HARM REDUCTION
IN THE CARE OF PEOPLE WHO USE DRUGS

"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 Harm Reduction Coalition

HARM REDUCTION IN TREATMENT OF SUBSTANCE USE DISORDERS

For people who use drugs, whether or not they are engaging in substance use treatment, clinicians should continue to offer medical care including HCV and HIV treatment and offer or refer for harm reduction services and counseling on safer drug use.

IMPLEMENTING A HARM REDUCTION TREATMENT PLAN:

- **Collaborate with patients to set treatment goals**; goals other than full abstinence are acceptable (e.g., changes in use resulting in increased well-being and decreased harm or potential harm).
- **Ask about the role and effects of drug use** in daily lives to assist patients in planning and reaching treatment goals.
- **Clinicians and patients should decide on an appropriate level of care** (e.g., venue and intensity) based on: 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.
- **Offer pharmacologic treatment** for substance use disorder, when indicated.
- **Clinicians should not discontinue substance use treatment** due solely to recurrences or continuation of use.

DEVELOP A SAFETY PLAN FOR PEOPLE WHO INJECT DRUGS:

Provide counseling to avoid sharing and reusing any drug injection equipment (e.g. needles, sniffing implements, pipes/stems, etc) using alone, and mixing drugs.
Provide counseling about fentanyl, a common and unidentified additive to heroin, cocaine and other drugs that can increase likelihood of a fatal overdose.
Educate patients regarding fentanyl test strips.
Offer to prescribe needles and syringes.
Discuss other options for accessing sterile needles and syringes, including use of the Syringe Service Programs.
Offer pre-exposure prophylaxis (PrEP) for HIV prevention.
Provide overdose prevention education and naloxone.

SYRINGE USE AND RISK

1. Use a new and sterile syringe every time
2. Use your own syringe if re-using
3. Rinse syringe w. bleach + water if sharing
4. Rinse stringe w. water if no bleach
5. Rinse syringe w. water + liquid soap if no bleach

Source: Kimberly Sue, MD, Medical Director, Harm Reduction Coalition.

REDUCING STIGMA

Examine your assumptions and decisions for any personal biases that may affect ability to provide effective care for persons who use drugs.

Use neutral terms to describe all aspects of substance use and avoid language that perpetuates stigma.

CHANGING THE LANGUAGE OF SUBSTANCE USE: USE NEUTRAL TERMS

Stigmatizing term	Neutral alternative
Substance abuse	Substance use
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"
Got clean	A person who formerly used drugs or alcohol
Relapse	A recurrence of use or "return" to use

For more information on words to use, please visit: *https://www.recoveryanswers.org/addiction-ary/*
For more information on Drug User Health and Harm Reduction, please see full guidelines at: *www.hivguidelines.org/* and *www.ceitraining.org*
To speak with a clinician experienced in managing Drug User Health call the CEI Line at

866-637-2342

cei CLINICAL EDUCATION INITIATIVE

BUPRENORPHINE /NALOXONE (BUP/NLX) TREATMENT FOR OPIOID USE DISORDER (OUD)

DOSING

INITIAL DOSE	BUP/NLX 2 mg/0.5 mg to BUP/NLX 8 mg/2 mg Individualized: patients with prior BUP/NLX experience and higher opioid tolerance can be initiated at higher doses i.e. 4mg/1mg. *Patients must be in moderate opioid withdrawal* (except during pregnancy)*
TITRATION	Adjust dose in increments/decrements of BUP/NLX 2 mg/0.5 mg or BUP/NLX 4 mg/1 mg up to BUP/NLX 16mg/4mg on Day 1 *To reach a level that will control opioid cravings, withdrawal symptoms and support treatment goals.*
MAINTENANCE	Maximum recommended** dose of BUP/NLX 24mg/6mg *Taken once daily or split into 2 doses*

** using either Clinical or Subjective Opioid Withdrawal Scales*
*** Patients with higher opioid tolerance, including those who use fentanyl, may benefit from a maximum dose of BUP/NLX 32mg/8mg*

CLINICAL CONSIDERATIONS

- Verify by observation or patient report that patient is in moderate opioid withdrawal before starting BUP/NLX; initiation of BUP/NLX may precipitate opioid withdrawal.
- Home-based, unobserved BUP/NLX inductionis as effective as office-based induction; choose an approach based on patient and clinician experience/comfort/preferences.
- Consider offering low-dose BUP/NLX initiation to reduce potential for precipitated withdrawal. Visit https://bit.ly/BUP-NLXMicroInduction for related resources
- If patients continue to have symptoms of opioid withdrawal or cravings on a maximum dose of BUP/NLX 24mg/6mg per day, review proper administration, intensify visit frequency and psychosocial support, address mental health needs. Consider referral to methadone treatment. Refer patients to experienced substance use treatment provider.

LOCATING A PROVIDER

- NYS: To contact qualified clinicians, call the NYS HOPEline ar 1-877-8-HOPENY or use the SAMHSA national Buprenorphine Practitioner Locator.

OVERDOSE PREVENTION EDUCATION:

- Provide or prescribe naloxone to all patients with OUD in case of witnessing or experiencing an opioid overdose, and encourage patients to have their partners, families or other close contacts trained to use naloxone.

ALTERNATIVE TREATMENT GOALS: Long-term cessation of illicit and/or unprescribed opioid use is not achievable for many patients. Alternative goals can lead to substantial improvements in the health and lives of those with OUD.
Medications for OUD should not be denied or discontinued for patients because of continued or return to use; patients who continue to use can benefit from treatment.

ALTERNATIVE GOAL	BENEFITS & EXAMPLES
1. Staying engaged in care	Facilitates prevention, diagnosis, and treatment of other conditions
2. Reducing opioid use	Improves overall health of those with OUD
3. Reducing high-risk behaviors	Reduces injection drug use, sharing of injection equipment, risk of reducing infection and overdose
4. Improving quality of life and other social indicators	Employment, stable housing and lowered risk of incarceration

BUP/NLX does not treat other substance use (e.g. cocaine use); do not expect that BUP/NLX will change other substance use, though often engagement in OUD treatment will decrease other substance use.

SUPPORT: Ongoing, regular follow-up is essential for support, encouragement. and modification of the treatment plan as needed.

Follow-up within 1-2 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.

Provide monthly or quarterly follow-up for patients stable on treatment, for ongoing evaluation to ensure goals are being met. Referral to counseling and mental health services is not a requirement for BUP/NLX treatment.

BEFORE PRESCRIBING BUP/NLX: NYS Prescription Drug Monitoring Program (PDMP) tracks a patient's history of dispensed controlled substances and must be consulted before providing each prescription for BUP/NLX (see New York State I-STOP/PMP – Internet System for Tracking Over-Prescribing – Prescription Monitoring Program). Medications dispensed in opioid treatment programs (i.e., methadone) are not included in the PDMP.

For all OUD treatment recommendations, including use of methadone or naltrexone, please see full guidelines at *www.hivguidelines.org*

For more resources on Drug User Health go to: *www.ceitraining.org* To speak with a clinician experienced in Drug User Health call the CEI Line at

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