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"YOU'RE HOPING FOR THE BEST, BUT PREPARING FOR THE WORST": DISCUSSIONS OF STARTING BUPRENORPHINE IN THE SETTING OF FENTANYL USE WITH CLINICIANS AND PEOPLE WHO USE FENTANYL

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OBJECTIVES

1. Describe the current state of buprenorphine initiations
2. Introduce the rapid analysis process for qualitative assessment
3. Understand barriers and facilitators to starting buprenorphine from the perspective of both clinicians and people who use fentanyl

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OUTLINE

- Background
- Methods
- Main Results
- Secondary Papers (2)

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BACKGROUND

- Fentanyl
  - Most common opioid involved in o
  - Different than other opioids
  - Increasing complexity of buprenorphine starts
- Clinical practices are ahead of the research
- Lack of knowledge about individual experiences, specific barriers for clinicians and people who use fentanyl

Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States

COMMENTARY

A Plea From People Who Use Drugs to Clinicians: New Ways to Initiate Buprenorphine Are Urgently Needed in the Fentanyl Era

Kimberly L. Sue, MD, PhD, Shawn Cohen, MD, Jess Tilley, and Avi Yocheved

With the worst opioid overdose death crisis in the United States history, urgent new approaches to assist people who use drugs onto medication for opioid use disorder are necessary. In this commentary, addiction medicine clinicians and drug user union representatives align to argue that conventional ways of buprenorphine initiation that require periods of withdrawal must be augmented with additional novel approaches to initiation. In the fentanyl era, members of the New England Users Union and Portland Users Union report encoun-

With a shift in the unregulated drug supply from heroin to predominantly illicitly manufactured fentanyl, there are concerns that fentanyl's lipophilicity potentially increases the risk of precipitated withdrawal even after waiting for symptoms of withdrawal to start, theoretically making initiations harder than with other opioids such as heroin.[2,3] Yet, buprenorphine initiations have remained largely unchanged. Buprenorphine initiation is conventionally taught as a multistep process to minimize risk of

Sue KL, Cohen S, Tilley J, Yocheved A. A Plea From People Who Use Drugs to Clinicians: New Ways to Initiate Buprenorphine Are Urgently Needed in the Fentanyl Era. J Addict Med. 2022 Jul-Aug 01;16(4):389-391. doi: 10.1097/ADM.0000000000000952. Epub 2022 Jan 11. PMID: 35020693.
Spencer MR, Garnett MF, Miniño AM. Drug overdose deaths in the United States, 2002–2022. NCHS Data Brief, no 491. Hyattsville, MD: National Center for Health Statistics. 2024. DOI
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STUDY AIM

Explore experiences, barriers, and facilitators related to starting buprenorphine and how these have changed in the setting of fentanyl use.

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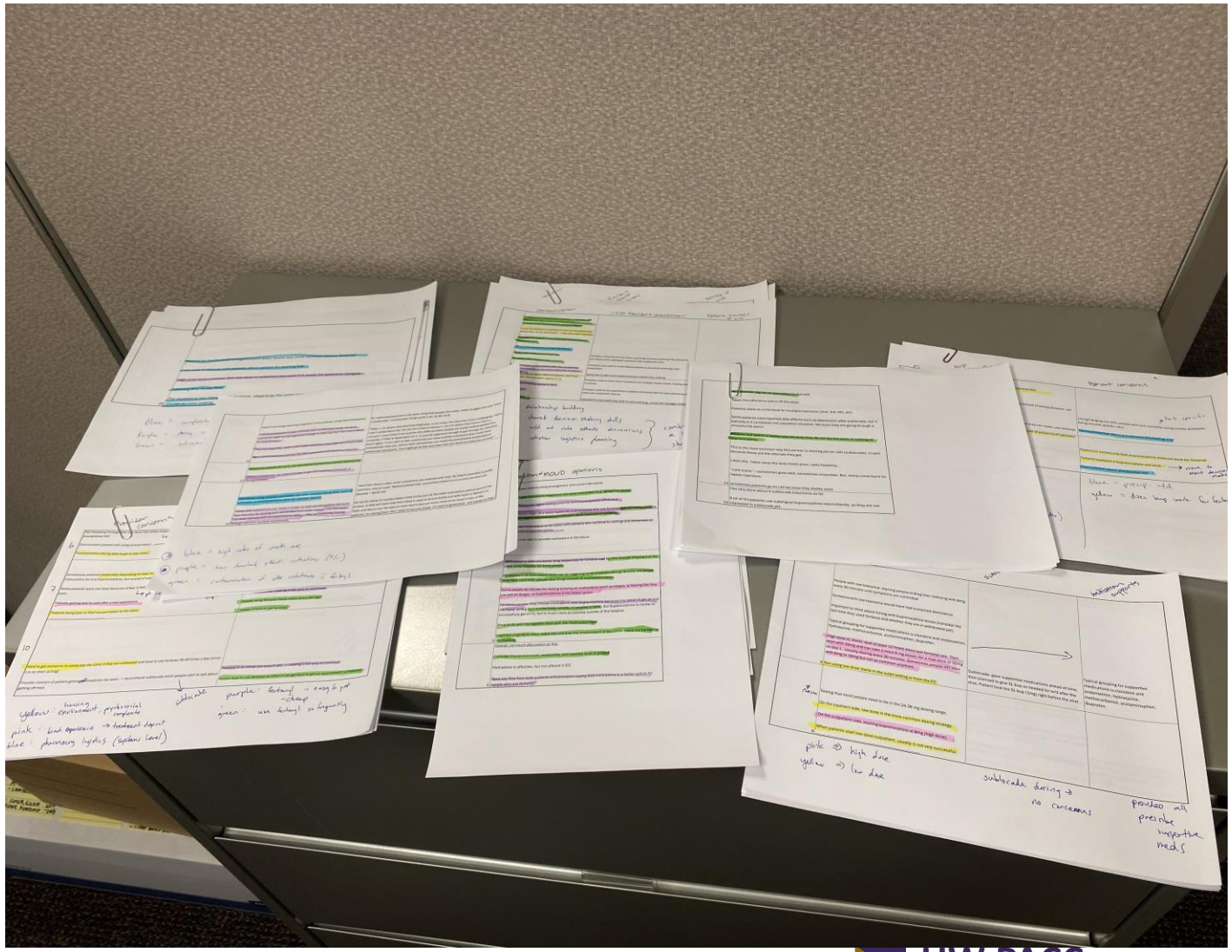
Methods

- **Design:** Semi Structured Qualitative Interview
- **Participants:** 18 or older, fluent in English, taken buprenorphine in the setting of fentanyl use (PWUF), prescribed/provided buprenorphine care (clinicians) within the last 6 months.
- **Recruitment:** All participants recruited from the Seattle area from May to November 2024. PWUF recruited via flyers and word of mouth. Clinicians recruited via direct email.
- **Analysis:** Rapid qualitative analysis process to group ideas and formulate themes.

Rapid Analysis Process

- Pulled topics and quotes from each transcript into a "RAP" sheet.
- Compiled RAP sheet entries into a matrix.
- Used color coding to organize overlapping ideas from different questions/domains.
- Created summary sheets with emerging themes.



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PWUF Characteristics

Characteristic (N=28)	**No. (%)**
Age, mean (SD, range), years	**43.8** (10.9, 24-64)
Gender	
Male	**18** (64.3)
Female	**9** (32.1)
Other	**1** (3.6)
Race/Ethnicity[a]	
White	**13** (46.4)
Black/African American	**9** (32.1)
Hispanic/Latino	**5** (17.9)
American Indian/Alaska Native	**2** (7.1)
Asian	**1** (3.6)
Native Hawaiian/Pacific Islander	**1** (3.6)
Other	**1** (3.6)

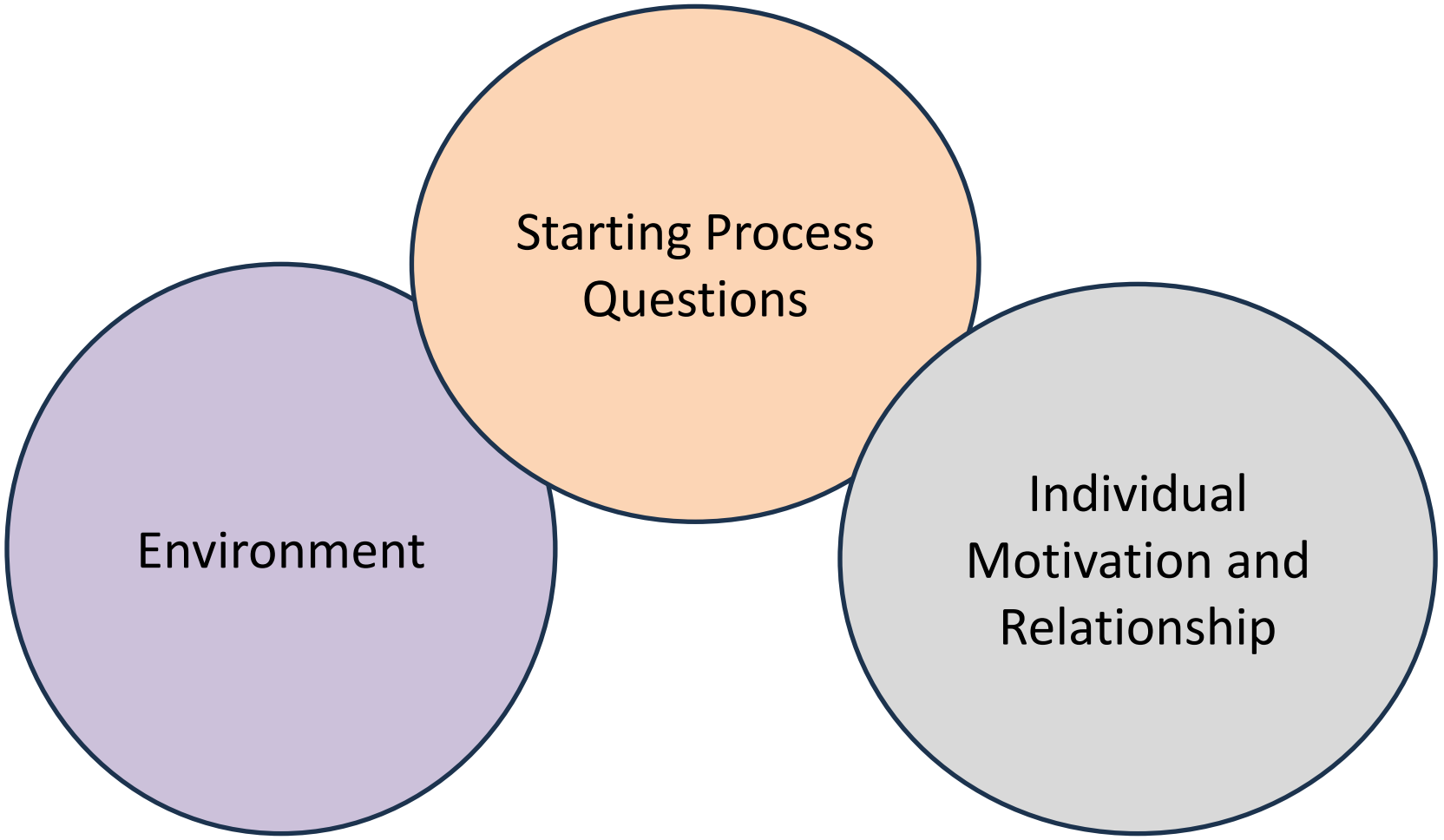
PWUF Characteristics

Characteristic (N=28)	**No.** (%)
Living arrangement[a]	
Own/rent home	**9** (32.1)
On the street(s) without shelter	**6** (21.4)
Residential addiction program	**5** (17.9)
Shelter	**5** (17.9)
Staying with friends/ family member(s)	**5** (17.9)
Times started buprenorphine (past 3 years)	
1	**8** (28.6)
2-5	**13** (46.4)
> 5	**7** (25)
Level of education	
No high school diploma	**4** (14.3)
High school diploma/GED	**15** (53.6)
Above a high school education (+/- degree)	**9** (32.1)

Clinician Characteristics

Characteristic (N=15)	**No. (%)**
Age, mean (SD, range), years	**39.9** (5.3, 33-49)
Gender	
Male	**8** (53.3)
Female	**7** (46.7)
Race/Ethnicity	
White	**14** (93.3)
Other	**1** (6.7)
Type of degree	
Medical Doctor	**8** (53.3)
Registered nurse	**5** (33.3)
Nurse practitioner	**1** (6.7)
Not reported	**1** (6.7)
Years of prescribing/providing buprenorphine care, mean (SD, range)	**6.8** (2.8 , 2-12)

MAIN COMPONENTS OF OUR THEMES



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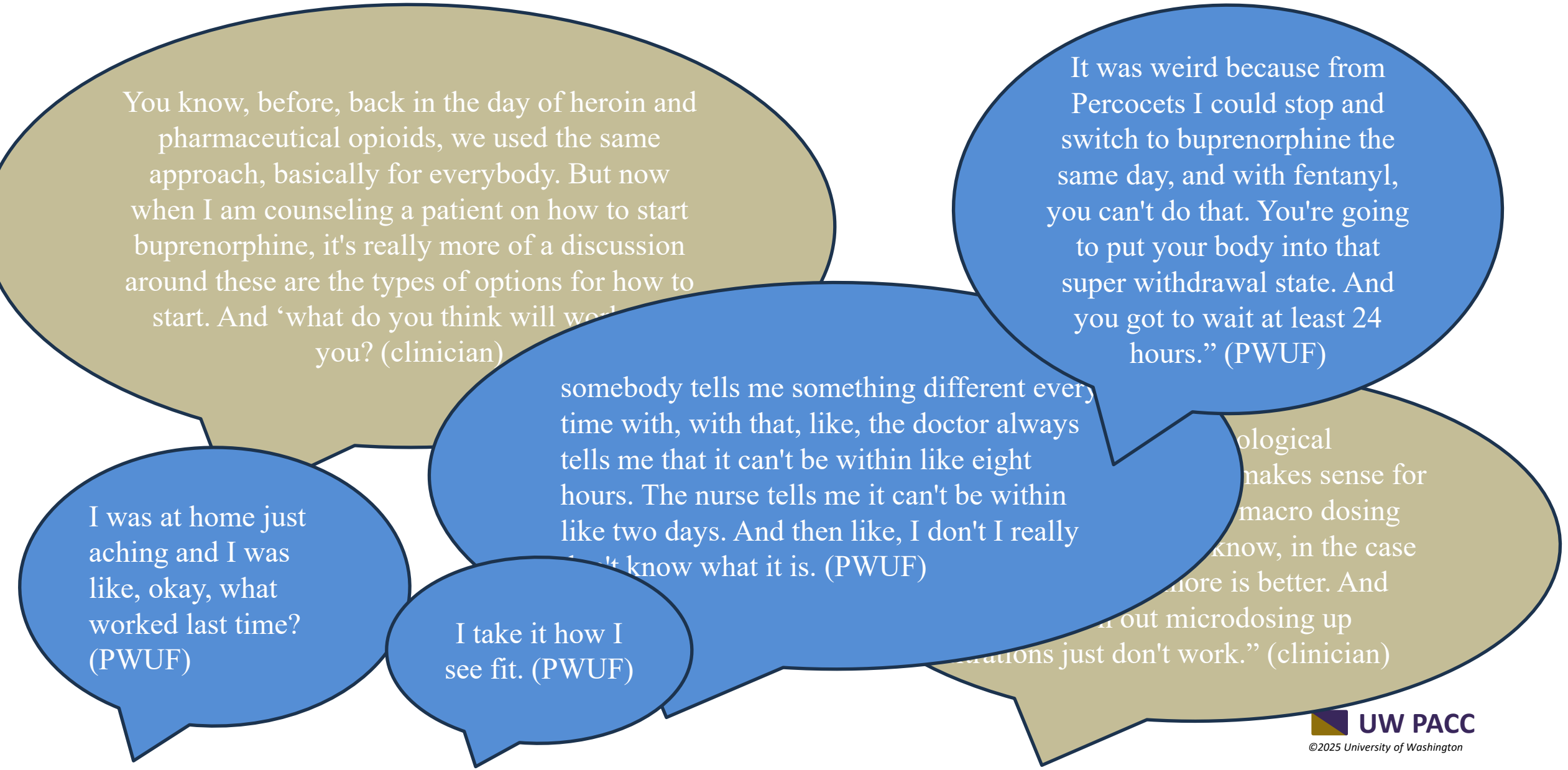
IN THE FENTANYL ERA THERE IS NO LONGER A ONE SIZE FITS ALL APPROACH TO BUPRENORPHINE INITIATION, LEADING TO UNCERTAINTY AMONG BOTH CLINICIANS AND PWUF



FEAR OF WITHDRAWAL, BOTH PRECIPITATED AND OTHERWISE, WAS A TOP CONCERN WHEN STARTING BUPRENORPHINE IN THE CONTEXT OF FENTANYL

"I guess what I'm most worried about is a really negative experience that would chase them away from not just buprenorphine, but any kind of treatment for opioid use disorder or to undermine trust in our clinic." (Clinician)

That was what scared me the most, is like that cusp of maybe getting that precip, precipitated withdrawals..That was it. That was the main thing. We are very scared to get dope sick. We as in addicts." (PWUF)

what makes it hard for people to get onto Suboxone is, is the is the comedown period. A lot of these people are homeless or have kids or have jobs or like obligations. They don't have 24 hours to devote to just being sick and struggling and uncomfortable until they can take something." (PWUF)

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EASY ACCESS TO CHEAP FENTANYL GETS IN THE WAY OF STOPPING FENTANYL USE.

"So I think the ease in which people are getting fentanyl right now, because it's so cheap, it's, you know, $0.80 to a dollar a pill, it's sometimes just easier to
And it's just everywhere, like e
smoking fentanyl..And even if
of fentanyl, someone else is go
using it nearby.." (clinician)

"I can throw a rock a
somebody selling fenta
outside the door. I guaran
walked outside with a $20
come back in five seco
fentanyl. It's everywh
Everywhere." (PWUF)

"And so I think there's been a tremendous difference of understanding about withdrawal for the current population that's using fentanyl, because we've worked with many people that have never been in withdrawal because the supply has been so readily available. But that was never the case with heroin. ..And so yeah, so now there's a there's a real intolerance to withdrawal …And so the result of that has been the people that are starting bup ..if they feel any sort of withdrawal, they think the situation has gone bad." (clinician)

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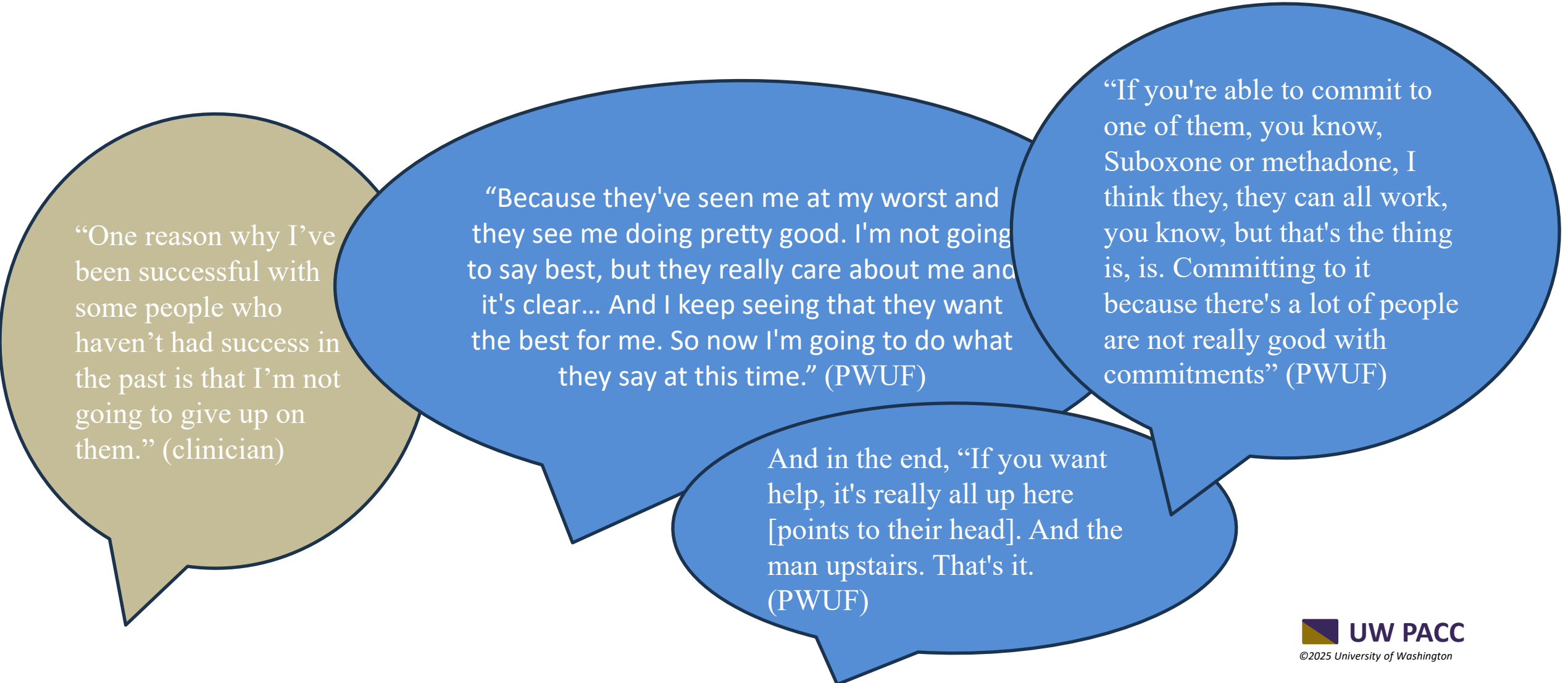
PWUF REPORTED SUCCESSFUL BUPRENORPHINE STARTS WERE FACILITATED BY THEIR OWN MINDSET AND DETERMINATION.



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CONCLUSIONS

- While both PWUF and clinicians identified PW as a major concern when starting buprenorphine, we saw that it is one of many reasons it is extremely hard to stop using fentanyl.
- As we aim to provide buprenorphine to more people it will be important to engage with PWUF to identify and address real world barriers.
- We need more research on this topic, as well as more support and education for providers.

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TWO ADDITIONAL PAPERS

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"Somebody tells me something different every time": Understanding of Buprenorphine and Sources of Information among People who use Fentanyl and Clinicians

Olivia L. Gregorich, MS Judith I. Tsui, MD, MPH Geetanjali Chandler, MD, MPH Elenore P. Bhatraju, MD, MPH

Qualitatively explore the understanding and sources of information on how buprenorphine/naloxone works.

Gain insight from clinicians and PWUF on possible barriers to starting buprenorphine/naloxone.

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RESULTS – THEMES

PWUF and clinicians both acknowledge confusion around how buprenorphine and naloxone work

“That one is an opiate, and the other is a blocker. So, I always wondered I'm like how do they put those two together without activating like that? But whatever it is, it works. ” (PWUF)

"I don't know much about the naloxone part to tell you the truth. All I know is it's just part of the reason why I get withdrawal." (PWUF)

"I think that more often than not, patients don't understand the biomechanics of what the naloxone is doing or not doing. (...) I won't go to great lengths to correct people unless it's harmful." (Clinician)

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Results – Themes

Misconceptions may lead to adverse events, anxiety, and/or lack of interest in starting buprenorphine, especially in the setting of fentanyl use

"I was told that Subutex wouldn't send you into precipitated withdrawal. Maybe it wasn't Subutex, or maybe that was misinformation, one or the other. Whatever it was, I actually shot it and it was like as soon as I shot it, I knew that I made a mistake because it came on immediately. Like I said, precipitated withdrawal. ” (PWUF)

“Because yeah, with the other one [naloxone] that Suboxone has, that's the, if you get high that could get you sicker than shit and could kill you” (PWUF)

"I think the last thing about fentanyl is that there's so many rumors in the community among my patients, you know, rumors about, like, well, buprenorphine doesn't work for fentanyl." (Clinician)

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Results – Themes

While PWUF had high regards for clinicians, the primary and most trusted source of information is people with lived experience and peers.

“I think a lot of information comes from the actual people using it, because I remember I never, I didn't, no doctor told me about precipitated withdrawals. I had heard it 150,000 times from people on the street before I ever heard a medical professional warn me against it." (PWUF)

"I'd say it's like 95% friends and then probably 2% the internet. Although (…) maybe I should say more the internet. And then like 2% the clinic. (...) I'm the last to weigh in.” (Clinician)

Conclusion

- Misinformation may be an addressable barrier to starting buprenorphine/naloxone products.
- The high value placed on information from people with lived experience supports increased work with community and peer support services.

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"It Might Be the Answer to My Problems Right Now, I'm Hoping": Patient and Clinician Perspectives on Long-Acting Injectable Buprenorphine for Treatment of Opioid Use Disorder

Maranda Newton BS[1], Olivia L. Gregorich MS[1], Geetanjali Chander MD MPH[1], Judith I. Tsui MD MPH[1], Jared W. Klein MD MPH[1], Elenore P. Bhatraju MD MPH[1]
[1]University of Washington Department of Medicine

There was nearly universal positive opinion of LAIs, although patients were often unaware LAI options existed.

"I think that's going to be the future of getting people started on Suboxone is rapid injectable Suboxone starts."
-P1 (clinician)

"I think that's pretty cool. I guess (…) when I get ready, that would be something I would look into."
-P22 (patient)

"Going from Suboxone to Sublocade is the biggest turning point. I would suggest it to anybody. I talked to people about it on the street every chance I get. Sublocade is the way."
-P8 (patient)

All identified the ease of monthly medication as a major benefit; clinicians were excited about overdose prevention.

"It's really nice to have a formulation of buprenorphine where people don't have to make that decision, like every single day, like, okay, do I take this or not?" -P7 (clinician)

"They will say, can I still use fentanyl? And I will share that people use fentanyl on it. I mean, It's like what is their goal? You know, are they trying to reduce? Are they trying to get overdose protection?"
-P11 (clinician)

"I don't know, there's something about the process of opening up a pill container. It's kind of triggering, you know, and like having that repetition. It's almost still like being in a, like a dope mindset, you know, of, like, you're so dosing yourself. I think that will help kind of get me away from it." -P13 (patient)

Patients voiced concerns about injection pain, needles, and continued cravings; clinicians described frustrations with access and insurance.

"the thing that scares me about it is the the needles and the pain. Also like that, if I miss that one month, once a month appointment that it could send me into finding a quicker way to, like, feel better, and I could relapse.

"Yeah, insurance is a barrier. We're very fortunate to live in a state where our state Medicaid plans cover the injectables. So for our patients who are on Medicaid, good to go. Commercial insurance is an absolute disaster."
-P28 (clinician)

"The injectable Sublocade is pretty painful. I've had patients either decline or stop getting Sublocade specifically because it makes this small lump on their body. And they don't like that. There's like dysmorphic feelings of having a visible lump on their abdomen."
-P28 (clinician)

QUESTIONS?

Thank you to my mentors, collaborators and to the participants!

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