A Short Term Outpatient Buprenorphine Detox Program for Clients of a Harm Reduction Clinic on Skid Row

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AKA…

- A BEHIND THE SCENES VIEW OF THE GENESIS OF A GRASS ROOTS 2 WEEK DETOX PROGRAM FOR SKID ROW HEROIN ADDICTS

Objectives:

- Behind the scenes view of a young project: a 2 week detox program for homeless heroin addicts on skid row (not a blue print)
- Introduce LA and the skid row homeless population
- Discuss our vision and intention
- Short literature review
- Discuss the nuts and bolts of project development
- Case studies (small groups)
- Discussion

Los Angeles County 2011 Count

- **51,340 homeless on any given night**
  - 3% decrease from 2009
  - 65% male
  - 14% Children
  - **44% Black**
  - 28% Latino
  - 25% White
  - **44% over age 55**
  - 63% Unsheltered
- **City of L.A. = 23,539**
  - 9% decrease from 2009
- **Skid Row 4,316**

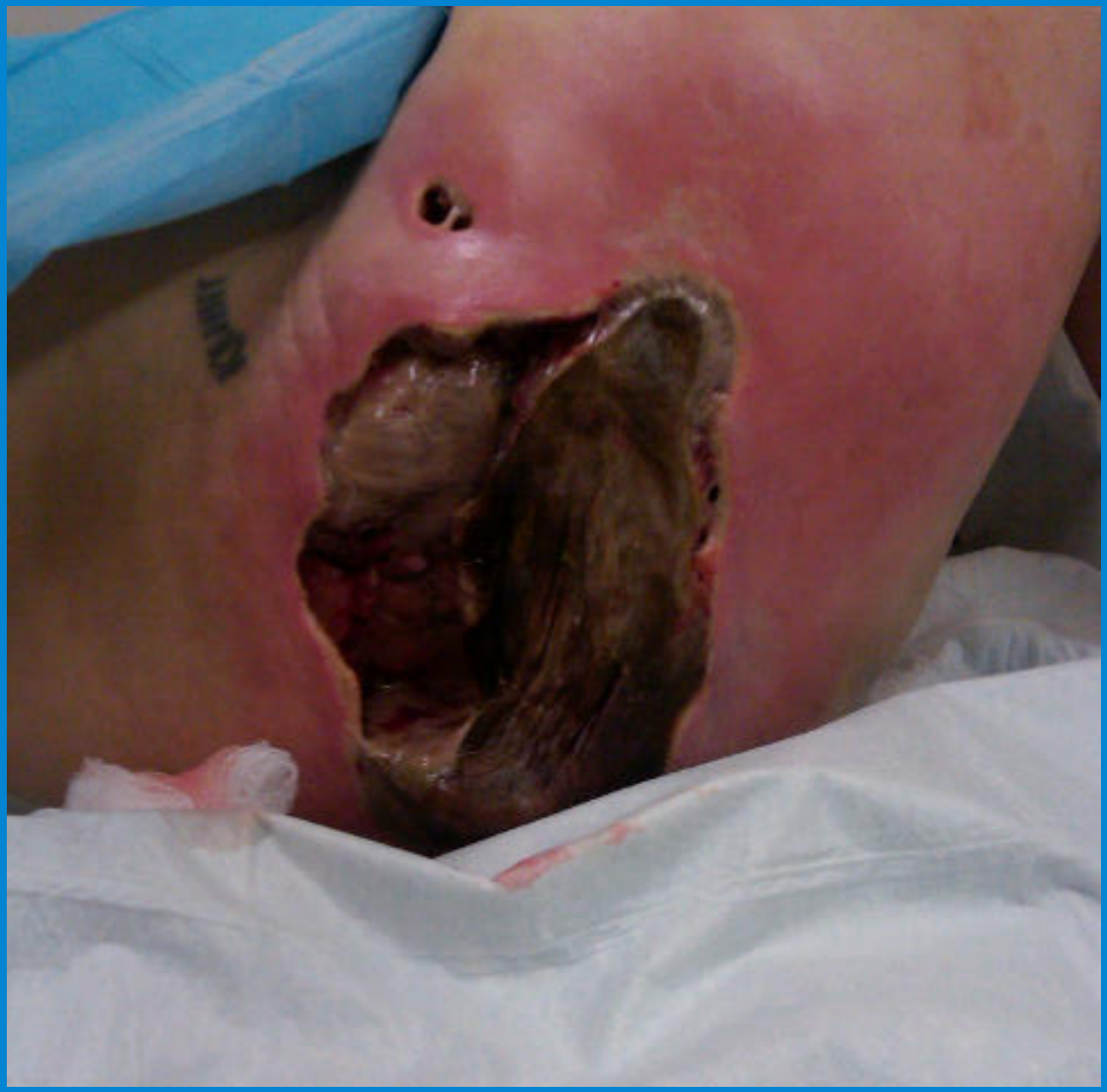
- Chronically homeless (24%)
- Members of Families (20%.. 6% decrease)
- **Mentally Ill** (33%)
- **Substance abuse** (34%)
  - 10% heroin users (17,456)
- **Veterans** (18%..3% increase from 2009)
- Physcially Disabled 22%


Bunker Hill
Los Angeles
W 3rd St
W 4th St
E 1st St
S San Pedro St
S Broadway
S Spring St
S Main St
E 5th St
E 4th St
E 4th Pl
A
Skid Row
Downtown
E 6th St
E 6th St
S Alameda St
E 6th St
E 9th St
San Pedro St

Homeless Health Care Los Angeles

- Center for Harm Reduction
  - Number of clients served per year receiving clean needles: 11,769
  - Unduplicated: 513
  - First Buprenorphine dose: 12/6/2011

Harm Reduction Center



This is an example of the desperation of addiction that we see EVERY DAY…

Cliff Hanger Case

- Ace: 24yo Puerto Rican man comes in with his pregnant girlfriend. He is an untreated paranoid schizophrenic, uses cocaine, strung out on heroin and willing "to do anything to detox for his family".
- He goes to see a psychiatrist, gets started on meds and brings in proof. He completes 6 sobriety meetings in record time; pays his 10 dollars.
- He completes the 2 week detox without incident.
- 2 days later he strains a muscle working out and when he gets home his girlfriend gives him a vicodin. The following day he relapses with heroin.
- He returns 1 week after relapse, begging for another chance, on his psych meds, ready to pay for the cost of his buprenorphine this time.

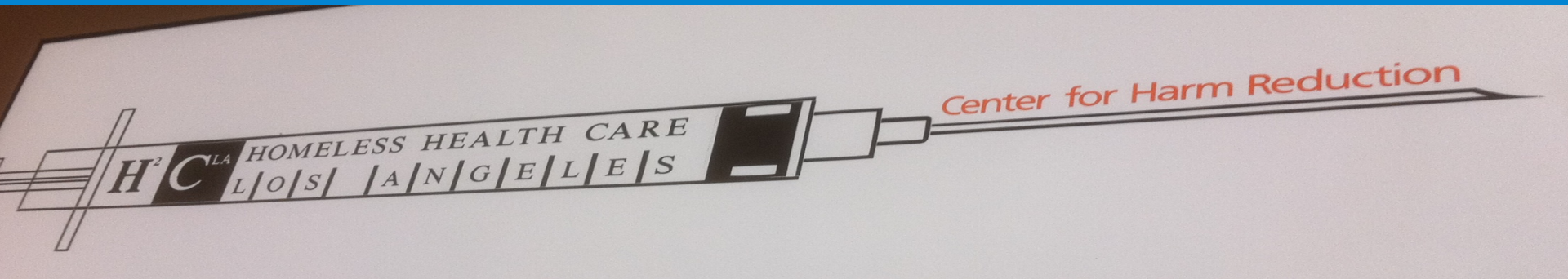

What would you
do for Ace?

Vision

- The creation of a model for a low-cost and cost-effective treatment program targeting the homeless opiate addicts
- **No opiate addicted individual should be considered too poor, too high risk, too addicted, or too complicated for treatment**
- To provide an opportunity to experience sobriety medication free should they desire

Vision

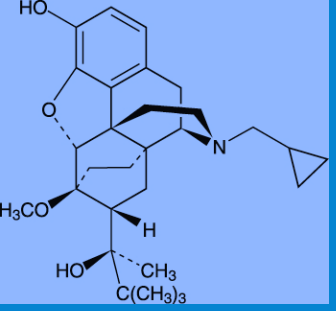
- **Develop a simple risk stratification tool**
  - Separate patients into categories of probability of success
  - Build a model to inexpensively detox those patients with the highest markers of success
  - Intensify case management and support for patients who have more risk factors for detox failure and early relapse



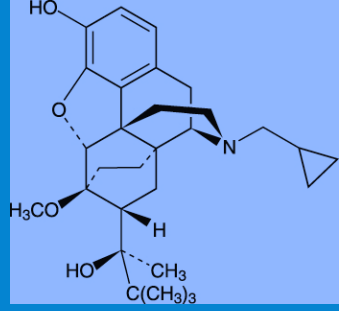
Vision

- **Phase 1 and 2: Create an all encompassing treatment program that includes all human beings**
  - Phase 1: Provide homeless opiate addicts who meet certain criteria an opportunity to detox
  - Phase 2: Expand care to include Buprenorphine maintenance therapy for higher risk individuals

- The risk stratification tool is a way to separate patients by severity of addiction to decrease cost and increase success.



Why Buprenorphine?



- **Buprenorphine is more effective than clonidine**
  - in ameliorating the signs and symptoms of opiate withdrawal
  - in treatment retention
  - has fewer adverse effects [1-4]
- **Buprenorphine and methadone are roughly equally efficacious** [1, 3, 5, 6]
- Methadone for addiction is tightly regulated
- Buprenorphine also blocks the euphoria of heroin use
- Extremely unlikely to overdose on buprenorphine

Why a Short Term Detox?

- Maintenance is more effective in treatment retention and in number of patients attaining long term sobriety than detox [7]
- BUT…long term treatment is expensive: in one cost-analysis study, a 12 week maintenance program was **$1514 more expensive** per patient than a 14 day detox [8]
- The cost for our 2 week detox is $45 per patient

Success of Similar Programs

- NIDA study, 13 day detox program: 68% of enrolled patients completed. The detox provided a gateway for longer term treatment and sobriety [9]
- A similar study in youth (15-21 years) showed good efficacy for a 14 day detox—39% opiate negative urine tests at one month [10]
- 5 similar studies, programs ranging from 3 days to 16 weeks: completion rates ranging from 65-100%. In two studies, 12-31% of patients remained opiate free at follow up. 10-33% of patients continued treatment after detox [11]


OCCUPY
SKiDROW

Homelessness and Detox

- 6x as many years of drug use and a greater number of prior detox attempts [12]
- A Boston study compared success rates in an outpatient bup treatment program (maintenance therapy for at least 4 and up to 12 months): There was no sig. difference in the percent completing 12 months (79% homeless, 78% housed, p =0.94)
- Many of the homeless individuals became housed and/or employed during treatment
- **Outpatient treatment of homeless individuals, if social support is available, is effective** [12]

Team Bup!

Nuts and Bolts

- **Moment One:** A client presents to the harm reduction center and asks about their options for detox
- They are normally offered:
  - A 21 day outpatient methadone detox
  - American Recovery Hospital inpatient detox
  - Redgate inpatient detox
  - Our 2 week buprenorphine outpatient detox
- Those that are interested in our program fill out the intake survey
- Surveys are reviewed for acceptance

NAME: **Phone #:**
Date of Birth:
Today's Date:

THE FOLLOWING QUESTIONS REFER TO HEROIN OR ANY OTHER OPIATE (VICODIN,OXYCONTIN,PERCOCET, MORPHINE TAKEN BY MOUTH or INJECTED)

Pre- Buprenorphine Questionnaire

1. What is the longest amount of continuous days of sobriety you have ever had (not including prison or forced)?	1. ≥30d=4
2. Have you been to a 12 step, NA or AA or equivalent meeting in the last 2 months? _____	2. Y=1
3. Do you have a trusted house or apartment to stay at for the whole next month? _____	3. Y=2
4. Do you have your own room? _____	4. Y=6
5. Are you currently employed? _____	5. Y=1
6. Do you live with constant strong pain in any part of your body that has lasted for greater than **6 months**? _____	6. Y=-6
7. Are you bipolar or schizophrenic? _____ IF YES: Do you take daily medication? _____	7. Y=-4 (if Yx2 = 0
8. Are you constantly sad/anxious or have Attention Deficit Disorder?_____ IF YES: Do you take daily medication?	8. Y=-2 (if yx2 =0)
9. If you are USING GOOD DOPE: How many balloons or bags of heroin a day are you using? _____	9. >4= -2
10. If you are using WEAK DOPE: How many balloons or bags of heroin a day are you using? _____	10. >15=-2
11. Have you taken any methadone in the last 2 week? _____	11. Y=-3
12. Do you have any history of physical or sexual abuse? _____	12. Y=-1
13. How many of your close friends are currently using heroin addicts? _____	13. >3 = -1
14. Is your main sex partner currently using heroin? _____	14. N=1
15. Do you live with a sex partner who currently uses heroin? _____	15. Y= -6
16. Have you used a Xanax, Ativan, Klonopins, or any other benzo's in the last 2 weeks? _____	16. Y= -2
17. Are you currently drinking more than 3 Alcoholic beverages a week? _____	17. Y= -2
18. Have you used cocaine or methamphetamines in the last 2 weeks? _____	18. Y= -2
19. How ready are you to quit heroin? From 1(not ready at all) to 10 (totally 100% ready for sobriety) _____	19. <9 =-6
20. Are you or could you be pregnant? _____	20. NULL
21. Are you breast feeding? _____	21. NULL
22. Do you have someone who is **SOBER** who is a source of support for you? _____ i. If so: list their name and relationship to you _____ (CONFIDENTIAL) ii. Do you live with this person? _____	22. Y= 2 i. ANY= 1 ii. Y=1
23. Answer only if you have tried suboxone: Does suboxone work for you? _____	23. N=NULL
24. Are you willing and able to come for visits every other day to pick up your dose of suboxone during detox and s manager? _____	24. Y = 1 N=NULL Null=Not a candidate

V. 4/24/12

Nuts and Bolts

- **Once accepted, the patient then completes the following steps in order:**
  - Referral to our administrative coordinator for orientation
  - Begin their sign off sheet to document 2 meetings
  - Physician consultation with full physical and assessment of individual barriers to treatment success
  - 2 additional meetings, along with any additional requirements identified from the assessment
  - Referral letter for liver function tests and a release of records
    - JWCH Weingardt
  - $10 deposit and 2 additional meetings
  - Schedule first day of detox

Nuts and Bolts

- Patients are given information explaining the buprenorphine detox and all requirements and sign a consent
- Basic Requirements:
  - Don't become pregnant
  - No drug use for 8-12 hours prior to detox
  - Compliance with appointments
  - Housing changes are also evaluated: if housing appears to be unstable for at least the first 3 days of detox the patients detox will be postponed. Stable tent, car living are allowed to go through
  - No repeat detox for 6 months

Nuts and Bolts: Risk Factors

- **What do we do with risk factors for detox failure?**

  - Chronic Pain: needs detailed non-narcotic pain management plan through PMD or specialist

  - Mental illness: (any kind) requires COPY of RX/pill bottle or note from MD or psychiatrist and stable on meds

Nuts and Bolts: Risk Factors

- Methadone:

  - once a week to once a month: will need clean urine to start

  - daily methadone: cancel detox

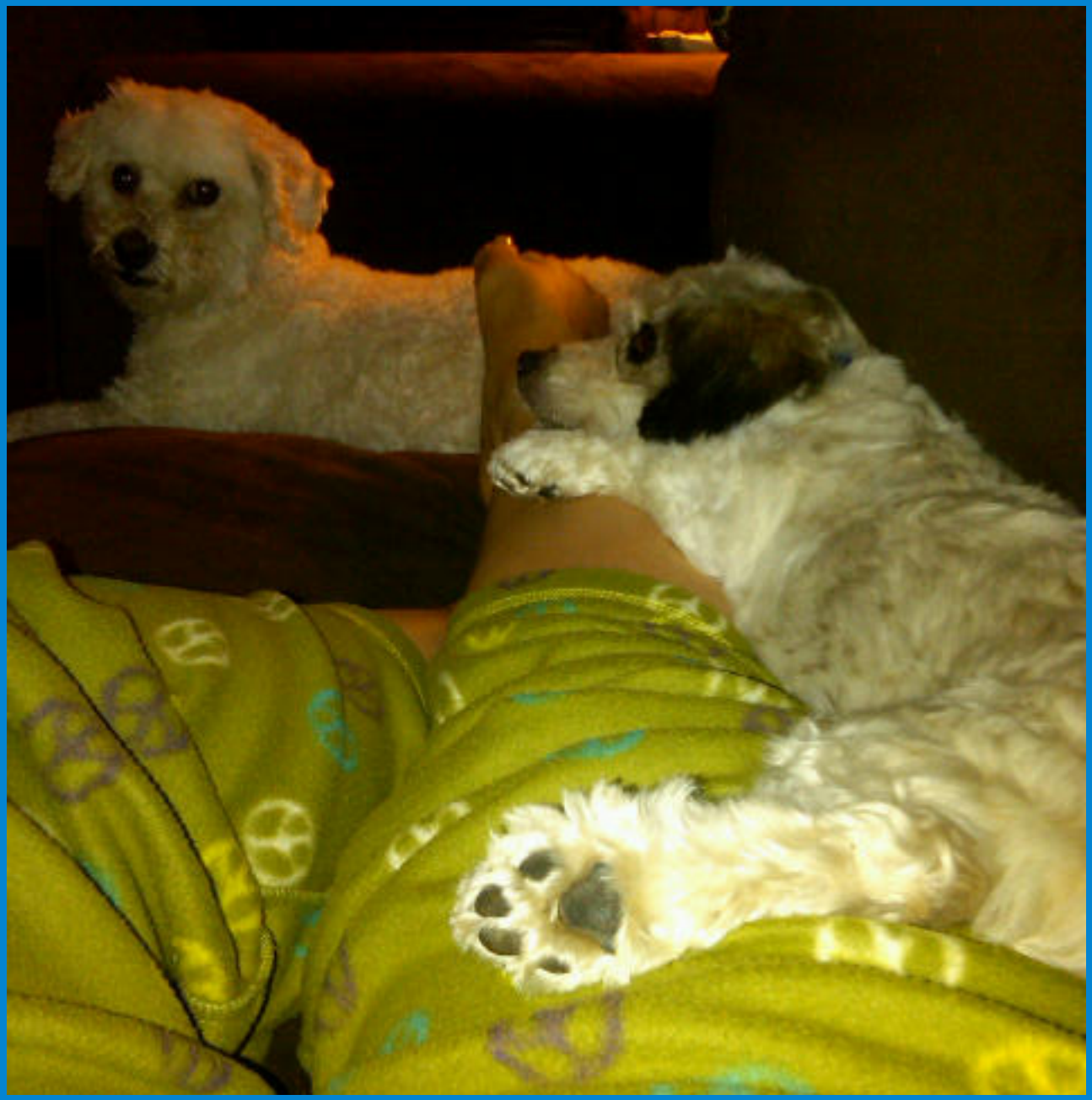
- Methamphetamines, cocaine and street benzodiazepines:

  - if evidence of dependence: cancel detox

  - no more than 4x a month: recommend cessation proceed to detox

Nuts and Bolts: Risk Factors

- Housing changes: No detox until stabilized
- Lives with partner who uses heroin: explain to client very poor likelihood of successful outcome
- ETOH use: abstain for one month



Nuts and Bolts: Risk Factors

- If a patient's detox is cancelled due to any high risk features, the following options are offered:
  - maintenance methadone therapy at local methadone clinic
  - private buprenorphine administering physicians
  - in- patient detox programs

- We hope to be able to address these higher risk patients in the future by providing buprenorphine maintence, but we are first planning on optimizing a treatment protocol for those more likely to succeed

Key Features of Detox Process:

- Use of COWS: Clinical Opiate Withdrawal Scale
- Direct Observed Treatment: Every Tuesday and Thursday
  - We place the pills under their tongue and observe them for at least 2 minutes.
- Maintain compliance with rules
- Visit by visit counseling on triggers, relapse, opiate use for pain
- Additional medications to manage withdrawal symptoms
- Assess need for conversion to maintenance therapy

Study Day	Buprenorphine	Actual Dose Given
1 (Observed dose)	4 + additional 4 + 2mg take home	
2	12	
3 (Observed dose)	14 + additional 2 as needed	
4	14+ additional 2 or 4 as needed	
5	12+additional 2 as needed	
6	10 +additional 2 as needed	
7	8 + additional 2 as needed	
8 (Observed dose)	6 +additional 2 as needed	
9	6+ additional 2 as needed	
10 (Observed dose)	4+additional 2 as needed	
11	4+additional 2 as needed	
12	2+ additional 2 as needed	
13	2+additional 2 as needed	
14	2	
15 (Observed dose at once)	2 as needed	

Review: Cliff Hanger Case

- Ace: 24yo Puerto Rican man comes in with his pregnant girlfriend. He is an untreated paranoid schizophrenic, uses cocaine, strung out on heroin and willing "to do anything to detox for his family".
- He goes to see a psychiatrist, gets started on meds and brings in proof. He completes 6 sobriety meetings in record time; pays his 10 dollars.
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- He returns 1 week after relapse, begging for another chance, on his psych meds, ready to pay for the cost of his buprenorphine this time.

Case Outcome:

- Ace was allowed to repeat detox.
- After completing 4 additional counseling meetings and understanding the risks of opiate use for pain, he pays for the cost of his own medications and commences with the detox.
- He does well until he doesn't show up on Day 10.
- We contact his bewildered and distraught girlfriend who tells us he has been picked up by the Feds for drug trafficking across state lines between California and New York.

Case #1: Scenario

- On day 6 of detox, a patient develops a toothache and takes a total of 4 vicodin tablets. He also drinks 2 beers. He tells you about this the next day in clinic. He also states that he "doesn't like meetings anymore" and refuses to go. Furthermore, he is living with people who are actively using. How should we manage him to increase his chances of success?

Case #1: Action

- Discussed dangers of opiate medications during sobriety
- Prescribed ibuprofen and ambesol/oil of clove for tooth pain and referred to a dentist
- Discussed the importance of counseling; suggested alternatives to the meetings he had been attending; strongly recommended that he attend a support meeting prior to the next visit
- Found different housing for him

Case #1: Outcome

- Patient attended a meeting and did not take any more vicodin
- He elected to remain in the housing he had, for fear of ending up on the streets
- He dropped out of the detox program on day 11
- At a follow up interview, he stated his reason for not completing the detox was “a poor environment” where people were using and “the temptation was too great”

Case #2: Scenario

- A couple is interested in participating in the detox program together. One scores very well on the intake survey, a sign that she may do well with an outpatient detox. The other scores very poorly, and is abusing alcohol in addition to heroin. Should they both do the program? Should one be accepted without the other?

Case #2: Action

- Enrolled the higher scoring partner
- We offered enrollment to the other partner on the condition that he was able to abstain from alcohol x 1 month
- We began implementing breathalyzer tests

Case #2: Outcome

- Low risk partner completed detox successfully, except did not return for last 2 mg dose or urine drug test
- She did not want to come in for follow up tests because "being at the exchange is a trigger"
- On phone interview was still clean almost 2 weeks post detox
- High risk partner refused our conditions
- He is waiting to complete an inpatient program

Case #3: Scenario

- A patient successfully completes the 2 week detox program, but relapses fairly immediately "because of stress." She returns to the clinic a few days after, requesting treatment for an early abscess. What other treatment options should we offer her for her addiction?

Case #3: Action

- Gave her clonidine, promethazine, diphenhydramine for withdrawal symptoms; TMP-SMX for the abscess
- We only offer the bup program every 6 months—we did not offer this again at this time

Case #3: Outcome

- Unknown, lost to follow up

Case #4: Scenario

- A patient in the detox program has a mood disorder and ADD. She was unable to get enough adderall to treat her ADD. What can we do to increase her chances of success in the program? How should we avoid this situation again?

Case #4: Action

- We expanded survey questions to include anxiety and ADD
- We require all participants to receive treatment for mental health conditions prior to starting detox
- We require patients to be on medications for psychiatric illnesses for 1 month prior to detox
- We request copies of prescriptions and mental health professional medical notes

Case #4: Outcome

- The stress of outpatient detox was too much for the patient; she withdrew and entered an inpatient detox program
- We called for follow up after her detox, and we were unable to contact her

Case #5: Scenario

- A patient doing well in detox falls and sprains his ankle. He goes to the ER and receives vicodin for his pain. He reports taking the vicodin when he returns to clinic. How should we manage his pain? What should we tell him about pain medications in the future? Can he ever take opiate pain medications again?

Case #5: Action

- We managed his ankle pain with RICE therapy, ibuprofen and an ankle brace.
- We advised him not to take more vicodin.

Case #5: Outcome

- The patient finished detox successfully
- At 1 month follow up he was using again. He stated that he thinks he would have done better in a longer program, as “not everyone is a two week person”.

Outcomes (So Far)

- 13 individuals enrolled in the program
- 46% completed the 2 week detox program
- Many patients reporting reductions in amount or frequency of use, even if not completing the program

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