

Community-Led High-Dose Buprenorphine Induction After Opioid Overdose Reversal: A Case Report

Rachel Lange

rjl149@med.miami.edu

¹University of Miami Miller School of Medicine

Jane Nguyen

¹University of Miami Miller School of Medicine

Matteo Torquati

¹University of Miami Miller School of Medicine

Ainsley Hanrahan

¹University of Miami Miller School of Medicine

Christopher P. Catalano

¹University of Miami Miller School of Medicine

Jerome Gilby

¹University of Miami Miller School of Medicine

Edward Suarez

¹University of Miami Miller School of Medicine

Tyler S. Bartholomew

¹University of Miami Miller School of Medicine

Hansel Tookes

¹University of Miami Miller School of Medicine

Case Report

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Abstract

Background

Individuals with opioid use disorder (OUD) face an elevated risk of overdose following periods of abstinence, such as during the weeks following release from incarceration. Syringe services programs (SSPs), grounded in a harm reduction approach, provide accessible, low-threshold opportunities for treatment and support within community settings. In this case report, we present what is, to our knowledge, the first reported community-led direct induction of buprenorphine in a syringe services program (SSP) setting using a community-sourced supply.

Case Presentation:

Following release from incarceration, a 37-year-old man with severe opioid and stimulant use disorders and multiple recent overdoses presented to the medical student-run clinic within the IDEA Miami Syringe Services Program (IDEA SSP) seeking buprenorphine re-induction. As Florida's first legal SSP, IDEA is operated by the University of Miami Miller School of Medicine. It aims to improve public health by reducing the spread of HIV, hepatitis C, other bloodborne diseases, and drug-related overdoses. Operating with a harm reduction philosophy, services provided include syringe exchange, naloxone, low-threshold healthcare, and social service referrals. While awaiting evaluation, the patient experienced an on-site overdose, which was reversed by a community member with a shared lived experience of substance use using 4 mg nasal naloxone from the SSP supply. Following reversal and onset of withdrawal, the patient was initiated on 8 mg of sublingual buprenorphine obtained from a community member's prescribed supply. This event marked what is, to our knowledge, the first reported community-led, community-sourced buprenorphine induction within an SSP.

Conclusions

This case highlights how harm-reduction environments, community-led initiatives, and access to buprenorphine can facilitate rapid, life-saving treatment in flexible, real-world settings, where the affected community members often serve as the true first responders.

Background

Opioid use disorder (OUD) remains a major public health crisis in the United States, particularly in the context of potent synthetic opioids such as fentanyl [4, 5]. Individuals with OUD often experience cycles of treatment engagement and return to chaotic use, placing them at heightened risk for overdose, especially following periods of forced abstinence [7, 8, 9]. Post-incarceration overdose is a particularly well-documented phenomenon, with multiple studies demonstrating a substantially increased risk of fatal and nonfatal overdose during the weeks following release [17, 18, 19]. A retrospective cohort study

of individuals released from the Oregon Department of Corrections found that the risk of overdose was 2.1-fold higher in the first two weeks following release than during the subsequent four-year follow-up period. Overdose rates were further elevated in those with diagnosed substance use disorders and/or an established need for mental health treatment—both of which applied to the patient centered in this case report [14].

SSPs are harm reduction programs that provide injection equipment, distribute naloxone, and offer education and linkage to medical and social services [6, 7]. SSPs have been shown to reduce infectious disease transmission, promote safer injection practices, and serve as critical points of engagement for individuals with OUD [9, 10]. Beyond material resources, SSPs often foster community networks that empower people who inject drugs (PWID) to act as first responders during overdose events, a strategy that has been associated with improved survival rates in community settings [10].

Buprenorphine, a partial mu-opioid agonist, is a cornerstone of OUD treatment [11].

As a Schedule III controlled substance, there are significant structural barriers to accessing these lifesaving medications. Prevailing concerns regarding the sharing and receipt of prescribed medications, insufficient physician oversight, and the potential for non-therapeutic misuse aimed at inducing euphoria compound these structural barriers. However, community-sourced buprenorphine may confer a protective benefit when utilized as a substitute for non-prescribed opioid use [23].

Community-based, peer-led interventions have emerged as effective strategies to facilitate timely treatment, particularly when integrated with low-threshold clinical programs grounded in harm reduction and medications as evidence-based treatment [12, 13, 16]. Given these persistent barriers to clinic-based initiation, the overdose-reversal encounter itself has emerged as a pivotal on-ramp to care. Post-overdose buprenorphine induction involves initiating treatment immediately after naloxone reversal to capitalize on a brief window of motivation, reduce return-to-use, and provide physiologic and symptomatic stabilization that reduces the risk of repeated overdose. Emerging reports of EMS-administered, prehospital buprenorphine after naloxone reversal describe high-dose, symptom-guided starts with safeguards against precipitated withdrawal [5, 24–27]. Embedding this approach within SSPs and other low-threshold settings aligns with harm reduction goals by pairing overdose response with same-encounter entry into treatment.

The intersection of community support, SSPs, and low-threshold clinics represents a novel approach to addressing OUD. Programs that equip community members with naloxone and center on their unique abilities to recognize overdose, while simultaneously providing access to medications like buprenorphine, create a dual safety net: immediate life-saving intervention and accessible entry into treatment. This case also demonstrates how community-led overdose response and community-facilitated buprenorphine use—known as community diversion—can fill critical gaps in care when traditional medical system routes are not timely or acceptable [22]. Understanding the dynamics of post-incarceration vulnerability, the role of SSPs, and the potential for community-based interventions is critical for developing effective strategies to reduce overdose morbidity and mortality.

Case Presentation

The patient was a 37-year-old man with severe OUD, stimulant use disorder, and a history of multiple recent overdoses—including eight in the preceding week—after his release from a period of incarceration. The patient had an 8-year history of injecting fentanyl and was experiencing homelessness in Miami, Florida. Two days prior, the patient was assessed by IDEA's attending psychologist for passive death wishes related to being unable to achieve optimal health outcomes due to housing insecurity, lack of income, and estrangement from his family. On the day of the encounter, he presented to the IDEA SSP during the University of Miami Miller School of Medicine's student-run low-threshold clinic night, seeking a buprenorphine re-induction [1].

During intake, the patient was seen by a medical student team, where he described his loss of opioid tolerance following a recent period of incarceration. While waiting to be seen by the attending physician, the patient informed another community member with shared lived experience of substance use, who was also awaiting care, that he planned to go to a nearby corner store before returning to the site for assessment. Upon his return, he was observed ambulating with an unsteady gait and speaking with slurred, incoherent speech. The patient was assisted into a chair in clear view of the clinic staff for monitoring. A few minutes later, the patient became unresponsive. According to the community member who alerted staff, the patient had "blue lips, pinpoint pupils, and gurgling noises coming from his throat." The on-site attending psychologist attempted to rouse the patient, including performing sternal rubs, but these efforts were unsuccessful. The community member expressed urgent concern that the patient had overdosed on fentanyl and requested naloxone to initiate the overdose reversal.

The SSP staff obtained 4 mg of naloxone from the in-house supply, which was immediately administered to the patient by the community member. The patient's agonal respirations resolved, and he quickly regained consciousness. The patient was disoriented, so the community member carefully explained that he had overdosed and strongly recommended that he take one of the community member's 8mg buprenorphine, which he gave to the patient.

Now in active withdrawal, the patient was guided into a private exam room with the healthcare team. Concordant with the recommendation of the responding community member, the physician strongly encouraged the patient to take the 8mg of sublingual buprenorphine to reduce discomfort and initiate treatment. With direct availability from that community member's prescribed supply, the patient consented and self-administered the macro-induction dose with quick relief of his withdrawal symptoms. Successfully induced, he was prescribed buprenorphine 8 mg sublingual tablets to be taken three times daily. Despite the presence of several medical students, two attending clinicians, and SSP staff, it was the responding community member—equipped with resources through the SSP—who led the overdose reversal and buprenorphine induction. The patient subsequently expressed gratitude for the life-saving intervention.

Approximately one month later, the patient returned to the IDEA SSP for buprenorphine refills and routine follow-up; during this visit, the patient's urine drug screening (UDS) was negative for all substances

except buprenorphine. The patient reported feeling optimistic, as this period was the longest single period of substance abstinence in his adult life; previous periods of abstinence were limited to two weeks. He also reported adherence to all medications, resulting in improved mood and overall functioning. However, prior to being seen by an on-site physician, the patient reported using an undisclosed amount of cocaine.

At a subsequent visit two weeks later, the patient reported loss of housing, which he attributed to his continued cocaine usage. He also described an inability to sustain medication adherence and health maintenance due to decreased social support. At this time, his UDS was positive for benzodiazepines, cocaine, fentanyl, and cannabinoids. Shortly thereafter, the patient was incarcerated for a substance-related offense. While macro-inductions onto buprenorphine are effective for individuals with OUD, particularly those with stable housing and adequate social support, supplemental counseling and care services may be necessary for patients with co-occurring substance use disorders or complex social needs.

Discussion and Conclusions

This case illustrates the intersection of harm reduction, community-led interventions, and medical trainee engagement in addressing the opioid overdose crisis. At the IDEA SSP's student-run clinic night, medical students engage with PWID in education on overdose response and safer injection practices, and provide comprehensive healthcare tailored for the community of people who use drugs. This model prepares future clinicians to deliver compassionate, evidence-based care and empowers PWID with the tools to act effectively in emergencies. Community overdose reversals, such as the one described in this case, demonstrate the vital role of SSPs in distributing naloxone and providing low-threshold buprenorphine, equipping PWID to serve as first responders.

The responding community member's rapid decision to encourage a post-overdose buprenorphine induction underscores a key reality: PWID are often the true first responders, with community members caring for one another [20, 21]. This intervention was particularly crucial given the patient's heightened vulnerability following recent incarceration, when loss of opioid tolerance substantially increased his overdose risk [7, 8, 9]. In this high-risk period, the student-run clinic night provided a vital safety net by offering naloxone, access to buprenorphine, and support from both community members and the medical community.

Moreover, this case underscores the potential benefits of community diversion where buprenorphine, even when obtained outside formal prescription channels, serves as a life-saving bridge to treatment rather than a misuse event. In this situation, traditional medical models requiring prescriber evaluation, pharmacy dispensing, and structured induction would not have met the patient's urgent needs. The community member's rapid recommendation to initiate buprenorphine prevented immediate relapse and stabilized the patient before the traditional medical protocols could take place.

Overall, this case demonstrates how community networks, harm reduction programs, and medical trainees can work collaboratively to save lives and initiate treatment outside traditional healthcare structures. As the opioid overdose crisis continues to evolve, integrating community-based strategies that combine support networks, naloxone distribution, and low-threshold buprenorphine access represents a practical approach to reducing overdose mortality and bridging gaps in OUD treatment. Through the infrastructure of an SSP, community-led action, and community diversion, this patient's survival became possible when the conventional medical model would have likely fallen short.

Abbreviations

OUD: Opioid use disorder

PWID: People who inject drugs

SSP: Syringe services program

IDEA: Infectious Disease Elimination Act

Declarations

Ethics approval and consent to participate: Ethics approval was not required for this case report.

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