



CLINICAL GUIDELINES PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV · HCV · SUBSTANCE USE · LGBT HEALTH

Harm Reduction Approach to Treatment of All Substance Use Disorders

Lead Author: Sharon Stancliff, MD, with the Substance Use Guideline Committee, August 2019

Contents

Purpose and Development of This Guideline	2
<i>Role of NYS Primary Care Providers in the Treatment of Substance Use Disorders</i>	2
<i>Guideline Development</i>	2
Definition of Terms	3
Box 1: Terms Used in this Guideline	3
Harm Reduction in Treatment of Substance Use Disorders	3
Box 2: Harm Reduction Counseling in the Medical Setting.....	4
Implementing a Harm Reduction Treatment Plan	5
Box 3: Substance Use Disorder Treatment Settings.....	6
Reducing Stigma	7
Box 4: Changing the Language of Substance Use: Use Neutral Terms*	7
All Recommendations	10



Harm Reduction Approach to Treatment of All Substance Use Disorders

Purpose and Development of This Guideline

Lead Author: Sharon Stancliff, MD, with the Substance Use Guideline Committee, August 2019

This guideline on a harm reduction approach to the treatment of substance use disorder (SUD) was developed by the New York State (NYS) Department of Health (DOH) AIDS Institute (AI) to guide primary care providers and other practitioners in NYS in treating patients with a substance use disorder.

This guideline aims to:

- Increase the number of clinicians in outpatient settings offering evidence-based treatment to individuals with a substance use disorder.
- Increase the number of NYS residents with substance use disorders who are engaged in treatment.
- Promote a harm reduction approach to treatment of all substance use disorders, which involves practical strategies and ideas aimed at reducing the negative consequences associated with drug and alcohol use (e.g., needle and syringe exchange for individuals who inject drugs).
- Increase awareness among healthcare providers about the stigma associated with substance use.
 - See the NYSDOH AI guideline *Treatment of Opioid Use Disorder* for detailed information specific to opioid use disorder.

Role of NYS Primary Care Providers in the Treatment of Substance Use Disorders

Primary care providers in NYS play an essential role in identifying and treating substance use disorders in their patients. Effective treatments that can be delivered in an outpatient setting are available for many SUDs, including tobacco, alcohol, and opioids, which increases treatment access. A substance use disorder is a long-term, chronic condition and, like other chronic conditions, can be successfully managed in a primary care setting.

This guideline recommends a harm reduction approach to SUD treatment that can be adopted by primary care providers and clinicians in all other treatment settings. A harm reduction approach promotes positive changes beyond abstinence, including reduction in substance use, safer use, and other lifestyle changes. This approach also emphasizes that clinicians should avoid coercion, discrimination, and bias when working with individuals with SUD.

Guideline Development

This guideline was developed by the NYSDOH AI Clinical Guidelines Program, which is a collaborative effort between the NYSDOH AI Office of the Medical Director and the Johns Hopkins University (JHU) School of Medicine, Division of Infectious Diseases.

Established in 1986, the goal of the Clinical Guidelines Program is to develop and disseminate evidence-based, state-of-the-art clinical practice guidelines to improve the quality of care throughout NYS for people who have HIV, hepatitis C virus, or sexually transmitted infections; people with substance use issues; and members of the LGBTQ community. NYSDOH AI guidelines are developed by committees of clinical experts through a consensus-driven process.

The NYSDOH AI SUD Guideline Committee was charged with developing evidence-based clinical recommendations for primary care providers in NYS who treat patients who have SUDs. The resulting recommendations are based on an extensive review of the medical literature and reflect consensus among this panel of SUD experts. Each recommendation

is rated for strength and for quality of the evidence (see below). If recommendations are based on expert opinion, the rationale for the opinion is included. See *About the Substance Use Disorder Guidelines* for a full description of the development process, including evidence collection and recommendation development.

AIDS Institute HIV Clinical Guidelines Program Recommendations Rating Scheme	
Strength of Recommendation	Quality of Supporting Evidence
A = Strong	1 = At least 1 randomized trial with clinical outcomes and/or validated laboratory endpoints
B = Moderate	2 = One or more well-designed, nonrandomized trial or observational cohort study with long-term clinical outcomes
C = Optional	3 = Expert opinion

Definition of Terms

Lead Author: Sharon Stancliff, MD, with the Substance Use Guideline Committee, August 2019

Box 1: Terms Used in this Guideline	
Substance use	Alcohol or drug use.
Illicit drug use	Use of non-prescription medication or drug.
Substance use disorder (SUD)	<i>Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)</i> diagnosis.
SUD treatment	Pharmacologic, psychosocial, or harm reduction intervention for individuals with SUD.
Pharmacologic treatment	Replaces “medication-assisted treatment” (MAT).
Medication	Pharmacologic agent used to treat SUD (e.g., methadone).
Harm reduction	In the clinical context, harm reduction is an approach and a set of practical strategies targeted to reduce the negative consequences associated with substance use. It is founded on respect for and the rights of those individuals who use drugs [adapted from the Harm Reduction Coalition]. For strategies, see <i>Box 2: Harm Reduction Counseling in the Medical Setting</i> .

Harm Reduction in Treatment of Substance Use Disorders

Lead Author: Sharon Stancliff, MD, with the Substance Use Guideline Committee, August 2019

The NYSDOH AI and this Committee strongly advocate a harm reduction approach in the care of all individuals who use substances, including those with a diagnosed substance use disorder (SUD). The recommendations below are based on emerging evidence and the extensive clinical experience of this Committee. For NYS-specific information on harm reduction, please see *NYSDOH Harm Reduction Services*.

RECOMMENDATIONS: HARM REDUCTION IN TREATMENT OF SUBSTANCE USE DISORDERS

- For patients who use substances, whether or not they are engaging in substance use disorder treatment, clinicians should continue to offer medical care and offer or refer for harm reduction services and counseling on safer substance use. (A3)
- For patients who inject drugs, clinicians should:

RECOMMENDATIONS: HARM REDUCTION IN TREATMENT OF SUBSTANCE USE DISORDERS

- Provide patient education on the risks of sharing injection equipment. (A3)
- Offer to prescribe needles and syringes. (B3)
- Discuss other options for accessing sterile needles and syringes, including use of the [Expanded Syringe Access Program and Syringe Exchange Programs](#), NYS’s syringe access initiatives. (A2)
- Follow the recommendations on providing naloxone (NLX) in the NYSDOH AI guideline *Treatment of Opioid Use Disorder*.

For individuals who use substances, regardless of their interest in treatment, it is important to provide ongoing medical care and to provide or refer for harm reduction services. Harm reduction services are particularly important for those who do not choose to reduce or stop substance use. Examples of harm reduction counseling are described in *Box 1*, below. If individuals are seen only intermittently in a healthcare setting, any visit can provide an opportunity to offer brief medical services, such as offering vaccinations, providing sexual health services, and other primary care services.

For individuals who inject drugs, harm reduction includes provision of or referral for sterile needles and syringes [Bowman, et al. 2013]. Sharing injection equipment can transmit bloodborne diseases, such as HIV and HCV; in the United States, injection drug use is the leading cause of HCV infection [CDC 2018]. Unsterile injection equipment is also associated with soft tissue infections, including methicillin-resistant *Staphylococcus aureus* (MRSA), *Candida albicans*, and *Staphylococcus aureus* [Hartnett, et al. 2019]. Syringe access has been associated with dramatic reductions in HIV transmission; as syringe exchange was expanded in New York City, HIV seroincidence decreased to 1/100 person years (PY) from 4/100 PY [Des Jarlais and Carrieri 2016]. Syringe exchange also has been associated with reductions in HCV transmission [Des Jarlais, et al. 2005; Saab, et al. 2018].

Box 2: Harm Reduction Counseling in the Medical Setting

Examples of harm reduction counseling:

- Discussing the risks of alcohol and substance use while driving. Many people do not recognize that cannabis use can impair driving skills [Wadsworth and Hammond 2018], particularly when mixed with alcohol [Smart, et al. 2018].
- Addressing the substance(s) that the individual uses and other substances that may be used by people in the individual’s family or social network so the patient can pass on information about harm reduction.
- Informing individuals who use drugs that fentanyl, a common and often unidentified additive to heroin, is much more potent than heroin and can increase the likelihood of a fatal overdose. It is important to inform patients who use drugs that, to avoid a fentanyl overdose, they should start with a small amount, carry naloxone (NLX) to reverse opioid overdoses, and avoid mixing drugs [Colon-Berezin, et al. 2019].
 - Some individuals who use drugs other than opioids may also be at risk of opioid overdose. In New York City, fentanyl has been identified in illicit cocaine and methamphetamine samples and has also been found in counterfeit pills that are made to look like various opioid analgesics and benzodiazepines [Colon-Berezin, et al. 2019].
- Informing individuals that the risk of an accidental fatal overdose can be reduced if they avoid injecting/using alone.
- Describing the role of NLX in the setting of an opioid overdose and ensuring that all individuals who use opioids and the people close to them know how to access and use NLX.
- Advising individuals who inject drugs to avoid sharing any injection equipment and, if possible, to avoid reusing any equipment.
- Informing individuals who are not currently injecting, but who use drugs that can be injected, how to obtain syringes.

Implementing a Harm Reduction Treatment Plan

Lead Author: Sharon Stancliff, MD, with the Substance Use Guideline Committee, August 2019

RECOMMENDATIONS: IMPLEMENTING A HARM REDUCTION TREATMENT PLAN

- Clinicians should collaborate with patients to set specific treatment goals (A3); goals other than full abstinence are acceptable (e.g., changes in use resulting in increased well-being and decreased harm or potential harm). (A3)
- To assist patients in planning and reaching treatment goals, clinicians should ask about the role and effects of substance use in their daily lives. (A3)
- Clinicians and patients should decide on an appropriate level of care (e.g., venue and intensity) based on:
 - Medically recommended treatment for the patient’s substance use disorder(s).
 - The patient’s need for other support and services, such as medical or mental health care and psychosocial support.
 - Availability of care.
 - Patient preference.
- For patients with a substance use disorder, clinicians should offer pharmacologic treatment when it is indicated. (A3)
- Clinicians should not discontinue substance use treatment due solely to recurrences or continuation of use. (A3)

Traditionally, substance use disorder (SUD) treatment providers have considered abstinence the primary goal of treatment, but this approach is evolving. Changing the pattern of or reducing an individual’s substance use has measurable health benefits and contributes to increased function, even if the individual continues to use the substance of choice or other substances [Gjersing and Bretteville-Jensen 2013; Collins, et al. 2015a; Collins, et al. 2015b; Charlet and Heinz 2017; Lea, et al. 2017].

For some individuals with a substance use disorder, use of other substances can reduce use of the more problematic substance. There is increasing interest in the use of cannabis, cannabidiol, and other substances to reduce the compulsion to use opioids [Socias, et al. 2017; Chye, et al. 2019]. This is important to consider for individuals with opioid use disorder (OUD) who, if untreated, are at increased risk for overdose and death.

→ KEY POINTS: FENTANYL

- Fentanyl is a common and often unidentified additive to heroin and other drugs [Colon-Berezin, et al. 2019]. In New York City, it has been found in samples of cocaine, methamphetamine, and in counterfeit pills that look like various opioid analgesics and benzodiazepines.
- Because fentanyl is much more potent than heroin, it can increase the likelihood of a fatal overdose.
- It is important to advise individuals who use drugs how to avoid a fentanyl overdose: start with a small amount of a drug, carry NLX to reverse an opioid overdose if it occurs, and avoid mixing drugs.

Working with a patient who has a substance use disorder to implement an appropriate treatment plan involves balancing a number of factors, and the choice of treatment may be limited by availability and other practical considerations. Some individuals may perceive substance use to be more helpful or pleasurable than harmful. Asking about and understanding the perceived benefits of substance use can help the clinician identify other ways for the patient to obtain the same or similar benefits and tailor a successful treatment plan.

A range of effective pharmacologic treatment is available for several SUDs, including alcohol [Overman, et al. 2003; Rosner, et al. 2010; Jonas, et al. 2014], tobacco [Piper, et al. 2009; Anthenelli, et al. 2016], and opioid use disorders [Mattick, et al. 2014; Lee, et al. 2018]. Clinicians should discuss pharmacologic treatments with patients and help them understand the benefits and risks. In NYS, most drug treatment programs licensed by the Office of Alcoholism and Substance Abuse Services (OASAS) are mandated to provide pharmacotherapy when indicated [OASAS 2016]. Some patients may misunderstand or have biases against pharmacologic treatment, so it may be helpful to continue these discussions over time. It is also important for clinicians to inform patients about the different treatment settings available (see Box 3, below).

Box 3: Substance Use Disorder Treatment Settings

- **Office-based services:** A variety of settings (e.g., primary care, psychiatry), including pharmacologic treatment.
- **Medically managed, monitored, or supervised withdrawal and stabilization:** Includes inpatient and outpatient settings and should be followed by additional treatment.
- **Outpatient services:** Includes counseling, educational group sessions, and other services; the length and intensity of treatment vary.
- **Opioid treatment programs (e.g., methadone programs):** Includes outpatient services, medical assessment, and pharmacologic treatment.
- **Residential treatment:** Includes a variety of programs from inpatient, medically supervised programs to supportive housing.

Adapted from *OASAS: Substance Use Disorder Service Descriptions*.

Clinicians should not deny or discontinue SUD treatment if a patient continues to or returns to use because the patient may still benefit from treatment [Gjersing and Bretteville-Jensen 2013]. In 2017, the U.S. Food and Drug Administration issued a *Drug Safety Communication* urging caution in denying methadone or buprenorphine when patients are taking benzodiazepines because the risk of opioid overdose is higher with no treatment than the risks of combining the medications [FDA 2017]. Instead, healthcare providers may consider intensifying SUD treatment, such as increasing frequency of visits, offering psychosocial treatment, or adding mental health treatment.

SUD is a chronic health condition that requires long-term management, including pharmacologic treatment [Saitz, et al. 2013]. It is important to continue treatment for as long as it is beneficial to a patient. Patients may opt to discontinue medication, but clinicians should encourage treatment resumption without suggesting failure or implying that no pharmacologic treatment is the preferred approach.

→ KEY POINTS

- Substance use disorder is a chronic health condition that requires long-term management, including pharmacologic treatment.
- SUD treatment medications and other treatments should not be denied or discontinued in individuals with SUD if or when they continue or return to use because patients may continue to benefit from treatment [Gjersing and Bretteville-Jensen 2013].
- If the criminal justice system or other entities, such as child welfare services, discontinue an individual’s OUD treatment plan, it is important for clinicians to advocate for their patient to continue their pharmacologic treatment plan.

Individualized follow-up during outpatient substance use disorder treatment: Ongoing, regular follow-up is essential for support, encouragement, and modification of the treatment plan as needed.

- Follow-up within 2 weeks of treatment initiation allows tailoring of the treatment plan (e.g., change in dose of pharmacologic treatment, addition of support services) according to individual needs.
- As individuals stabilize on treatment, monthly or at least quarterly follow-up allows for ongoing evaluation to ensure that the patient’s goals are being met.

As with all diseases and disorders, patients who have a substance use disorder may present with medical complexities beyond a clinician’s expertise. Adolescents may require specialty care, as may individuals who are pregnant or who have co-occurring psychiatric disorders. When individual patient factors may complicate diagnosis and treatment, local and national resources are available for consultation and referral. For opioid-related issues, the *Providers Clinical Support System (PCSS)* is a national resource for clinicians.

Reducing Stigma

Lead Author: Sharon Stancliff, MD, with the Substance Use Guideline Committee, August 2019

RECOMMENDATIONS: REDUCING STIGMA

- Clinicians should examine their assumptions and decisions for any personal biases that may affect their ability to provide effective care for individuals who use substances. (A3)
- Clinicians and other staff interacting with patients should use neutral terms to describe all aspects of substance use and avoid language that perpetuates stigma (see Box 3: *Changing the Language of Substance Use: Use Neutral Terms*). (A2)

It is often challenging for clinicians to recognize and set aside personal biases and to address biases with peers and colleagues. Clinician bias has been associated with health disparities [Hall, et al. 2015; FitzGerald and Hurst 2017] and can have profoundly negative effects. Consciously or unconsciously, negative or stigmatizing assumptions are often made about patient characteristics, such as race, ethnicity, gender, sexual orientation, mental health, and substance use [Livingston, et al. 2012; van Boekel, et al. 2013; Avery, et al. 2019]. Individuals who use substances may also be stigmatized by assumptions about substance use and criminal behavior. For more information, see:

- “Attitudes Toward Individuals With Mental Illness and Substance Use Disorders Among Resident Physicians,” Avery JD, Taylor KE, Kast KA, et al. *Prim Care Companion CNS Disord* 2019;21(1).
- “Some Advice for Physicians and Other Clinicians Treating Minorities, Women, and Other Patients at Risk of Receiving Health Care Disparities,” White A, Stubblefield-Tave B. *J Racial Ethn Health Disparities* 2017;4(3):472-479.
- “Avoiding Unintended Bias: Strategies for Providing More Equitable Health Care,” Van Ryn M. *Minn Med* 2016;99(2):40-3, 46.

To acknowledge and address stigma, clinicians are advised to consciously change their substance use-related vocabulary to avoid stigmatizing terms, to use neutral medical terms instead, and to help colleagues and staff adopt neutral language (see Box 4, below). For example, the term “dirty urine test” elicits a more negative reaction toward a patient than the more accurate and neutral term “opiate-positive test result” [Kelly JF and Westerhoff 2010]. Patients may choose to use stigmatized words in describing themselves, but clinicians and staff should strive to use language that is respectful of the individual and easy to understand.

Box 4: Changing the Language of Substance Use: Use Neutral Terms*	
Stigmatizing Term	Neutral Alternative
Substance <i>abuse</i>	Substance <i>use</i>
Drug addict, drug abuser, alcoholic, junkie, crackhead, tweaker, etc.	A person who uses drugs, alcohol, or substances
“Clean” or “dirty” toxicology results	“Negative” or “positive” toxicology results “Unexpected” or “expected” results
Got clean	A person who formerly used drugs or alcohol
Relapse	A recurrence of use or “return” to use
*[Kelly J, et al. 2016]. For additional terms and definitions see Addictionary .	

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All Recommendations

Lead Author: Sharon Stancliff, MD, with the Substance Use Guideline Committee, August 2019

All RECOMMENDATIONS: HARM REDUCTION APPROACH TO TREATMENT OF ALL SUBSTANCE USE DISORDERS

Harm Reduction in Treatment of Substance Use Disorders

- For patients who use substances, whether or not they are engaging in substance use disorder treatment, clinicians should continue to offer medical care and offer or refer for harm reduction services and counseling on safer substance use. (A3)
- For patients who inject drugs, clinicians should:
 - Provide patient education on the risks of sharing injection equipment. (A3)
 - Offer to prescribe needles and syringes. (B3)
 - Discuss other options for accessing sterile needles and syringes, including use of the [Expanded Syringe Access Program](#) and [Syringe Exchange Programs](#), NYS’s syringe access initiatives. (A2)
 - Follow the recommendations on providing naloxone (NLX) in the NYSDOH AI guideline [Treatment of Opioid Use Disorder](#).

Implementing a Harm Reduction Treatment Plan

- Clinicians should collaborate with patients to set specific treatment goals (A3); goals other than full abstinence are acceptable (e.g., changes in use resulting in increased well-being and decreased harm or potential harm). (A3)
- To assist patients in planning and reaching treatment goals, clinicians should ask about the role and effects of substance use in their daily lives. (A3)
- Clinicians and patients should decide on an appropriate level of care (e.g., venue and intensity) based on: (B3)
 - Medically recommended treatment for the patient’s substance use disorder(s).
 - The patient’s need for other support and services, such as medical or mental health care and psychosocial support.
 - Availability of care.
 - Patient preference.
- For patients with a substance use disorder, clinicians should offer pharmacologic treatment when it is indicated. (A3)
- Clinicians should not discontinue substance use treatment due solely to recurrences or continuation of use. (A3)

Reducing Stigma

- Clinicians should examine their assumptions and decisions for any personal biases that may affect their ability to provide effective care for individuals who use substances. (A3)
- Clinicians and other staff interacting with patients should use neutral terms to describe all aspects of substance use and avoid language that perpetuates stigma (see [Box 3: Changing the Language of Substance Use: Use Neutral Terms](#)). (A2)