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FROM REFERRALS TO PRESCRIPTION:

A Spectrum of Models to Implement Medications for Opioid Use Disorder (MOUD) within Syringe Services Programs

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INTRODUCTION

- Medications for opioid use disorder (MOUD)—such as methadone, buprenorphine (suboxone), and naltrexone—have been shown to dramatically decrease the risk of death and harm among people who use opioids.
- Syringe services programs (SSPs) play a key role in expanding MOUD because of their unique, trusting relationships with clients who may otherwise not have access.
- This guide focuses on how to design SSP-based MOUD services, drawing from a range of existing models in California.[1]

> "We've built trust with them…They're coming to us consistently already… They may not access [MAT] right away…but when they're ready, they know where to come. They don't have to make an appointment. They can just one day, decide, 'hey, I want to change this aspect of my life, and they can walk up to the table and do that."
>
> *-SSP MOUD services staff*

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[1] In 2025, the Center at Sierra Health Foundation hired Facente Consulting to interview 22 staff from 16 SSPs in California. The information in this guide comes from the experience and advice of those SSP staff. Funding for this report was provided by the California Department of Public Health, Office of AIDS (CDPH/OA) through the California Overdose Prevention and Harm Reduction Initiative, which is supported by The Center at Sierra Health Foundation. Harm reduction and MOUD services described in this report were enabled through the generous support of the California Department of Health Care Services (DHCS), CDPH/OA, and other local government and private funders.

SSP-Based MOUD: Key Tips

No matter the size or scope of your SSP-based MOUD services, consider the following:



1. Center participants in MOUD service design

- **Hire people with lived experience**. Staff who share participants' experiences—including those who have used MOUD themselves—are uniquely qualified to design impactful MOUD services and build relationships with clients. Ensure compensation rates value lived experience and not only formal education.
- **Ask what participants want.** Facilitate compensated conversations with participants to guide initial service design. After services have begun, get participant feedback. Ask "how easy/hard was it to get your medication?", "what would have made the induction process easier?", "what advice do you have for other participants?", and "what support would help you continue MOUD?"
- **Follow up with MOUD participants**. Check in to show you care. Ask questions like "how are you feeling today?", "what can I do to support you right now?", and "what would make the MOUD program easier to access for you?"

> *"Before a program makes a move…they need to deeply talk with their participants. Ask: What would you visualize? What do you want? What do you need? You can't craft a responsive program in a boardroom or at a computer. It must be rooted in community."*
>
> *-SSP MOUD services staff*



2. Understand the landscape of your MOUD services

- **Clarify what exists locally.** Map out MOUD providers and resources. Document what you know about them, including the cultural responsiveness of their services for people who use drugs.
- **Plan strategically.** Explore how collaboration can optimize limited resources and avoid service duplication. Note any feasibility constraints in collaborating with local providers depending on your staff and program capacity.

> *"Start with meeting all the providers in your area…A lot of SSPs are doing a lot of really cool things…you can be inspired by other people and other organizations, but at the end of the day, you can only do what your county is set up to do."*
>
> *-SSP MOUD services staff*



3. Integrate MOUD into your existing culture & approach

- **Uplift MOUD as an extension of your services—not a separate service.** Integrate MOUD into your whole-person, harm reduction, and overdose prevention services menu.
- **Equip all staff to engage in conversations about MOUD.** Have staff that flow between MOUD and other services. Let participants know they can talk about MOUD with any staff member they're comfortable with.

> *"Make clear that any [MOUD] program services…are deeply intertwined…that the philosophy going into [MOUD]….is just as harm reduction oriented and avoidant of stigma, judgment, and any attempt to control how people intend to use."*
>
> *-SSP MOUD services staff*



4. Identify possible resource paths

- **Explore funding to cover the basics of MOUD services** (e.g., grants, Medi-Cal). Be mindful of the opportunities and barriers for each funding source.
- **Be creative about funding important but often forgotten parts of MOUD services.** This includes transportation to pharmacies and MOUD provider sites.

> *"It's about having a rainy day fund. It's about getting private money in your bank account so you can do the things that won't be funded."*
>
> *-SSP MOUD services staff*



5. Mitigate known logistical barriers

- **Minimize MOUD intake burden.** Work with providers to streamline MOUD intake, including flexible access points, insurance navigation, same-day appointments, and minimal paperwork.
- **Keep services reliable.** If services are within a specific time window (not available anytime), keep them at a consistent weekly time that participants can rely on.
- **Support transportation.** Provide transport or vouchers to pharmacies/providers.
- **Reduce pharmacy barriers.** Build relationships with pharmacists. Deliver prescriptions if participants lack ID, lack transportation, or fear mistreatment.

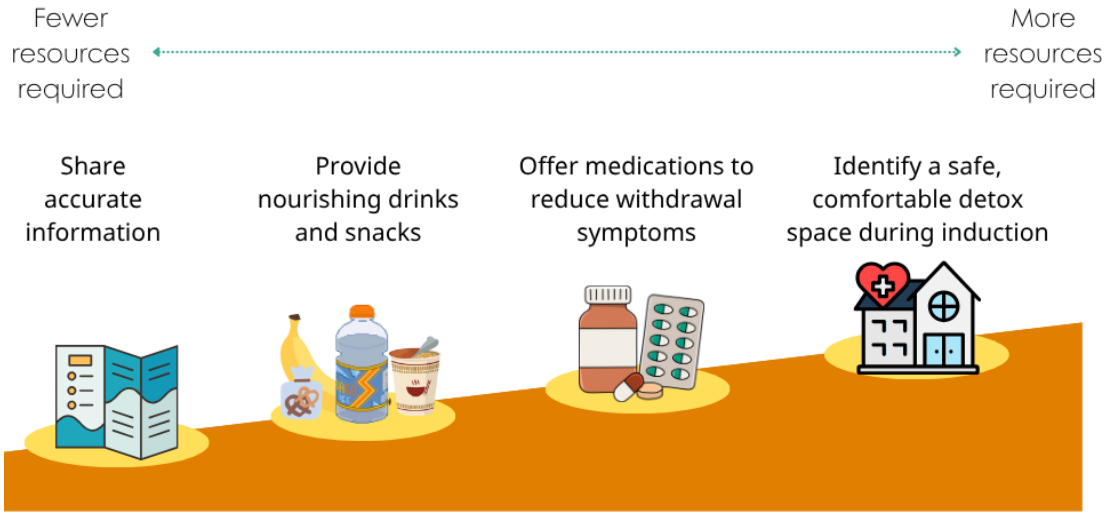


6. Address precipitated withdrawal

- **Be transparent and empathetic about this possible side effect of buprenorphine.** Provide accurate information, and connect participants to additional resources about precipitated withdrawal, including resources to make withdrawal symptoms less uncomfortable.
- **Take extra care to discuss withdrawal with participants who are unhoused**. They are unlikely to have a safe, comfortable, and supportive place to start medication. Consider options and resources available to give unhoused participants respite for a few days during induction.

> *"How can I help you tolerate something really uncomfortable for an hour? Oftentimes that's like a few extra Clonidine, a few Gabapentin, maybe a milligram of Ativan, maybe something like a sugary treat, or a place where you can honestly, just yell and b*tch at someone. Those are the ways that we are like, 'how can we get you to manage distress."*
>
> *-SSP MOUD services staff*

Examples strategies to address precipitated withdrawal, ranging in resource intensiveness



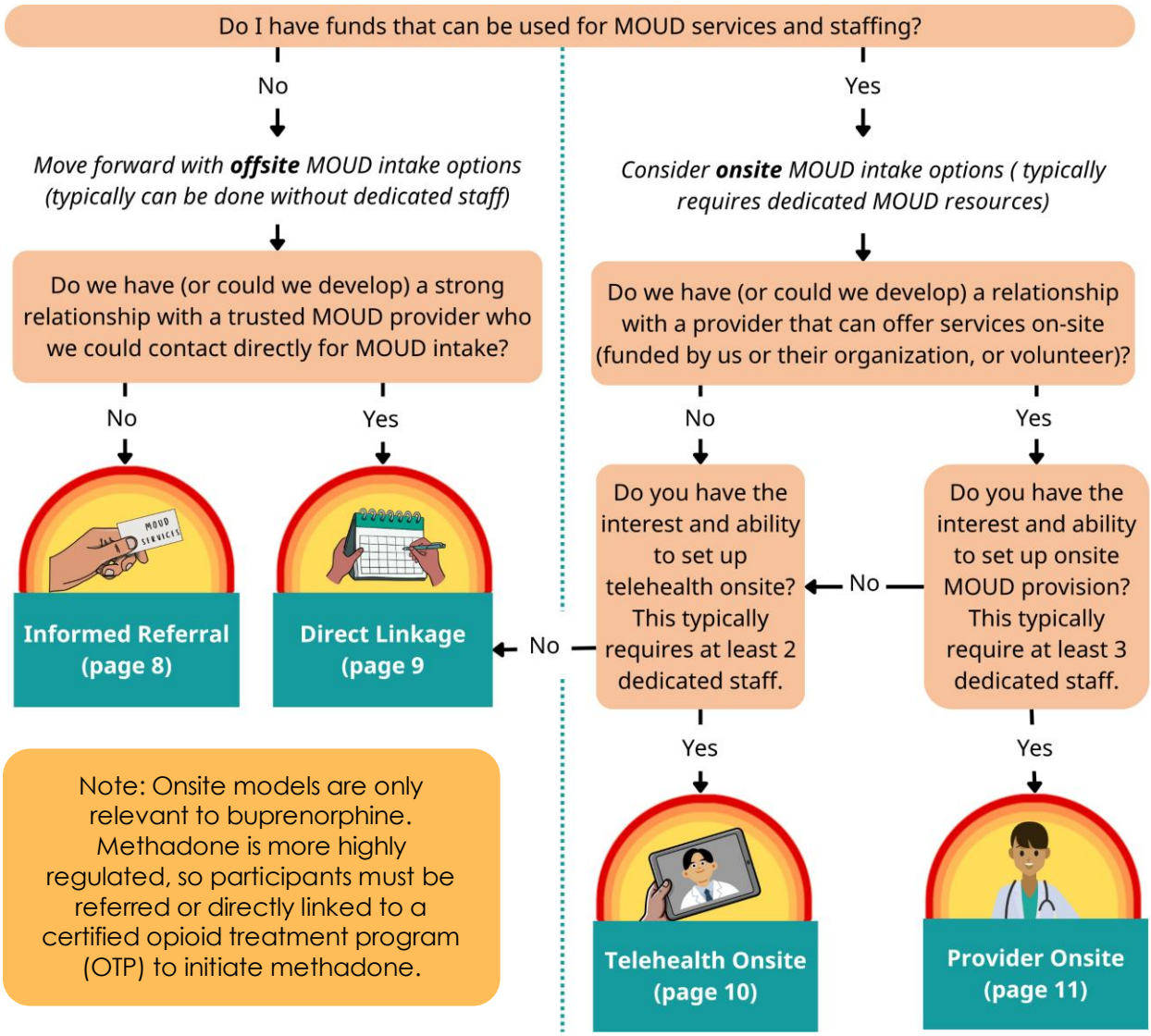
MOUD Models for Your Context

All types of SSP-based MOUD require resources in the form of funds, staffing, facilities, and time. However, there are a spectrum of options based on your local needs and program capacity.

This guide includes **four common models** for SSP-based MOUD services. Use the decision tree below to identify the model that most aligns with your program's resources OR review the table on the next page to compare all four models side by side.

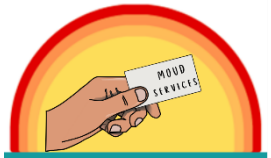
The best model for SSP-based MOUD services is one that can be implemented well. Consider the fit of the model for your agency, including how doable the model is.

Decision Tree: Follow the flow to identify a MOUD model for your SSP. Click on a model for more details.



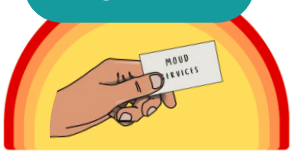
Note: Onsite models are only relevant to buprenorphine. Methadone is more highly regulated, so participants must be referred or directly linked to a certified opioid treatment program (OTP) to initiate methadone.

Model comparison: Review the four SSP-based MOUD models below to explore which might fit your agency. From left to right, the models typically require more resources and offer more comprehensive MOUD services.

	 **Informed Referral (page 8)**	 **Direct Linkage (page 9**	 **Telehealth Onsite (page 10)**	 **Provider Onsite (page 11)**
Description	• Referral to a trusted, low-barrier MOUD provider • Service options regularly reviewed for changes	• Pre-established direct call/text relationship with MOUD provider • SSP schedules intake	• On-site telehealth access, either through a contracted telehealth provider or a local provider who can prescribe by phone or video	• Your own or partnering on-site clinician who can prescribe MOUD during certain days/times
Medication options	• Buprenorphine, methadone (if referring to OTP)*	• Buprenorphine, methadone (if referring to OTP)*	• Buprenorphine*	• Buprenorphine*
Staffing resources needed	• Staffing to maintain accurate information about MOUD providers • Staffing to support warm hand-off	• Staffing to develop and maintain relationship and coordination with collaborative provider	• Staffing to manage the telehealth relationship, support intake, navigation, and monitoring, and follow up with participants	• Staffing to manage the provider relationship, support intake, navigation, and monitoring, and follow up with participants
Non-staffing resources needed	• Phones/tablets for staff to make referrals	• Phones/tablets for staff to make referrals	• Phones/tablets for telehealth • Funds for private space (e.g., tent) and prescriber (unless volunteer)	• Funds to pay prescriber (unless they are paid by their clinic or volunteering) • Funds for creating private space (e.g., extra tent)
Additional helpful resources	• Transportation support (to pharmacy and provider) • Pharmacy pick-ups and deliveries • Substance use disorder counseling		• Supports for withdrawal symptoms (e.g., printed information, snacks/hydration, medication for symptoms, safe detox space) • Case management	

*Note: Naltrexone is a less commonly prescribed MOUD. You can ask providers to see if it is an option.

MODEL #1



Informed Referral

MINIMUM RESOURCES NEEDED

- ☑ Staff time to maintain up-to-date information on local, culturally responsive MOUD providers

What does this model look like?

- Your SSP is up to date on local, culturally responsive MOUD providers.
- You refer participants to MOUD services that fit their needs and eligibility.
- You support navigation and ideally a warm hand-off (e.g. set up the intake appointment)

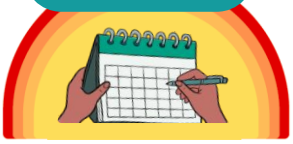
REAL-WORLD EXAMPLE

One California SSP has a staff navigator who maintains up-to-date information about local providers. When a participant is interested in treatment of any kind, the navigator asks open-ended questions, finds out if they are interested in medications, and refers them to a provider based on their insurance, location, eligibility, and preferences. The SSP does not transport patients or set up their appointments but will follow-up to support their journey.

What else should I know about launching this model?

Consideration	Questions to Ask
Availability of culturally responsive community resources	☐ In general, how accessible is low-barrier MOUD in my community (e.g., local methadone clinic, local buprenorphine providers)? ☐ Which MOUD providers are rated highly by participants (or well-known to our agency because we have visited them before)? ☐ What relationships do we already have with local MOUD providers, and where do we need new relationships or to strengthen them?
Evolving MOUD services landscape	☐ How can we be intentional and consistent in tracking the service landscape to ensure we give accurate information? ☐ What are the eligibility and intake processes for MOUD providers? ☐ What information about MOUD providers should I share with participants (e.g., directions, contact information of intake person)?
Additional support	☐ What support can we provide related to transportation, medication pick-up/delivery, buprenorphine induction, and case management? ☐ How can we elicit participant feedback on the MOUD experience to guide adjustments to where and how we refer them?

MODEL #2



Direct Linkage

MINIMUM RESOURCES NEEDED

- ☑ Partnering off-site MOUD prescriber
- ☑ Staff time to deepen and maintain relationship with the provider
- ☑ Phones to contact the provider

What does this model look like?

- You have a strong relationship with an offsite MOUD provider, with a mutual understanding that they will support your participants with MOUD services within a set schedule.
- You schedule the participant for MOUD services via a direct phone or text connection to the provider or team.

REAL-WORLD EXAMPLE

One California SSP has a strong relationship with a specific MOUD prescriber at a local clinic. When a participant requests MOUD at the SSP or during outreach, the SSP calls or texts the provider directly, and the SSP then works as the navigator between the provider and the participant to get them to the clinic. The SSP provides transportation to the appointment if needed.

What else should I know about launching this model?

Consideration	Questions to Ask
Finding a partnering MOUD provider	☐ What low-barrier, culturally responsive MOUD providers exist locally? ☐ Which providers may be willing to develop a formal partnership, including sharing a direct line of access where we can refer and schedule participant MOUD intake appointments? ☐ What steps should we take to deepen our relationship with this provider? Do we need a formal agreement (e.g., MOU)?
Linkage process	☐ How can we structure our linkage process? For example, can we call/text the partnering provider anytime, or within certain windows? How will the provider inform us of any changes to their availability? ☐ What is our back-up plan if the partnering provider is not available when a participant is ready to start MOUD?
Additional support	☐ What support can we provide related to transportation, medication pick-up/delivery, buprenorphine induction, and case management?

MODEL #3



Telehealth Onsite

MINIMUM RESOURCES NEEDED

- ☑ Formal relationship with telehealth prescriber
- ☑ Phones/tablets for telehealth
- ☑ 2 -5 staff to support telehealth relationship, intake, navigation, and tracking

What does this model look like?

- Your SSP has a relationship with a MOUD provider via a telehealth contracted company, provider network, or a local provider who can prescribe buprenorphine by phone or video.
- SSP staff set participants up with their telehealth appointment (20–30 minutes) in a private area of your site and support intake and navigation (e.g., assessment, consent, insurance).

REAL-WORLD EXAMPLE

One California SSP partners with Bright Heart Health to provide standing buprenorphine intake hours by telehealth. The SSP provides a tablet for appointments that take place in a tent to support participant privacy. SSP staff help participants fill out online intake forms and facilitate the call to Bright Heart. When buprenorphine is prescribed, SSP staff pick up medications for the participant if desired. SSP staff also track active buprenorphine clients. This program uses a director and an assistant for telehealth services directly, with an additional 1–2 staff or volunteers at the site to support the process. If capacity allows, SSP staff connect participants to other services or provide additional case management.

What else should I know about launching this model?

Consideration	Questions to Ask
Telehealth provider	☐ Do we want a formal telehealth relationship (e.g., contract with a paid telehealth company) or an informal relationship (e.g., call a local provider who can prescribe by phone/tablet)? What culturally responsive, low-barrier providers exist for each option?
Telehealth infrastructure	☐ Where can we physically provide telehealth services, considering privacy and space needs (e.g., a room in our drop-in center, tent)? ☐ Do we have tablets/phones that can be used for telehealth, as well as adequate charging, WiFi/cell reception, and storage capacity?
Telehealth service hours	☐ When should we offer telehealth (e.g., set hours, vs. as needed), considering cost, staffing capacity, and participant preferences?
Additional support	☐ What support can we provide related to transportation, medication pick-up/delivery, buprenorphine induction, and case management?

MODEL #4



Provider Onsite

MINIMUM RESOURCES NEEDED

- ☑ Funding for on-site or partnered prescriber (or volunteer)
- ☑ 3 - 7 staff to support intake, navigation, and tracking.

What does this model look like?

- Your SSP has an onsite MOUD prescriber, typically with set hours (e.g., 4-8pm M & Th).
- The onsite provider is either paid by you, a volunteer, or paid by a clinic that is partnering with you by sharing the provider during certain days and times.
- SSP staff support intake, navigation, and follow up.

REAL-WORLD EXAMPLES

One California SSP partners with a local clinic that has addiction medicine residents. The residents attend multiple SSP sites each week and can prescribe MOUD directly within a few minutes. They are supported by SSP staff, including a substance use navigator who can direct people to the provider, pick up prescriptions, troubleshoot insurance issues, and do follow-up check in calls.

Another California SSP that operates a drop-in center has MOUD providers 20 hours/week. They use a medical assistant (MA) and telehealth as back-up options when the prescriber is not present. All program staff support MOUD access and troubleshooting.

What else should I know about launching this model?

Consideration	Questions to Ask
Finding an on-site MOUD provider	☐ Do we know a MOUD provider who can be onsite (e.g., local community clinicians, residents in training for addiction medicine)? ☐ What funding/resources do we have available for an onsite provider, if any (e.g., direct funding, subcontracting, partnerships)? ☐ How might the provider interface with our services (e.g., come to street-based outreach with us, be present in our drop-in space)? ☐ What is our sustainability plan if our main provider is not available (e.g., sick, volunteer no longer can volunteer time, etc.)?
MOUD provider hours	☐ What would the ideal on-site provider hours be? Consider provider availability, participant preferences, feasibility for staffing, and cost.
Additional support	☐ What support can we provide related to transportation, medication pick-up/delivery, buprenorphine induction, and case management?