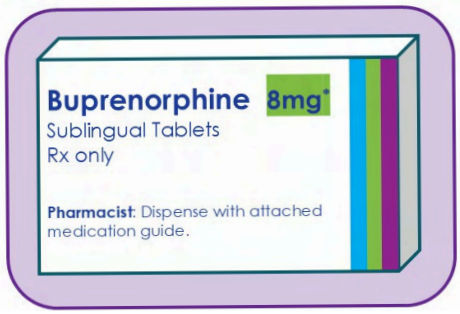
Improving Buprenorphine Access:

Considerations for Syringe Services Programs

Syringe Services Programs (SSPs) can serve as a bridge for people who are interested in starting medication for an opioid use disorder (OUD).[1] For people with OUD, a low-threshold, medication-first approach—in which people start treatment as quickly as possible and with minimal obstacles—is recommended to prevent overdose and overdose deaths.[2] However, only 18% of people with an OUD received medication in 2023, suggesting significant barriers to access.[3]

Buprenorphine (including brand name versions such as Suboxone, Subutex, and Sublocade) is a partial opioid agonist that can help reduce opioid withdrawal and cravings that can be prescribed and administered in a variety of settings, which can help improve access.[2,4,5] For example, buprenorphine can be prescribed in office-based settings or by telehealth and taken elsewhere. This flexibility means people with OUD may be linked to buprenorphine through organizations they already engage with and trust, like SSPs.

Staff members from 20 SSPs, ranging in organizational type and region, shared their experiences integrating buprenorphine.[1] Here, we summarize interviewees' experiences, expert considerations, and recent literature to support SSPs and other harm reduction organizations interested in integrating this service.



THE SSP ADVANTAGE

- **Trusted relationship.** Harm reduction organizations like SSPs focus specifically on engaging people who use drugs with dignity and are ideal for connecting those with OUD to treatment. For those who are interested in treatment but avoid traditional clinical care settings because of previous negative experiences, SSPs offer an alternative path to accessing services.[6]
- **Best fit implementation model.** SSPs have options and can implement any combination of models that work best in their context and for their participants. For example, offering access to buprenorphine via telehealth helps remove barriers to treatment such as transportation, travel time, and associated costs (e.g., bus fare, missed work), which are especially relevant to those in rural areas. This approach allows SSPs to work with prescribers who also serve other SSPs because the prescriber can split their time more efficiently.[6]
- **Innovative operations.** SSPs adapt to dynamic community and participant needs to find innovative solutions ensuring continued access to needed services. In an ever-changing policy landscape, this flexibility is vital to any service provider hoping to connect participants to treatment.[1]

NSSSP NATIONAL SURVEY OF SYRINGE SERVICES PROGRAMS
NATIONAL HARM REDUCTION COALITION
RTI INTERNATIONAL
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HOW IT WORKS

To access buprenorphine, a medical provider must screen the interested person for OUD, then prescribe the medication. The person then needs to pick up the prescription from a pharmacy to take the medication. Throughout this process, there are several opportunities for SSP involvement, such as connecting participants to a prescriber, facilitating transportation to prescription pick-up, and providing continued support in navigating treatment.

SSP staff we interviewed described four models to connect participants to prescribers.

- **Referral to in-person treatment:** SSP refers participants to in-person appointments with external prescribers. Most SSPs (16) used this model, which included making appointments for participants, providing contact information for the prescriber, and securing transportation to appointments and pharmacies. SSPs that want to refer participants to treatment may be interested in using SAMHSA's Buprenorphine Practitioner Locator to find nearby prescribers.
- **In-person treatment provided in-house:** SSP offers participants in-person appointments with the SSP's prescribers. Some SSPs (4) facilitated access this way when funding and supportive policies were in place. SSP staff still needed to support participants in understanding treatment options and securing transportation to the SSP and pharmacies.
- **Referral to telehealth treatment:** SSP refers participants to telehealth appointments with external prescribers. A few SSPs (2) referred participants to telehealth treatment. Buprenorphine is available via telehealth in many areas, however each state has its own policies related to telehealth (see cchpca.org). Staff can further support participants by providing equipment to attend telehealth appointments, helping participants navigate online systems, and securing transportation to pharmacies.
- **Telehealth treatment provided in-house:** SSP offers participants telehealth appointments with their own prescribers. One SSP provided in-house telehealth treatment in addition to in-person treatment, with appointments via telehealth or in person depending on participant and prescriber preferences. Although funding and supportive policies must be in place for this model, it offers the fewest barriers to treatment access. Staff may still need to support participants in understanding treatment options and securing transportation to pharmacies.

We see a similar pattern of model implementation in data from the National Survey of Syringe Services Programs (NSSSP).[7] Of 529 participating SSPs, 40% reported providing buprenorphine on site in 2023, either directly or through partners, and 17% did so via telehealth. Depending on which model an SSP selects, other considerations include establishing confidential spaces for appointments and understanding external prescriber requirements (e.g., drug testing, attending community support meetings).

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WHO TO ENGAGE

Regardless of the model, SSPs can engage various groups to support implementation. Based on interviews, we identified a few priority groups that can help SSPs connect participants with buprenorphine treatment, some which may be considered part of the participant's "care team."

- **People who have taken buprenorphine.** SSPs said it was helpful to work with care team members who have taken buprenorphine and were willing to share their own experiences taking the medication.
- **Prescribers.** SSPs described several ways to connect participants to external prescribers. SSPs that used referral models found it beneficial to have personal relationships with buprenorphine prescribers to streamline "warm handoffs" (i.e., a personal introduction of the participant to the prescriber by the SSP). Because buprenorphine prescribers can come from a variety of specialties, SSPs may deepen relationships with existing partners (e.g., primary care or infectious disease providers) or seek out new provider partnerships.
- **Pharmacies.** SSPs said the extra step of going to a pharmacy was a barrier for many participants to access buprenorphine because prescribers do not typically have an in-house pharmacy. To minimize this barrier, SSPs could build relationships with pharmacy staff to support third-party pick-up for medication delivery.
- **Community partners.** SSPs worked with other organizations serving people with OUD to strengthen street-based outreach efforts, increase availability of transportation to treatment (e.g., provide rides or bus fare), and improve general care coordination through warm handoffs.
- **SSPs that have implemented buprenorphine.** SSPs reported confusion about how to facilitate participant access to buprenorphine, especially through telehealth. By connecting with other SSPs that offer buprenorphine, SSPs can get answers to their questions such as what telehealth providers are available nationally and how to navigate logistics around telehealth provision.

> *"I met the owner of [organization]...he showed up at the town hall meeting to support us...And then we became very friendly and started learning more about each other's organizations. We were like, 'Why don't we just combine [our services], we should just go out next to each other.'"*
>
> **—Community-based organization providing referrals to in-person treatment**

FUNDING SOURCES

Funding is critical for SSPs to help participants access buprenorphine. SSPs named opioid abatement funds, state opioid response grants from SAMHSA, and insurance reimbursement as funding sources for their buprenorphine services.[1,6] One study in a state with Medicaid expansion found that when telehealth buprenorphine appointments were reimbursed, 92% of SSP participants were covered by Medicare or Medicaid and 4% by private insurance, while the remaining 4% paid out-of-pocket.[6] As such, SSPs hoping to offer in-house treatment may be able to cover some of the costs through health insurance. SSPs may want to pursue other funding sources while setting up to bill insurance and helping participants get enrolled (see NHRC's Healthcare Toolkit).

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CHALLENGES & OPPORTUNITIES

Interviewed SSP staff highlighted several factors that influenced how they implemented buprenorphine.

- **Stigma.** SSPs reported stigma toward people who use drugs as a barrier to any harm reduction or treatment service. Stigma impacts access to buprenorphine in several ways, including by limiting the overall resources allocated to SSPs, which trickle down and impact the availability of prescribers and supports (e.g., transportation, care coordination). Continuing to advocate for and educate others about the needs of people with OUD can help minimize stigma and its negative impacts on buprenorphine access.
- **Policy environment.** The political landscape has had a mix of positive and negative impacts on treatment access. One SSP described a successful relationship with a police chief who wanted to reinstate a diversion program whereas another mentioned a shift in legislative prioritization from mobile Suboxone clinics to telehealth, making in-house mobile induction more challenging. These impacts demonstrate how SSPs must work within their local political systems, which sometimes limits what services they can offer and how. Engaging the surrounding community and partners can help garner support for harm reduction policies.
- **Funding systems.** SSPs with allocated funding were able to support in-house prescribers. Having in-house prescribers may provide additional transparency about how services are delivered to ensure quality of care. For SSPs with limited funding, referral to external prescribers may be more realistic.
- **SSP priorities and capacity.** SSPs reported limited capacity and other priorities (e.g., distributing safer drug use equipment) that prevented them from taking on additional work to help participants access buprenorphine. These types of constraints limit an SSP's ability to implement their preferred model. Developing strong partnerships with prescribers and focusing on warm handoffs may be the best option for SSPs with these limits.
- **Prescriber willingness.** Even though X waivers are no longer required for prescribing, SSPs described a lack of providers willing to prescribe buprenorphine. Connecting participants with prescribers located farther away via telehealth models may be most helpful for overcoming limited availability of local prescribers without creating transportation barriers.
- **Customizable treatment.** The traditional approach requires patients to stop using opioids for 12 to 24 hours before taking buprenorphine and be in the early stages of withdrawal.[2] However, there is growing evidence to support buprenorphine "micro-induction" in which patients can start with small doses to minimize withdrawal symptoms and increase the medication's appeal while maintaining its feasibility in nontraditional settings like SSPs.[8] SSPs can hire or refer participants to prescribers with experience tailoring treatment approaches to best meet participant needs.
- **Staff perceptions.** SSP staff perceived their participants as preferring buprenorphine micro-/macro-dosing methods or methadone, a full opioid agonist, over traditional buprenorphine treatment, specifically when participants are transitioning from fentanyl. Engaging people with experience taking buprenorphine can help SSP staff and participants understand when buprenorphine can be most helpful to facilitate successful treatment initiation.

> *"We haven't had great access to Suboxone for a lot of reasons that are mostly based on health equity and racial discrimination. [And now] a lot of folks are just used to methadone and it's very hard to transition from methadone to Suboxone…We have those barriers."*
>
> **—Community-based organization providing in-person treatment in-house**

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ADDITIONAL RESOURCES

For more information about facilitating access to buprenorphine at your organization, email training@harmreduction.org.

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