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Perspective

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A Good Place to Start — Low-Threshold Buprenorphine Initiation

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I started my morning by knocking on the door of a white van illegally parked outside the gates of the Baltimore City Detention Center, a busy correctional facility. In a resilient city struggling with the country's highest opioid-overdose fatality rate, this vehicle had been repurposed as a mobile health unit to address the overdose crisis (see photo). The humming generator heated the van and lent the "clinic" a faint aroma of gasoline. When the door opened, I walked up the narrow steps and through a small wooden entryway to the 6-by-6-foot "doctor's office," dropped off my backpack, and greeted the rest of the team.

Our driver, Larry, was a native Baltimorean with wireless headphones dependably resting on his shoulders. Every morning, he navigated the van through narrow streets to its designated place and assumed the role of clinic site manager.

The enormous stockade façade had narrow, evenly spaced windows. Painted on the side facing Interstate 83 was a colossal image of a handgun with the caption: "Drop the gun or pick a room." The near-abandoned building was once a frenetic city jail but was mostly shut down after years of corruption. The remaining portion of the complex is now a central booking facility and short-term detention center. Anyone who is arrested in the city of Baltimore passes through these gates while awaiting sentencing or placement elsewhere.

Each day when Larry parked the van, an inspired nurse, often having just finished a night shift on the Johns Hopkins Hospital HIV unit, would climb aboard and start preparing for the day. A peer counselor joined to help guide conversations and offer resources. I always arrived last. Armed with a laptop, stethoscope, and prescription pad, I was one of the van's volunteer "docs." We never wore white coats.

This team was prepared to — quite literally — meet patients with addiction where they were. One third of people with opioid use disorder (OUD) have been involved with the criminal justice system in the previous year. But despite robust evidence showing the effectiveness of addiction treatment in correctional facilities, people with OUD who are incarcerated rarely receive medication. Reentry into the community can be a dangerous time: people recently released from prison are 129 times more likely than the general population to die of an overdose.[1] To help save lives, our van goes to them.

A clinic visit started with pounding on the van door. We'd welcome our patient in with granola bars and hot chocolate. Some visitors were return patients; others had learned about the van from word-of-mouth referrals, our primary marketing strategy. Some mornings were quiet, with only a few knocks. Passersby would stop and ask what we were doing. But after a few months, more and more clients were arriving for evaluation.

Mobile Treatment Van of the Behavioral Health Leadership Institute (Baltimore, MD).

My role was to prescribe buprenorphine to people recently released from incarceration; we set a low threshold for treatment initiation. Evidence-based medication for addiction treatment, like buprenorphine, is the standard of care for OUD, and it significantly reduces the risk of overdose.[2] Low-threshold buprenorphine initiation reflects the well-accepted philosophy that, to help save lives, medication should be prescribed at the moment that people express interest and without any additional barriers to treatment. This practice aligns with recommendations to prescribe buprenorphine even if people also use nonopioid substances, take benzodiazepines, have a relapse, or seek assistance outside the traditional clinic setting.[3]

Buprenorphine initiation isn't complicated. The latest American Society of Addiction Medicine guidelines encourage clinicians to have a low threshold for home initiation of buprenorphine. In the Covid-19 era, prescribing can be done by phone. Coaching a patient through this process is among the easiest tasks I've performed as a physician, in part because patients can often teach me whatever I don't know.

Mr. A. was one of my first patients. After rapping on the door, he went through a comprehensive intake screening process with our nurse, who showed him to the exam room. He sat on the other folding chair in my office. My knees almost touching his, we discussed how to get started.

"So, we'll get you meds today, but you can't start them until you start feeling sick from withdrawal. If you take the medicine before you start feeling sick — "

"I know, Doc," Mr. A. interrupted. "I've used it on the street."

The one substantial risk associated with buprenorphine is, paradoxically, a "precipitated withdrawal," which can occur if the medication is taken while other opioids are still in the body. Street use of buprenorphine is common: nearly one third of our patients reported use of nonprescribed buprenorphine.[4]

"For the first dose, you can cut the film in half so it's a smaller dose."

"Yeah, Doc, I know. It's easier to tear them while they're still in the foil," he told me. I didn't know the medication came in foil.

"OK, well, take half when you start feeling sick and then wait a couple hours to take the next half. Then take a strip twice a day. That's it. Do you know about naloxone, or Narcan?"

"Yeah, I know, Doc. I have it. Thanks."

Mr. A. came back almost every week and eventually transitioned to a primary care doctor. One of every five people we saw wound up in long-term treatment.[4]

Although this model has been successful, the need to prescribe buprenorphine from a van is a tragedy. Our society criminalizes the disease of addiction and stigmatizes patients. We often force people, many of whom are stable on maintenance medication, to experience painful and dangerous opiate withdrawal by failing to offer such medication when they're incarcerated. Pharmacologic treatment costs money, but untreated addiction accounts for a substantial amount of recidivism, mortality, and societal cost. Denying treatment is not only ethically questionable but also financially shortsighted.

Despite court rulings supporting a constitutional right to medication for OUD in jails and prisons, few facilities offer these lifesaving treatments. In 2016, Rhode Island became the first state to offer comprehensive medication for addiction treatment in jails and prisons: anyone with OUD can be started on

Behavioral Health Leadership Institute.

medication and will have a follow-up appointment on release. The program has demonstrated a reduction of more than 60% in overdose mortality after incarceration.[5] For every 11 people whose treatment was initiated during incarceration, one life was saved.

On reentry into the community, people still struggle to obtain access to medication. Barriers such as the X-waiver requirement prevent many clinicians from helping. To be "waivered" to prescribe buprenorphine, practitioners must undergo at least 8 hours of additional coursework. (Yet to prescribe more powerful and dangerous opiates, such as oxycodone and fentanyl, no additional training is required.) Some people in this field argue that the waiver ensures essential addiction education for prescribers. It would be possible, however, to make training available but remove the unnecessary hurdle of the waiver requirement.

Optimistically, I believe the landscape is changing. The push for greater education in addiction treatment is intensifying. More physicians and advocacy groups are calling for eliminating the X waiver, and legislation to remove this requirement has been proposed. Slowly, the number of jails and prisons offering medication for addiction treatment is increasing. But in the meantime, we still need the van for people like Mr. A., and we still need solutions for the 80% of patients who didn't connect to long-term treatment.

An audio interview with Dr. Berk is available at NEJM.org

The opioid-overdose epidemic will not be ended easily. Opioid-related deaths have been increasing at an alarming rate. Illicit fentanyl has exacerbated the dangers of untreated addiction. Financial, logistic, and philosophical barriers to providing buprenorphine to people in correctional facilities — only one segment of the population affected by addiction — remain. Policy changes alone are unlikely to lead to widespread availability of OUD medication.

But the van offers hope in the face of these challenges.

When the van left around noon each day, so did a primary treatment option for patients who have difficulty obtaining care. As I walked past the detention center after my shift, I thought about how vulnerable to dying so many of the people inside would be on their release. If OUD treatment can be so easily prescribed in a van, surely it can also be more widely provided in clinics, jails, emergency departments, and broader health systems.

A first step in ending the overdose epidemic is ensuring that vulnerable populations have access to lifesaving medication. Low-threshold treatment initiation is safe for patients and easy for clinicians. Buprenorphine can be prescribed on a street corner with nothing but compassion, hot chocolate, and granola bars. If we truly want to prevent overdose deaths, at least we have a good place to start.

Identifying details have been changed to protect the patient's privacy.

Disclosure forms provided by the author are available at NEJM.org.

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When Prescribing Isn't Enough — Pharmacy-Level Barriers to Buprenorphine Access

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For more than a decade, federal and state governments have made efforts to end the epidemic of opioid-related harms in the United States, including increasing access to buprenorphine. A partial opioid agonist, buprenorphine is an effective treatment for opioid use disorder (OUD) and reduces the risk of overdose, hepatitis C virus (HCV) infection, and HIV infection. In 2016, the