Low Barrier Care for Substance Use Treatment

David Kispert MD
Medical Director
CAP Quality Care

Disclosures

- I have no disclosures

Objectives

- Define and identify principles of low barrier care
- Provide evidence supporting the model
- Discuss barriers to implementation

Focus on Opioid Treatment Programs (OTPs)

The Problem

- Less than 10% of people who need treatment have sustained access to care
- In 2021, only 22% of individuals with a past year opioid use disorder (OUD) reported receiving medications for treatment
- Only 6.3% of people with a past year illicit drug or alcohol use disorder reported receiving any substance use treatment

Definition – Low Barrier Care

- A model for treatment that minimizes the demands placed on clients

- Guided by 4 principles:
  1. Same-day treatment entry
  2. Risk reduction approach
  3. Flexibility
  4. Available and Accessible

- Additionally:
  - Provides a non-judgmental and welcoming environment
  - Culturally responsive and trauma informed
  - Individualized

Principles – Same Day Treatment Entry

- Individuals receive services on the same day without an appointment
  - “What brought you into treatment today?”
  - Intake Times - CARF vs Joint Commission
- Medication is provided at the first visit if the patient chooses
- Individualized medication dosage
  - Updated SAMHSA guidance

Principles – Same Day Treatment Entry

- Provision of medication is not contingent on a positive drug screen or active withdrawal symptoms
- Extended hours of operation
- Offer telehealth services
  - SAMHSA Final rule
    - Allows intakes via audiovisual telehealth
    - Need in-person follow up within 14 days
    - Must pick up methadone at OTP

Principles – Risk Reduction

- Focus on empowering each individual patient
- Reducing substance use is an acceptable goal
- Toxicology results used to prioritize patient safety rather than punishment
  - Helps to establish a therapeutic alliance
- Overdose prevention and infectious disease prevention services are practical and transformative approaches
  - Naloxone on-demand
  - State does not require HIV/Hep C testing

Principles - Flexibility

- Adapt to the individual's needs and preferences
  - Providing multiple levels of care within a single program
- Rigid requirements can deter patients from seeking or sustaining treatment
  - Counseling requirements
  - Monthly random drug screens
- Ongoing substance use does not lead to treatment discontinuation or dose reduction

Principles - Flexibility

- Treatment engagement conditions should not be placed on the patient
- Counseling should be offered, but the provision of medication should not be contingent upon participation
- Support a patient's preferences for short-term (i.e. withdrawal management) versus long-term medication use
- Visit frequency should be based on clinical stability and patient preference

Principles – Available and Accessible

- Socioeconomic factors can make it difficult to access treatment
  - **Transportation**
    - Medicaid ride share service
  - **Employment**
  - **Childcare responsibilities**
- SAMHSA Take-Home Flexibilities

Criteria for Take Homes

Traditional Requirements

- (i) Absence of recent abuse of drugs (opioid or nonnarcotic), including alcohol;
- (ii) Regularity of clinic attendance
- (iii) Absence of serious behavioral problems at the clinic;
- (iv) Absence of known recent criminal activity, e.g., drug dealing;
- (v) Stability of the patient's home environment and social relationships
- (vi) Length of time in comprehensive maintenance treatment;
- (vii) Assurance that take-home medication can be safely stored within the patient's home; and
- (viii) Whether the rehabilitative benefit the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

Updated Guidance - SAMHSA

- (a) Absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;
- (b) Regularity of attendance
- (c) Absence of serious behavioral problems that endanger the patient, the public or others;
- (d) Absence of known recent diversion activity; and
- (e) Whether take home medication can be safely transported and stored; and
- (f) Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

Take-Home Flexibilities

Traditional Requirements

- 1st 90 days - 1 TH/week
- 90-180d – 2 THs/wk
- 180-270d – 3 THs/wk
- 270-360d – 6 THs/wk
- After 1yr – 13 THs/wk
- After 2yrs – 1 month THs

Updated SAMHSA Guidance

- 0-14d - up to 7 take-homes
- 15-30d - up to 14 take-homes
- >31d in treatment, up to 28 take-homes

Principles – Available and Accessible

- Leverage mobile medical units
  - No need for additional DEA license for mobile unit

- Embedding SUD treatment across the healthcare system
  - 3 day rule
    - Non-OTP physicians can administer methadone for up to 3 days to a patient awaiting treatment
      - Maine Medical Pharmacy
      - EDs, Bridge clinics

Principles – Available and Accessible

- Incorporate a whole health approach that encompasses a range of services
  - Access to medications
    - Offering all forms of MOUD
  - Counseling

  - Peer support
  - Case management
  - Mental health care
  - Education
  - Housing support
  - Vocational services

Additional Principles

- Non-judgmental and welcoming environment
  - Staff greeting patients at dosing area
  - Music in lobby
- Culturally responsive and inclusive care
  - Burden of SUDs is disproportionately experienced by people from racially and ethnically marginalized communities
- Trauma Informed Care
  - Improves patient engagement, treatment adherence, and health outcomes

Additional Principles

- Individualized Care
  - Individual versus group-based counseling
  - Meeting with partners/guardians/family members
  - Following up with other community providers
  - Offering multiple formulations of medication

Evidence Supporting Low Barrier Care

- A low barrier care clinic serving individuals with several substance use disorders found that 70% of clients were engaged in treatment – higher than the national average

- Low barrier buprenorphine offered at a syringe services program
  - Nearly 3 fold increase in buprenorphine use (from 33 to 96%)
  - Substantial declines in use of illicit opioids (from 90 to 41%) between clients' 1st and 6th visits

- Low-barrier care is cost-effective
  - Reduces ED visits and hospitalizations

Evidence Supporting Low Barrier Care

- Canada
  - Methadone was deregulated in 1996 allowing for prescribing in office-based settings, including syringe service programs
  - Associated with reductions in HIV risk behaviors, incidence, and mortality

- Netherlands
  - Offers low-threshold clinics operating in mobile settings
    - Reductions in mortality, HIV/Hep C incidence, and criminal activity

Evidence Supporting Low Barrier Care

- Expanded Take-Home Flexibilities
  - Decline in drug overdose deaths involving methadone relative to all drug overdose deaths from 4.5% to 3.2% from 2019 to 2021
  - Expanded access not associated with significant changes in urine drug test results, ED visits

Barriers to Access

- Individual
- Social
- Structural

Individual Barriers to Access

- *Wrong belief about treatment*
  - Treatment is unnecessary
  - Beliefs about MOUD
    - “Trading one addiction for another”

- *Perceived fears*
  - Fear of incarceration/withdrawal while incarcerated
  - Stigma
  - Loss of custody of children, termination of parental rights

Individual Barriers to Access

- *Personality traits*
  - Low self-esteem/confidence
  - Privacy Concerns
  - Motivational factors

- *Psychiatric comorbidities*

Social Barriers to Access

- *Stigma and lack of social support*
  - Embarrassment or stigma
  - Lack of recovery capital
  - Not having anything else going on in one's life
    - Boredom as trigger

- *Family factors*
  - Influence of partners/family members/peers
  - Partner dropped out of treatment
  - Intimate Partner violence

Social Barriers to Access

- *Friends network*
  - “People, places, things”
  - Lack of role models

- *Problems with a therapeutic team*
  - Staff burnout
    - Inappropriate pt to counselor ratios
  - Non-empathic relationships with staff
  - Poor staff education
  - Dependent relationships with staff

Structural Barriers to Access

- *Related to treatment provider services*
  - Insufficient locations
  - Waitlists
  - Costs
  - EKG Requirement
  - Barriers to dose adjustment

- *Legal barriers*
  - Restrictive policies
    - ID
    - Bloodwork
  - Diversion Control Measures
    - Callbacks
    - Observed drug screens

Structural Barriers to Access

- *Policy barriers*
  - OTP culture
    - Each clinic is unique
  - Lack of focus on vulnerable sub-communities
    - Unhoused population
  - Recovery residences not accepting individuals taking methadone
  - Cycle of addiction and incarceration
  - Lack of linkage or coordination between correctional facilities and clinics
    - Maine Correction Center

Caveat

- Low barrier care does not mean “no threshold” treatment
- Requires application of SUD diagnostic criteria
- Providers should address concerns about diversion if they arise
- If a patient is not taking their medication stopping the prescription is likely warranted

Citations

- Substance Abuse and Mental Health Services Administration. Low Barrier Models of Care for Substance Use Disorders. Advisory. Publication No. PEP23 02-00-005. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023
- Farhoudian A, et Al. Barriers and Facilitators to Substance Use Disorder Treatment: An Overview of Systematic Reviews. Substance Abuse: Research and Treatment. Volume 16: 1–11. 7/2022.
- Jakubowski A, et al. Defining low-threshold buprenorphine treatment. J Addict Med. 2020 ; 14(2): 95–98.
- Chatterjee A, et. Al. Prescribing Syringes to People Who Inject Drugs: Advancing Harm Reduction in Primary Care. April 2023. Journal of General Internal Medicine. 38 (6).

Questions?