2006) and somatic experiencing (Levine, 1997). All of these approaches and interventions take place in a context of relational psychodynamic therapy (Rothschild, 2007) and of modern analytic processes of emotional communication and joining (relational alternatives to analytic interpretation) (Ormont, 1992).

Trauma Informed

Program structures and therapist expectations must avoid replicating any of the key characteristics of trauma. Important elements of trauma include coercion, intrusion, loss of control, powerlessness, loss of trust, often an element of surprise, and physical and emotional attacks. Trauma survivors have great difficulty developing trust. They are hypervigilant. They doubt the safety of their surroundings. Enormous numbers of trauma survivors abuse alcohol and drugs (Goetz, 2003; Little, 2012). Programs must first of all do nothing that replicates the characteristics of traumatic experiences. They must then

Takes into account the impact of past experiences on the present

Each client has both a real and a transference relationship with his or her therapist, with host agencies, and with the context in which our programs are held. The real relationship is based on the actual encounters each client has with staff and structures. How accommodating is the schedule? How accessible are the rooms? Are they decorated with comfort and warmth in mind? Does staff greet prospective clients with a big smile and a warm welcome or with a rote "What do you need today?" Is staff interested and curious or anxious to get on with the business of the encounter? These factors, and many more, trigger responses in each client and influence the subsequent course of the work.

Each client also approaches the agency and its staff with expectations. These expectations are formed by prior experiences of treatment at the hands of other institutions, social service agencies, and treatment programs. Given the clients' multiple problems, and given that most have been in the foster care and/or criminal justice system, these experiences have been largely negative. The job of the harm reduction therapist (and others) is to undo negative expectations by repeatedly expressing welcoming affect, making affirming statements, and offering a respectful and collaborative relationship.

SPECIFIC PRACTICE GUIDELINES

Set the stage for honest communication: Relationship

Above all, we view everything that we do as treatment, from the briefest hello to an ongoing therapy relationship. We view all interactions as in the service of building and maintaining the therapeutic relationship, knowing that relationship is the key to all behavior change. We build relationships by providing the space and time for people to either move toward us, or to invite us to move toward them in their time, not ours.

No punitive sanctions for drug use

Policies regarding opiate or other drug use during treatment must be as permissive as possible given safety (overdose) concerns. Refusing or significantly restricting services in response to illicit drug or alcohol use will only increase the chances that clients will lie to us and engage in other behaviors that we interpret as “drug seeking”. More frequent contact, honest exchange of conflicts, and adjusted dosing schedules should be the primary interventions.

Flexible and non-contingent dosing schedules/locations, etc.

Flexibility is the key to beginning a therapy relationship. Services should offer drop-in or sidewalk sessions, drop-in support groups, regular therapy appointments, and psychiatric medications This means meeting and engaging individuals on the street, in the waiting room, or outside a bathroom door to begin the process of developing a trusting relationship in which people can, over time, bring themselves to the therapeutic encounter and begin to see that relationship as a resource rather than an intrusion.

Chronic stress must also be treated

Self medication is usually an important component of chronic opiate dependence. Lifestyles, homelessness, psychiatric issues, etc. are well soothed by opiates. Programs should provide clients opportunities for respite, relaxation, and fun.

Use adjunct medications to treat underlying depression and anxiety

When people move from personal opiate use to medically supervised use, they often find that the medicine doesn't work as well for anxiety and depression. This can be a major source of relapse or of misusing prescribed medicines.

Assess stage of change for all target behaviors, symptoms, etc.

People may be ready to take action, adhere to different tx recommendations at different times.

Welcomes people in crisis who present difficult behaviors : Work with difficult behaviors rather than prohibit them

We practice radical inclusion of all people, and all behaviors that they bring into our programs. We understand that behavior serves a purpose, and despite sometimes self-destructive aspects, it

communicates essential information about a person's history, feelings, and response to the present environment.

Under the guise of creating "safety" for both clients and staff, programs frequently create rules and systems to prohibit these and many other "disruptive" behaviors. Often this is more about staff comfort than actual safety.

At some point, most of our clients have crises. All staff are trained in crisis evaluation and are authorized to commit clients to an involuntary hold if absolutely necessary, which it is not often. Crisis prevention is our priority; however, because emergency hospitalization is rarely therapeutic and is often traumatizing, we might spend hours talking with and settling a client who is in crisis in order to avert a dangerous situation.

Take care of staff

We also consider the care of our therapists a critical component of all programs. Opportunities for individual and group supervision must be standardized, and other stress-reducing components added (continuing education, vacations, communal lunches, etc.) Therapists must embody flexibility and responsiveness to 100 different crises and stories in any given day. Just as the harm reduction therapist prioritizes developing the therapeutic relationship, the same is true for supervisors supporting harm reduction therapists as they offer their full attention to the many participants in our community-based programs.

Albuquerque Health Care for the Homeless: Re-Entry Collaborative (REC) Fact Sheet

Program Description

Established in 2009, Albuquerque Health Care for the Homeless' (AHCH) Re-Entry Collaborative (REC) is designed to reduce human suffering in Bernalillo County residents who are opiate addicted, without homes, and recently released from incarceration, and to reduce the societal damage and systems costs that result from crime and rearrest/conviction that occur in the event of a relapse, including reduced overdose deaths. Community partners include: the NM Department of Health; Bernalillo County Substance Abuse Treatment Services; the NM Department of Corrections; and the University of New Mexico Health Sciences Center, Project ECHO.

Model

Integrated primary care and social services treatment model, including a) opiate replacement therapy using Suboxone, b) enhanced services through Care Coordination, c) Stages of Change and Motivational Interviewing for individual risk reduction, including overdose prevention training and Narcan distribution, d) Housing First philosophy for ending homelessness, e) substance abuse treatment group, f) Trauma Informed Care, and g) collaborative model for Systems Integration and Enhancement.

Notes from the Director



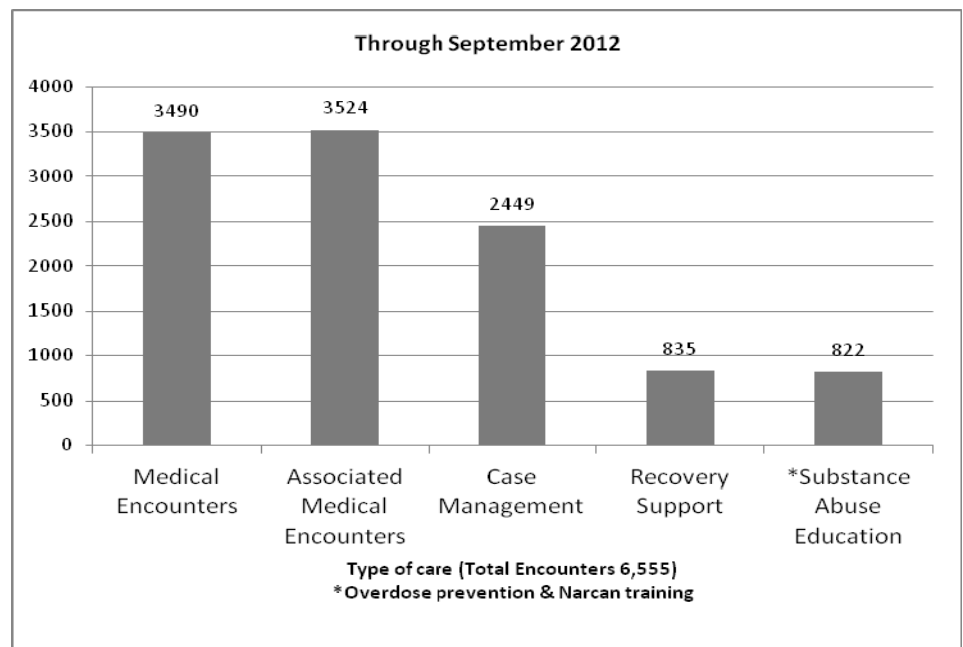
Albuquerque
HEALTHCARE
for the homeless

The Re-Entry Collaborative is a reflection of AHCH's commitment to tangible collaboration across sectors, and to very innovative but practical solutions for people struggling with substance use disorders in our community. We appreciate our partners' willingness to share leadership in making this happen. Together we have proven that a smart mix of community-based care, access to medications, like Suboxone and Narcan, matched with wrap-around social services and behavioral health do end homelessness, end untimely opiate overdoses and keep people from re-entering the criminal justice system. See below for more on the facts.

Since February 2009, REC has enrolled 405 clients. Key outcomes include:

- Increased the rate of abstinence 79%.
- Increased the number of clients with stable housing 517%.
- A 37% increase in employment or attending school.

Your continued support makes it possible. We appreciate our clients, their families and friends, and our community partners.



Potential Interactions with Common Drugs of Abuse

COCAINE

Cocaine may interact **pharmacokinetically** and increase drug levels of the following formulary medications:

- amitriptyline
- paroxetine
- duloxetine
- venlafaxine
- risperidone
- aripiprazole
- metoprolol
- dextromethorphan

Cocaine may react **pharmacodynamically** with the following formulary medications:

- **Tricyclic Antidepressants**-adrenergic stimulation
- **Beta Blockers**- unopposed alpha adrenergic stimulation (*WHAT IS THE SIGNIFICANCE IN NON-OVERDOSE SITUATIONS?*)
- **SSRI**-serotonin syndrome
- **SNRI**-serotonin syndrome, adrenergic stimulation
- **Albuterol**-adrenergic stimulation
- **Phenylephrine**-adrenergic stimulation
- **Clonidine**-has been reported to increase CNS effects of cocaine.

The formation of the more toxic metabolite **Norcocaine** may be enhanced by:

- Carbamazepine
- Phenytoin

HEROIN

Heroin levels may be increased **pharmacokinetically** by the following 2 pathways:

3A4 system promotes conversion to morphine. These formulary drugs inhibit this system:

- clarithromycin
- grapefruit Juice

2D6 system promotes the metabolism and breakdown of morphine. These formulary meds inhibit this system:

- bupropion (more likely)
- fluoxetine (more likely)
- paroxetine (more likely)
- duloxetine (less likely)

Heroin may react **pharmacodynamically** with the following:

- Antihistamines- increase CNS effects (especially first generation antihistamines)
- Clonidine- Increase CNS effects, opioid sparing effects

METHAMPHETAMINE

Methamphetamine may react **pharmacodynamically** with the following formulary medications:

- **SSRI**-serotonin syndrome
- **SNRI**-adrenergic enhancement
- **Tricyclic Antidepressants**-adrenergic stimulation
- **Albuterol**-adrenergic stimulation
- **Beta Blockers**- unopposed alpha adrenergic stimulation (*WHAT IS THE SIGNIFICANCE IN NON-OVERDOSE SITUATIONS?*)
- **Phenylephrine**-adrenergic stimulation.

DEXTROMETHORPHAN

Dextromethorphan effects may be enhanced **pharmacokinetically** by the following:

- bupropion (more likely)
- fluoxetine (more likely)
- paroxetine (more likely)
- duloxetine (less likely)

Dextromethorphan may react **pharmacodynamically** with the following:

- SSRI-serotonin syndrome

Pharmacokinetic Interaction- An interaction that occurs due to drug metabolism.

More information on interaction affecting the cytochrome P450 pathway can be found at:

<http://medicine.iupui.edu/clinpharm/ddis/clinicalTable.aspx>

Pharmacodynamic Interaction- An interaction that occurs through mechanisms of action.