

# Towards an Improved Substance Use Disorder Treatment Landscape in Rhode Island – Barriers, Current Progress, and Next Steps

HANNAN M. BRAUN, MD; JULIETTE A. HOLTZMAN, LICSW, LCDP; CAROLINE WUNSCH, MD; SETH A. CLARK, MD, MPH

## ABSTRACT

Expanding addiction treatment services in Rhode Island has never been more urgent. Today, we face colliding syndemics of COVID-19, preventable drug overdoses, and HIV, with another year of record overdoses. While the treatment of substance use disorder (SUD) is an essential component of general medical care, numerous barriers prevent broader treatment access for patients in Rhode Island. Buprenorphine and methadone therapy have restrictions that are not applied to other areas in medicine, including for more dangerous medications. In this piece, we highlight existing barriers to care, applaud current progress being made in our state, and provide recommendations for next steps to turn the tide of this deadly epidemic. We hope that these proposed changes will help develop a robust treatment landscape for all patients with SUD in Rhode Island.

## INTRODUCTION

With the colliding syndemics of COVID-19, opioid overdoses, HIV, and viral hepatitis,<sup>1</sup> as well as another year of record overdoses,<sup>2</sup> expanding addiction treatment services in Rhode Island has never been more urgent. Treatment of substance use disorder (SUD) is an essential component of general medical care, and any absence of its evidence-based prevention, screening, and treatment in healthcare is a matter of social and racial inequity. Too often, the medical and public health community treats substance use disorder as an acute condition, rather than a chronic and treatable disease with rates of successful management similar to that of hypertension and type II diabetes.<sup>3</sup> Fortunately, we have multiple efficacious interventions to reduce morbidity and mortality, improve wellbeing, and increase treatment retention for patients with SUDs; however, numerous barriers prevent broader access for patients in Rhode Island.

## CURRENT BARRIERS

Buprenorphine and methadone therapy have restrictions that are not applied to other areas in medicine, including for more dangerous medications. Methadone treatment is tightly regulated by federal regulations and remains siloed

from traditional clinical care, leading to disruptions in care and inaccessible treatment. For example, if a patient is newly initiated on methadone while hospitalized, this creates multiple barriers for continued care in post-acute care settings or inpatient addiction treatment after discharge. Rigid scheduling for daily methadone dosing frequently interferes with work scheduling, and certain occupations (i.e. truck driver) prohibit patients from methadone therapy. Buprenorphine clinics are often in inconvenient locations, have limited hours, and may require frequent visits or meetings with behavioral health as a prerequisite to medication initiation. Across the nation, neighborhood racial segregation predicts differences in access to both buprenorphine and methadone, with highly segregated Black and Hispanic/Latinx communities having more methadone facilities, while counties with segregated white communities having more buprenorphine facilities.<sup>4</sup>

Barriers are not limited to buprenorphine or methadone treatment. Spanish and other language services remain particularly limited in Rhode Island, especially among residential and intensive outpatient program (IOP) settings. Group counseling – which forms the crux of most IOP and partial hospital programs – can be especially difficult when interpreters are needed. Patients who lack insurance may only be able to seek SUD treatment at free clinics or mutual-aid meetings (Alcoholics Anonymous, etc.) and medications are often cost prohibitive. Patients on Medicaid are limited to certain residential treatment programs, Medicare does not cover inpatient addiction treatment, and insurance, rather than clinical stability, may dictate length of treatment for others. Residential facilities may legally reject patients who experience homelessness, or are not able to accept patients leaving the hospital with complex medical issues or who are not independent with activities of daily living. Group sober homes are largely unregulated, provide variable quality of living conditions, and may reject a patient for being prescribed opioid agonist treatment (OAT) or other prescribed controlled substances. Because of these systemic barriers, only a minority of patients receive evidence-based care,<sup>5</sup> such as OAT and interventions to address the social determinants of health. US immigration law dictates that a person is not eligible for a green card or a visa if they have a substance use disorder,<sup>6</sup> a policy routed in stigma, fear, and discrimination.

## CURRENT PROGRESS

Our state has taken several important steps forward. For example, in 2016 the Rhode Island Department of Corrections became the first state correctional system to offer treatment with all FDA-approved medications (i.e., methadone, buprenorphine, and naltrexone) to incarcerated people with opioid use disorder; in the first year of this program's implementation, there was a 12% drop in statewide overdose deaths and a 61% drop in post-incarceration overdose deaths.<sup>7</sup> At the onset of the COVID-19 pandemic, after federal regulations changed to temporarily allow buprenorphine initiation via telehealth,<sup>8</sup> Rhode Island established a 24-hour buprenorphine hotline to serve as a "tele-bridge" clinic. Hotline providers evaluate callers in real time, initiate buprenorphine in appropriate patients, and then link them to longitudinal care in the community.<sup>9</sup> The Rhode Island Hospital Emergency Department has expanded their buprenorphine induction protocol after unintentional overdose (an intervention associated with a 37% reduction in all-cause mortality<sup>10</sup>) by post-ED visit outreach. Research initiatives are also being explored to address the overdose crisis by providing buprenorphine managed through the pharmacy (via a collaborative practice agreement)<sup>11</sup> and by increasing drug-checking services. Project Weber/RENEW, a peer-driven harm reduction organization, had provided over 900 HIV and hepatitis C tests, over 10,000 naloxone doses, over 48,000 condoms, and over 100,000 new needles in 2020 and 2021. To facilitate access to low-barrier treatment for opioid use disorder (OUD) and to increase screening and connection to care for HIV and viral hepatitis, Project Weber/RENEW has partnered with outreach physicians and the Miriam Immunology Clinic to create a clinic co-located in one of their drop-in centers. Project Weber/RENEW case managers and physicians are working together to provide wound care, rapid HIV and Hepatitis C screening, on-site STI screening, and streamlined treatment for hepatitis C and HIV pre-exposure prophylaxis initiation. In July 2021, Rhode Island became the first state in the nation to authorize an overdose prevention site (OPS)—a space for people to consume pre-obtained drugs with sterile supplies. Additionally, local legislation was recently changed to reclassify drug possession charges from a felony to a misdemeanor (for up to 10 grams of a substance) and decriminalize possession of nonprescribed buprenorphine.<sup>12</sup>

## NEXT STEPS

A coordinated, compassionate, and evidence-based response can turn the tide of this deadly epidemic. Health service providers should examine and replace policies that penalize ongoing substance use (for example, employing punitive urine toxicology testing) in favor of harm-reduction practices, recognizing that ongoing use often indicates a need for more treatment rather than less. Establishing additional

inpatient addiction consult services to more hospitals in the state is likely to benefit both patients and health systems.<sup>13–15</sup> Opening the newly sanctioned OPSs can be expected to reduce overdose mortality, drug use, and infectious disease risk, and facilitate access to health and social services.<sup>16–19</sup> In the first three weeks of their operation in November 2021 in New York City, the nation's first two sanctioned OPSs reversed 59 overdoses.<sup>20</sup> And in the setting of an increasingly toxic illicit drug supply, we need expanded access to opioid reversal agents (i.e. naloxone) and drug-checking technology (i.e. fentanyl or methamphetamine test strips). Drawing on the success of several injectable OAT programs in parts of Canada and Western Europe, it's time to have a serious conversation about safe supply, especially for treatment-refractory OUD.<sup>21,22</sup> Housing First is also an additional evidence-based practice to serve patients experiencing chronic homelessness with mental illness and SUD.<sup>23</sup>

## Opioid Agonist Treatment

Changes are needed to increase the accessibility and flexibility of OAT. While the in-person daily dosing requirement for methadone is helpful for many, it is currently applied across the board and providers have limited ability to adjust or titrate as patients stabilize in recovery. During the COVID-19 pandemic when many clinics liberalized their take-home policy, many Opioid Treatment Program (OTP) patients did well with increased access to take home doses.<sup>24</sup> A change to consider is allowing for a limited or modified OTP license in academic health centers or community health centers<sup>25</sup>—settings in which patients with SUD already access care. We should consider allowing primary care providers to prescribe methadone for OUD with pharmacy-based administration, the current model for methadone delivery in several provinces in Canada, Australia, and the UK.<sup>26</sup> With appropriate clinical caution, primary care and outpatient addiction providers are well equipped to manage methadone maintenance therapy.

For buprenorphine, immediate steps to lower barriers to treatment include continuing the COVID-19 emergency exception authorizing audio-only tele-initiation and eliminating the prior authorization requirement for injectable buprenorphine. Additionally, discontinuing the X waiver requirement would allow more providers to prescribe buprenorphine.<sup>27,28</sup> At present, only higher-dose sublingual, buccal, subdermal, or subcutaneous buprenorphine formulation may be prescribed for OUD. Given the significant risk of precipitated withdrawal during buprenorphine initiation with increasingly pervasive fentanyl use,<sup>29–31</sup> expanded access to lower-dose transdermal and buccal buprenorphine formulations would support micro-induction in an outpatient setting. Currently, it remains illegal to prescribe these products for OUD, even for short courses to bridge patients to OUD-treatment dose buprenorphine. Anecdotally, some providers send their patients to the ED to obtain

these medications to facilitate induction, creating unnecessary strain for ED providers for care that otherwise could be delivered in the outpatient setting. Additionally, many buprenorphine formulations require prior authorization based on insurance preference and/or dispensing limits. The delay to treatment that these additional steps can cause can prove fatal given the current drug supply.

Primary care settings can take many harm reduction steps to better serve patients who use drugs,<sup>32</sup> such as providing naloxone, offering treatment on demand, approaching urine drug testing as just one tool in their overall assessment (and consider ordering only when the results will change management, such as confirming the presence of prescribed buprenorphine), and installing reverse motion detectors in high-risk areas to prevent overdose. To reduce and treat infections they could offer HIV, viral hepatitis, and bacterial STI testing, prescribe HIV pre- and post-exposure prophylaxis, vaccinate against hepatitis A and B, and co-locate hepatitis C and SUD care, in addition to providing harm reduction supplies such as syringes and fentanyl test strips to spark discussion on safer consumption technique.

### Optimizing the Addiction Medicine Workforce

Diversification of the addiction treatment workforce provides a path to improve care. Steps include: promoting Black, Hispanic, and Native individuals to leadership, hiring individuals from affected communities, and formally including people with lived experience.<sup>33</sup> Since tailored care such as street outreach improve perceptions of treatment,<sup>34</sup> steps to combine street outreach and telemedicine offer promising opportunities to extend addiction providers' reach. More residential and inpatient medically managed withdrawal (i.e. detox) beds are needed in the state, especially for elderly patients and patients from the community rather than solely from hospitals. There is a particular need for inpatient addiction treatment programs that do both psychosocial support and treat medical complications of SUD.

### LIMITATIONS AND CONCLUSION

These investments need to be developed while considering the impact that structural racism has on how patients with SUD are viewed and treated. Any efforts to improve addiction treatment must include support for justice-involved populations, and acknowledge the historic and systemic racism that has led to mass incarceration, particularly in communities of color.<sup>35</sup> We must continue to advocate for evidence-based criminal justice reform as existing laws often disrupt treatment and can prevent sustained recovery.

We recognize that many of the included points are most applicable to OUD. At the same time, opioids remain the main driver of overdose-related deaths. However, it is also vital to study and fund research into treatment for stimulant use disorders, and to promote access to safer stimulant

consumption services. We also recognize that many of these changes described above require federal legislative and regulatory action. Still, we hope that these proposed changes will help develop a robust treatment landscape for all patients with SUD in Rhode Island.

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## Authors

Hannan M. Braun, MD, Addiction Medicine Fellowship, Department of Medicine, The Warren Alpert Medical School of Brown University; Division of General Internal Medicine, Rhode Island Hospital, Providence, RI.

Juliette A. Holtzman, LICSW, LCDP, Addiction Medicine Fellowship, Department of Medicine, The Warren Alpert Medical School of Brown University; Addiction Medicine Consult Service, Rhode Island Hospital, Providence, RI.

Caroline Wunsch, MD, Department of Medicine, The Warren Alpert Medical School of Brown University, Providence, RI.

Seth A. Clark, MD, MPH, Division of General Internal Medicine, Rhode Island Hospital; Division of Psychiatry and Human Behavior at Warren Alpert Medical School of Brown University, Rhode Island Hospital, Providence, RI.

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## Correspondence

Hannan M. Braun, MD  
Addiction Medicine Fellow  
Department of Medicine  
Rhode Island Hospital  
593 Eddy Street, Plain St. Bldg., 1st Floor  
Providence, RI 02903  
[Hannan.Braun@gmail.com](mailto:Hannan.Braun@gmail.com)