



# **HARM REDUCTION AS A TRAUMA-INFORMED APPROACH TO SUBSTANCE USE**

**A GUIDE FOR PRIMARY CARE PROVIDERS**

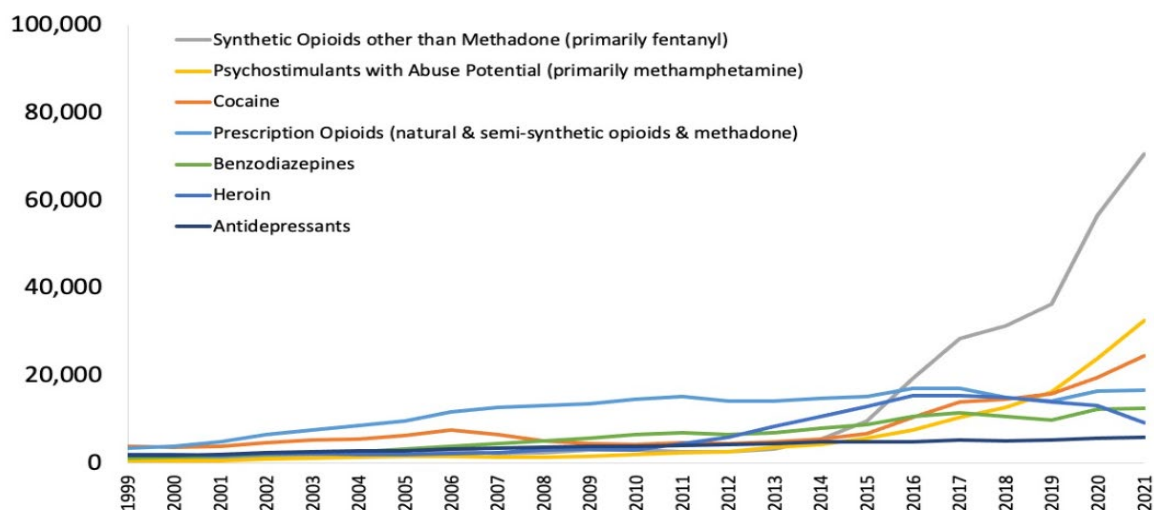


## Background

Deaths from drug overdose have continued to rise and are now one of the leading causes of injury and death in the United States. In 2021 alone, more than 106,000 people died from drug-involved overdoses in the United States.<sup>i</sup> Since the start of the COVID-19 pandemic, the number of drug overdose deaths have exceeded 100,000 between May 2020 and April 2021, with most of these deaths involving opioids.<sup>ii</sup> Opioid-involved deaths accounted for 74.8% of drug overdoses in 2020 and of those opioid-related deaths, 82.3% of them involved synthetic opioids (other than methadone).<sup>iii</sup> While these numbers alone are staggering, they fail to capture the many thousands more who have experienced a non-fatal overdose, live with opioid use disorder, or have lost a loved one in this crisis.

Figure 1<sup>viii</sup>

**Figure 2. National Drug-Involved Overdose Deaths\*, Number Among All Ages, 1999-2021**



\*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

The increased prevalence of potent synthetic opioids in the drug supply – fentanyl is 50 times stronger than heroin – poses an increased risk for overdose, particularly for people with no or low tolerance.<sup>iv</sup> Data indicates that synthetic opioids represent the newest phase of the overdose epidemic with 70,601 overdose deaths in 2021 involving synthetic opioids.<sup>v</sup> Additionally, psychostimulant use has increased with the number of overdose deaths involving psychostimulant increasing from 12,122 in 2015 to 53,495 in 2021.<sup>vi</sup>

## Harm Reduction and Trauma Informed Care

People who use substances and have trauma histories need an approach to primary care that considers the impact of trauma. Trauma can impact someone physically, neurologically, emotionally, and cognitively. Some people may attempt to manage trauma symptoms through substance use. This use can increase their risk of future victimization, which increases risk of ongoing substance use. Trauma informed care (TIC) is a critical component for working with patients who use substances because it realizes, recognizes, responds to, and resists retraumatization.<sup>vii</sup> TIC and harm reduction help patients feel safe, which helps to strengthen the patient-provider relationship, allowing the provider to empower patients and providing a space to patients that welcomes them as they are. TIC and harm reduction reinforce each other in this respect – both approaches help patients to make choices that make sense for their own personal health and safety.<sup>viii</sup>

### Harm Reduction Principles<sup>viii</sup>

#### Trauma Informed Care Principles<sup>vii</sup>


Safety 



Trustworthiness & Transparency 



Peer Support 


Collaboration & Mutuality 



Empowerment Voice & Choice 




Cultural, Historical, & Gender Issues 




  Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.




  Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.



 Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.

  Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

   Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

   Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use.

   Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

  Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

## Driving Factors of Substance Use and the Socio-Ecological Model

The major factors that influence substance use and potential for substance use disorder are often described amongst four main levels: **the individual, interpersonal, community and society** using the Socio-Ecological Model (SEM).<sup>ix</sup> The SEM's framework demonstrates the multiple levels of influence that impact one's behavior, such as substance use, as well as the multi-level interventions that can be used to modify behaviors.<sup>v</sup>

- **Individual:** Opioid use and OUD span sociodemographic, health and mental health, biological and psychosocial domains.
- **Interpersonal:** Family, friends and social networks significantly shape the beliefs, attitudes, and behaviors of individuals, influencing initiation and use of substances.
- **Community:** The community and the immediate context in which individuals live affect their daily behaviors in significant ways. Variables such as geographic conditions, treatment accessibility, medication disposal services, or workplace environment are all major risk factors that contribute to opioid use.
- **Society:** The major risk factors of opioid use are shaped by the larger social context, which encompasses opioid supply and demand, government regulations, economic conditions and unemployment rates, or law enforcement.

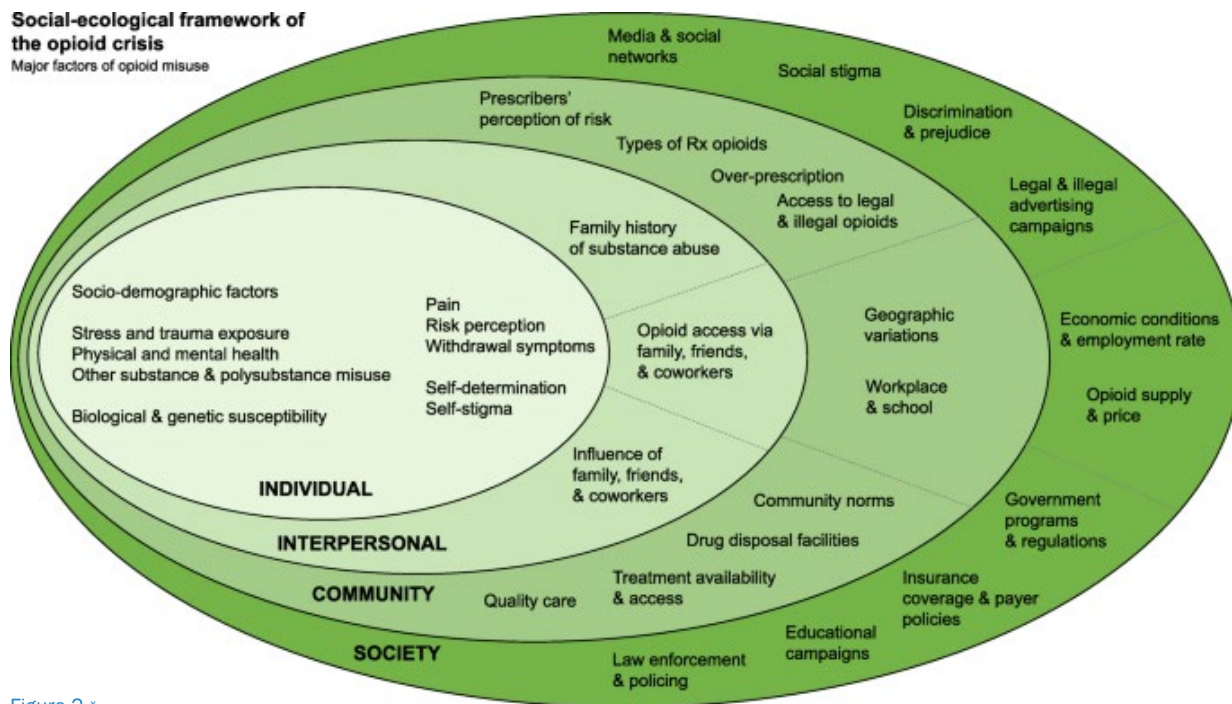


Figure 2.<sup>x</sup>

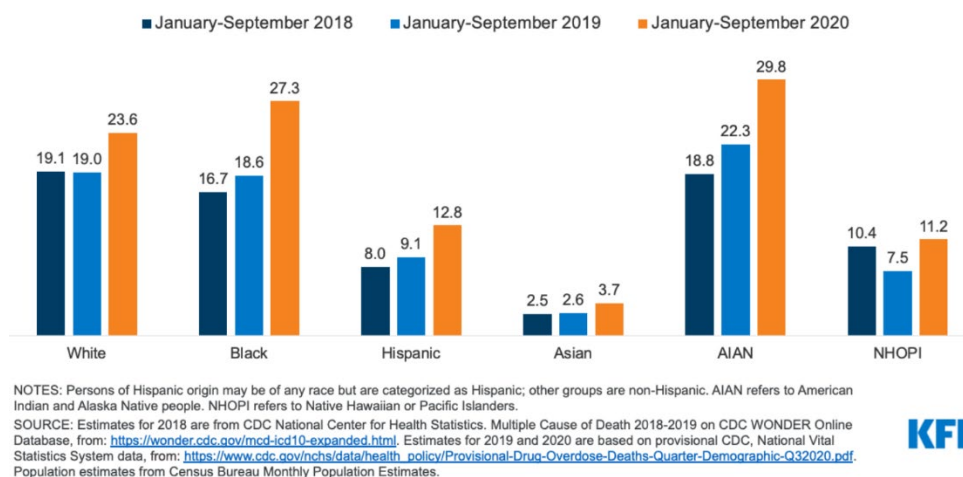
It is important to consider the multi-level drivers of substance use. Individual choice is just one component, and the majority of individual choices are in some way related to social and structural determinants of health (SDoH)<sup>xi</sup>, which are the “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.”<sup>xii</sup> SDoH are especially important to consider as they include elements such as availability of resources to meet basic needs, healthcare services, employment and educational opportunities, as well as exposure to segregation, racism, and discrimination, violence, and concentrated poverty, which are drivers of a multitude of health behaviors and outcomes, including substance use.<sup>xiii</sup>

## Disproportionately Affected Populations

Substance use is not unique or exclusive to any community, however people from communities and backgrounds that experience structural inequities (e.g. exposure to toxic stress and discrimination, concentrated disadvantage, limited access to quality, trauma-informed healthcare, etc.) often have higher rates of substance use and higher rates of overdose deaths.<sup>xiv</sup> Overdose deaths disproportionately impact BIPOC communities, people with a mental health disorder, and people within the LGBTQ+ community. Between 2018 and 2020, drug overdose death rates increased across all racial and ethnic groups, but increases were larger for Black and Indigenous communities.<sup>xv</sup> Members of the LGBTQ+ populations also experienced higher rates of substance use compared to their non-LGBTQ+ counterparts, with 6.7% of LGBTQ+ adults reporting using opioids in 2020 compared to 3.6% in the overall adult population.<sup>xvi</sup>

Drug Overdose Deaths Per 100,000, by Race/Ethnicity

Figure 3.<sup>xvi</sup>



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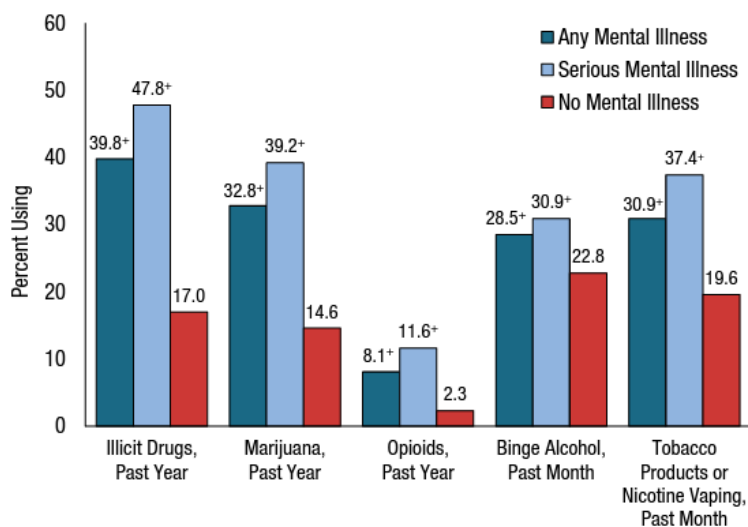
Disparities also exist in access to Medications for Opioid Use Disorder (MOUD), such as methadone and buprenorphine. In 2019, 1.6 million Americans were diagnosed with Opioid Use Disorder (OUD), but only 1 in 4 of people diagnosed with OUD reported receiving MOUD in the past year.<sup>xvii</sup> Disparities in access to MOUD treatment stem from multiple barriers including stigma, treatment experiences and beliefs of patients, knowledge gaps among practitioners, and logistical issues (e.g. transportation, methadone clinics location and capacity, location and capacity of providers who prescribe buprenorphine, etc.).<sup>xviii,xix</sup> The compounding effect of structural barriers, namely racial inequities stemming from a history of racism and substance use criminalization, has led Black communities in the South to have some of the lowest access to MOUD.<sup>xx</sup>

A low-threshold approach to OUD treatment could help increase rates of MOUD initiation and retention.<sup>xxi</sup> Principles of providing a low-threshold approach to MOUD access include same-day treatment entry and medication access, a harm reduction approach, flexibility in MOUD protocol, and wide availability of MOUD treatment in non-traditional settings.<sup>xxii</sup>

Around half of individuals who experience SUD during their lives will also experience a co-occurring mental disorder and vice versa.<sup>xxiii</sup> Co-occurring disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others.<sup>xxiv</sup> Due to the overlapping symptoms of certain mental health disorders and substance use, providers should use appropriate assessment tools to properly diagnose patients and provide tailored treatment programs.<sup>xxv</sup> For more information about diagnosis, treatment and educational resources on substance use and co-occurring mental disorders please visit: [National Institute of Mental Health » Substance Use and Co-Occurring Mental Disorders](#).

**Figure 37. Substance Use: Among Adults Aged 18 or Older; by Mental Illness Status, 2020**

Figure 4.<sup>xv</sup>



<sup>+</sup> Difference between this estimate and the estimate for adults without mental illness is statistically significant at the .05 level.



## Conversation Starters Adapted from: *Addiction Medicine Toolkit*<sup>xxvi</sup>

Listed in the table below are strategies for talking to patients about harm reduction, treatment, and services for substance use through a trauma informed lens. This is not an exhaustive checklist of questions, but rather is meant to serve as a conversation starter. This list of conversation starters is not an exhaustive list.

Empathy: Talking to Patients About Substance Use <sup>xxvii</sup>	Recommendation	Description/Rationale	Examples
	<b>Ask for permission to discuss substance use with your patient and provide options.</b>	<ul style="list-style-type: none"> <li>• Start by letting your patient know that you care about them and want to partner with them in getting them the help they want and need.</li> <li>• Reassure your patient that they have the option of not answering a question if it makes them feel uncomfortable.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“Would it be alright with you if I asked you some questions about your substance use?”</i></li> </ul>
	<b>Address confidentiality concerns honestly.</b>	<ul style="list-style-type: none"> <li>• Let patients know that you respect their confidentiality and will comply with the protections provided by law. Patients have a right to be informed about any limitations you may face in providing 100% confidentiality (threats to harm self/others, disclosures of child abuse and neglect, etc.).</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“I respect your confidentiality, so before we discuss this more, I want to inform you that I am required by law to disclose information in cases of [XXXX] to [XXXX].”</i></li> </ul>
	<b>Normalize the conversation.</b>	<ul style="list-style-type: none"> <li>• Tell your patient that any discomfort they are feeling is normal and that they are not alone.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“This is not unusual. Many patients find it hard to talk about their substance use.”</i></li> <li>• <i>“Talking about substance use can be uncomfortable.”</i></li> </ul>
	<b>Be transparent.</b>	<ul style="list-style-type: none"> <li>• Explain that it is important for you to ask specific questions because it is relevant to their treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“I need to ask you some very specific questions about your use of [XXXX] in order to better understand how I can support you.”</i></li> </ul>
	<b>Work collaboratively with patients.</b>	<ul style="list-style-type: none"> <li>• Make yourself available to explore patient goals and brainstorm what support would be helpful to reaching their goals.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“I can see you working hard in [XXXX], what would help you to achieve [XXXX]?”</i></li> <li>• <i>“Last time we spoke, you mentioned you were interested in changing your use of [XXXX]? Is that still your goal? How can I support you?”</i></li> </ul>
	<b>Establish trust and show empathy.</b>	<ul style="list-style-type: none"> <li>• Actively listen to your patient.</li> <li>• Engage with your patient in a non-judgmental manner using first-person language.</li> <li>• Treat your patient with respect and address their substance use disorder as the medical condition that it is.</li> <li>• Help your patient understand that you intend to connect them to the treatment and services that best support their goals.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“I hear you are having a tough time with [XXXX]. Substance use disorder can be a difficult condition to manage.”</i></li> <li>• <i>“It sounds like it has been a really difficult few months.”</i></li> </ul>

Motivational Interviewing to Assess and Support Readiness for Change <sup>xxviii</sup>	Recommendation	Description/Rationale	Examples
	Ask for permission to discuss substance use with your patient.	<ul style="list-style-type: none"> <li>Let your patient know that you care about them and want to partner with them in getting them the help they need.</li> <li>Reassure your patient that they have the option of not answering a question if it makes them feel uncomfortable.</li> </ul>	<ul style="list-style-type: none"> <li><i>“Would it be alright with you if I asked you some questions about your substance use?”</i></li> </ul>
	Have a conversation with your patient about their history of substance use.	<ul style="list-style-type: none"> <li>This allows the patient to explore the positive and negative aspects of using substances and encourages them toward identifying opportunities for positive change.</li> </ul>	<ul style="list-style-type: none"> <li><i>“People use substances for many different reasons. Are you comfortable sharing with me what yours were both in the beginning and now?”</i></li> <li><i>How have substances helped you? How have they not helped, or even caused harm?</i></li> </ul>
	Listen attentively and summarize to ensure clear communication.	<ul style="list-style-type: none"> <li>Thank them for trusting you and sharing. Reflect what you understood the patient to have said, building on what the patient has shared.</li> <li>Summarize after the patient has recounted a personal experience or when the conversation is nearing an end.</li> </ul>	<ul style="list-style-type: none"> <li><i>“Thank you for trusting me with that information. So, what I have heard you say is that on the one hand you have felt that substances have helped you with [XXXX] But on the other hand, have not particularly appreciated how your substance use has [XXXX]. Where does this leave you?”</i></li> </ul>
	Ask how ready they are to change their substance use on a scale of 1 to 10.	<ul style="list-style-type: none"> <li>Using a 1-10 scale allows for the patient to reflect on how they are already considering change and for the patient and provider to both identify and discuss barriers to change.</li> </ul>	<ul style="list-style-type: none"> <li><i>“On a scale of 1 to 10, how important is it for you to change [name the behavior] if you decided to?” ... “Can you share why you selected [insert number]?”</i></li> </ul>
	Discuss resources and referrals based on the expressed needs and wants of the patient.	<ul style="list-style-type: none"> <li>Discuss the all evidence-based options available to the patient, including both harm reduction services and MOUD. It is important to discuss both harm reduction and MOUD as complementary options to build trust with the patient regardless of their level of use and stage of change.</li> <li>Ask the patient if they have had experience with any of the named resources/referrals and if they are interested in being connected.</li> </ul>	<ul style="list-style-type: none"> <li><i>“Paths to improving health and safety can look different for different people. I want to support you in a plan that works for you. You mentioned that you are interested in [XXXX], have you ever been gone to/been connected to [XXXX]?”</i></li> <li><i>“Would you like a referral to [XXXX]?”</i></li> </ul>
	Provide referrals and offer naloxone, and follow-up with the patient.	<ul style="list-style-type: none"> <li>Prescribe naloxone to promote patient safety in the event of future overdoses and let patients know where they can access naloxone in their community.</li> <li>Use a clear and available “warm handoff” to transition the patient to ongoing resources and treatment.</li> <li>Follow up with patients about referrals. If they have not acted on a referral, discuss challenges or barriers that might be stopping them and ways to overcome them. Ask if they have any new or different needs.</li> </ul>	<ul style="list-style-type: none"> <li><i>“I’d like to give you a prescription for naloxone so you’ll be prepared in case you or someone you know has an overdose – would that be okay?”</i></li> <li><i>“Last time we talked you mentioned you were interested in a referral to [XXXX], how did that work out for you?”</i></li> </ul>



Remove Stigma: Talk with Your Patients About Substance Use <sup>xxix</sup>	Recommendation	Description/Rationale	Examples
	Use person-first language.	<ul style="list-style-type: none"> <li>• Use person-first language to center humanity and describe people as having a condition or circumstance, not being a condition. Certain terms have negative implications that can impact the medical care while also reducing the patient’s willingness to self-disclose or engage in treatment.</li> <li>• Remember, language and identity are personal; the goal is not to challenge or question self-identification but rather to acknowledge that as a provider the words you choose have meaning and can inadvertently reinforce harmful stigma.</li> <li>• Respect the language that patients use to refer to themselves. If they do not use person-first language, do not correct them, just continue to model the use of person-first language.</li> </ul>	<ul style="list-style-type: none"> <li>• Say “<i>person who uses substances or person with a substance use disorder</i>” because it separates the person from their diagnosis.</li> </ul>
	Avoid stigmatizing nonclinical language.	<ul style="list-style-type: none"> <li>• Using clinical language when discussing the results of medical practices, like urine screening, to reinforce the fact that substance use disorder is a medical condition.</li> </ul>	<ul style="list-style-type: none"> <li>• Use clinically accurate language as you would for other medical conditions, such as “<i>tested positive</i>” or “<i>not actively taking drugs.</i>”</li> </ul>
	Speak to your patient as a whole person when talking about substance use.	<ul style="list-style-type: none"> <li>• Ask questions to understand other factors (clinical and nonclinical) that might play a part in a patient’s symptoms instead of focusing only on their substance use.</li> <li>• By meeting patients where they are functionally, emotionally, and socially, you can provide hope which may lead to a more positive outlook and increase the likelihood of positive outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>• “<i>What is something you felt went well today?</i>”</li> <li>• “<i>On a scale of 1-10, how physically healthy are you feeling today? How emotionally healthy? How safe?</i>”</li> <li>• “<i>What is your housing situation like? Is it something that you feel supports you? Do you have regular access to transportation, etc.</i>”</li> </ul>
	Demonstrate empathy and understanding.	<ul style="list-style-type: none"> <li>• Remind your patient that change is possible and that paths to change look different for different people.</li> </ul>	<ul style="list-style-type: none"> <li>• “<i>I can see you working hard in [XXXX].</i>”</li> <li>• “<i>Thank you for coming today. I know it can be tough when the buses are always running late.</i>”</li> <li>• “<i>I heard you tell the nurse that you’ve been in your treatment program for a week today. That’s great! How are you feeling about it?</i>”</li> </ul>

## Impact and Outcomes of Harm Reduction Strategies

Harm reduction activities – specifically syringe services programs (SSPs), naloxone, drug checking, sterile injection supplies, and safe disposal – have proven to prevent death, injury, disease, overdose, and future substance use. Harm reduction services can:<sup>xxx</sup>

- Reduce overdose deaths, promote linkages to care, facilitate co-location of services as part of a comprehensive, integrated approach.
- Lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and soft tissue infections.
- Harm reduction can reduce overdose deaths by connecting individuals to naloxone and overdose education, counseling, and promote linkages to care and referrals to treatment for substance use as part of a comprehensive, integrated approach.
- Reduce infectious disease transmission among people who use drugs by providing testing sterile injection supplies and a safe method of disposal, equipping them with accurate information, and facilitating referrals to resources and treatment.
- Reduce stigma associated with substance use and co-occurring disorders.
- Promote a philosophy of hope and healing by involving people with lived and living experience in the management of harm reduction services, and connecting those who have expressed interest to treatment, peer support workers, and other recovery support services.

*State policies may impact the access to and legality of the spectrum of harm reduction resources and strategies. We strongly suggest that you research the laws, policies, and statutes in your state regarding topics such as syringe prescribing, MOUD access, and insurance codes. In additional, state or local harm reductionists can provide insight into the local harm reduction landscape.*

Harm Reduction Strategy	Overview	Supporting Research
<b>Overdose Education and Naloxone Distribution (OEND)</b>	Naloxone is an opioid antagonist that can quickly and safely reverse the potentially fatal effects of an opioid overdose.	<p>Access to an OEND can result in long-term increases in knowledge about:</p> <ul style="list-style-type: none"> <li>• preventing opioid overdoses</li> <li>• safely and effectively responding to an opioid overdose</li> </ul> <p>and improvements in participants' attitudes toward naloxone.<sup>xxxii</sup></p> <p>OEND reduces fatal overdoses by both training PWUD and potential bystanders on how to both prevent and respond to overdoses.<sup>xxxii</sup></p>
	Distribution programs seek to train and equip individuals who are most likely to experience or witness an overdose—especially people who use drugs (PWUD) and first responders—with naloxone kits, which they can use in an emergency to save a life.	
	There are many different approaches to distributing naloxone to people at high risk of experiencing or witnessing an overdose. Effective approaches include community distribution programs, co-prescription of naloxone, and equipping first responders. <sup>xxxiii</sup> It is often more effective to provide naloxone to PWUD, as they are most likely to be present when an overdose occurs and can quickly act if they have naloxone. Moreover, PWUD face barriers to calling 911 in the aftermath of an overdose due to the potential of criminal legal system consequences.	

Harm Reduction Strategy	Overview	Supporting Research
<p><b>Syringe Services Programs</b> (also known as syringe exchange programs and needle exchange programs)</p>	<p>Syringe services programs (SSPs) are community-based prevention programs that can provide a range of services, including linkage to substance use treatment; access to and disposal of sterile syringes and injection equipment; testing; wound care; treatment for infectious diseases; and linkage to medical, mental health, and social services.</p>	<p>SSPs reduce HIV and HCV incidence by 50%, and when combined with MOUD it can reduce HCV transmission by 50-80%.<sup>xxxv</sup></p> <p>People who inject drugs (PWID) who regularly use an SSP are five times as likely to access substance use treatment and three times as likely to reduce or stop injection drug use than PWID who have never used an SSP.<sup>xxxvi</sup></p> <p>SSPs can save lives by reducing fatal and nonfatal overdoses through the provision of OEND to PWUD to prevent and respond to overdoses.<sup>xxxvii</sup> SSPs vary in the range of services that they provide, but around 94% of SSPs offer OEND, which has been shown to reduce overdose-related hospital admissions and save lives.<sup>xxxviii</sup></p>
<p><b>Drug Checking</b> (fentanyl test strips)</p>	<p>Drug checking services and tools such as fentanyl test strips, provide PWUDs with additional information about their drugs to reduce overdose risk and empower people to make more informed decisions. Drug checking services are often integrated with syringe services; however, they can also be adapted to a variety of settings, such as pharmacies, healthcare facilities, or schools.<sup>xxxix</sup></p>	<p>Fentanyl test strips show promise for preventing fatal overdose by individuals modifying their behavior prior to using from a specific drug supply based on the result of the test strip. They may choose to discard the substance(s), use a smaller quantity, ensure they have naloxone first, and/or use with someone else present.<sup>xl</sup></p>

Harm Reduction Strategy	Overview	Supporting Research
<p><b>Overdose Prevention Sites</b> (also known as supervised consumption/injection sites)</p>	<p>Overdose prevention sites are designated sites where people can use pre-obtained drugs under the safety and support of trained personnel.<sup>xli</sup> Overdose prevention sites also provide counseling on harm reduction practices, and facilitate referrals to healthcare services, education, etc.</p>	<p>Overdose prevention sites reduce fatal overdoses in the immediate vicinity of the facility.<sup>xlii</sup></p> <p>Overdose prevention sites facilitate referrals to treatment and other supportive services, which can result in cessation of injection drug use.<sup>xliii</sup></p>
<p><b>Medications for Opioid Use Disorder (MOUD)</b><sup>xliv</sup></p>	<p>Methadone is a full agonist with a long half-life making other opioids less effective while also protecting against overdose. Patients taking methadone to treat OUD must receive the medication under the supervision of a practitioner. After a period of stability (based on progress and proven, consistent compliance with the medication dosage), patients may be allowed to take methadone at home between program visits.<sup>xlv</sup></p> <p>Buprenorphine works similarly to methadone, but only partially activates opioid receptors, often reducing drug use and protecting patients from overdose.</p> <p>Naltrexone works differently from methadone or buprenorphine. It completely blocks opioid receptors and is used after detoxification to prevent relapse. It has no abuse potential, no overdose risk, and there is no withdrawal when the medication is stopped.<sup>l</sup> It can be administered in a primary care providers PCP's office with single doses effective for up to 30 days, however to prevent withdrawal symptoms it is important that the patient has not used opioids between 7-14 days depending on the type of opioid last used.<sup>li</sup></p>	<p>Buprenorphine and methadone have the strongest evidence base that shows reductions in overdose and opioid morbidity.<sup>xlvi</sup></p> <p>The evidence base for Naltrexone is not as strong as it is for buprenorphine and methadone. Studies have found that while naltrexone is FDA-approved, it does not necessarily reduce the risk of overdose.<sup>xlvii</sup> Providers should consider the research on the outcomes of all types of MOUD medications and make a decision about the best course of treatment in collaboration with their patients.</p> <p>Behavioral health interventions can complement MOUD treatment, but are not necessary for MOUD treatment, alone, to be effective.<sup>xlviii</sup></p> <p>Patients with chronic pain and/or depression have complex needs and providers should consider all MOUD options in collaboration with their patients to best provide support.<sup>xlix</sup></p>

## Resources/Additional Information

National Harm Reduction Technical Assistance Center: <https://harmreductionhelp.cdc.gov/s/>

NaRCAD Intervention Toolkit: Best Practices in Academic Detailing for Opioid Safety: <https://www.narcad.org/opioid-safety-toolkit.html>

SAMHSA's Evidence-Based Practices Resource Center: <https://www.samhsa.gov/resource-search/ebp>

- Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings
  - <https://www.samhsa.gov/resource/ebp/practical-tools-prescribing-buprenorphine-primary-care>
- Treating Concurrent Substance Use Among Adults
  - <https://www.samhsa.gov/resource/ebp/treating-concurrent-substance-use-among-adults>
- Telehealth for the Treatment of Serious Mental Illness and Substance Use
  - <https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders>
- Substance Use Disorders Recovery with a Focus on Employment
  - <https://www.samhsa.gov/resource/ebp/substance-use-disorders-recovery-focus-employment>
- Substance Use Prevention for Younger Adults
  - <https://www.samhsa.gov/resource/ebp/substance-misuse-prevention-young-adults>

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: [https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA\\_Trauma.pdf](https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf)

Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices: [Linking People with Opioid Use Disorder to Medication Treatment | Feature Topics | Drug Overdose \(cdc.gov\)](#)

MOUD Overview and Regulations: [Medication for Opioid Use Disorder \(MOUD\) Overview - National Harm Reduction Coalition](#)

- Certification of Opioid Treatment Programs (OTP)
  - <https://www.samhsa.gov/medication-assisted-treatment/become-accredited-opioid-treatment-program>
  - [Update to Accreditation and Certification Standards of OTPs 42 CFR Part 8 Notice of Proposed Rulemaking - Frequently Asked Questions | SAMHSA](#)
- SAMSHA'S Practitioner Training Resources
  - <https://www.samhsa.gov/practitioner-training>
- MOUD Statutes, Regulations, and Guidelines
  - <https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines>

Legal Advocacy to Protect Health Care Access for People who Use(d) Drugs: [https://www.lac.org/assets/files/Advocacy-Guide\\_v4-w-attach-a.pdf](https://www.lac.org/assets/files/Advocacy-Guide_v4-w-attach-a.pdf)

## Endnotes

- <sup>i</sup> National Institute on Drug Abuse (NIDA). (2023). Drug Overdose Death Rates. [Drug Overdose Death Rates | National Institute on Drug Abuse \(NIDA\) \(nih.gov\)](#)
- <sup>ii</sup> Centers for Disease Control and Prevention. (2021). [Drug Overdose Deaths in the U.S. Top 100,000 Annually \(cdc.gov\)](#)
- <sup>iii</sup> Centers for Disease Control and Prevention. (2022). [Death Rate Maps & Graphs | Drug Overdose | CDC Injury Center](#)
- <sup>iv</sup> Center on Rural Addiction. University of Vermont. Illicit Drug Supply: Fentanyl and Xylazine. (Webinar). <https://www.youtube.com/watch?v=OVVLd942YM>
- <sup>v</sup> National Institute on Drug Abuse (NIDA). (2023). Drug Overdose Death Rates. [Drug Overdose Death Rates | National Institute on Drug Abuse \(NIDA\) \(nih.gov\)](#)
- <sup>vi</sup> National Institute on Drug Abuse (NIDA). (2023). Drug Overdose Death Rates. [Drug Overdose Death Rates | National Institute on Drug Abuse \(NIDA\) \(nih.gov\)](#)
- <sup>vii</sup> Trauma Informed Care Principles. Trauma Informed Oregon. 2022. <https://traumainformedoregon.org/resources/new-to-trauma-informed-care/trauma-informed-care-principles/>
- <sup>viii</sup> Principles of Harm Reduction. National Harm Reduction Coalition. 2020. <https://harmreduction.org/about-us/principles-of-harm-reduction/>
- <sup>ix</sup> Jalali, M.S., Botticelli, M., Hwang, R.C. et al. The opioid crisis: a contextual, social-ecological framework. *Health Res Policy Sys* 18, 87 (2020). <https://doi.org/10.1186/s12961-020-00596-8>.
- <sup>x</sup> Jalali, M.S., Botticelli, M., Hwang, R.C. et al. The opioid crisis: a contextual, social-ecological framework. *Health Res Policy Sys* 18, 87 (2020). <https://doi.org/10.1186/s12961-020-00596-8>
- <sup>xi</sup> Brandeis Opioid Resource Connector. *Addressing the Opioid Crisis through Social Determinants of Health: What Are Communities Doing?* Opioid Policy Resource Collaborative; 2021. <https://opioid-resource-connector.org/sites/default/files/2021-02/Issue%20Brief%20-%20Final.pdf>
- <sup>xii</sup> Substance Abuse and Mental Health Service Administration (SAMHSA). (2019). 2019 National Survey of Drug Use and Health (NSDUH) Releases <https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases>
- <sup>xiii</sup> Healthy People 2020. Social Determinants of Health. Office of Disease Prevention and Health Promotion. Updated February 6, 2022. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
- <sup>xiiii</sup> Healthy People 2020. Social Determinants of Health. Office of Disease Prevention and Health Promotion. Updated February 6, 2022. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
- <sup>xv</sup> Centers for Disease Control and Prevention. Drug Overdose Deaths Rise, Disparities Widen. <https://www.cdc.gov/vitalsigns/overdose-death-disparities/index.html>
- <sup>xvi</sup> Panchal, N., Garfield, R., Cox, C., & Artiga, S. Substance Use Issues Are Worsening Alongside Access to Care. Kaiser Family Foundation. Published August 12, 2021. <https://www.kff.org/policy-watch/substance-use-issues-are-worsening-alongside-access-to-care/>
- <sup>xvii</sup> National Institute on Drug Abuse (NIDA). [Substance Use and SUDs in LGBTQ\\* Populations | National Institute on Drug Abuse \(NIDA\) \(nih.gov\)](#)
- <sup>xviii</sup> Mauro PM, Gutkind S, Annunziato EM, Samples H. Use of Medication for Opioid Use Disorder Among US Adolescents and Adults With Need for Opioid Treatment, 2019. *JAMA Netw Open*. 2022;5(3):e223821. doi:10.1001/jamanetworkopen.2022.3821
- <sup>xix</sup> Mackey K, Veazie S, Anderson J, Bourne D, Peterson K. Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review. *J Gen Intern Med*. 2020 Dec;35 [Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review - PMC \(nih.gov\)](#)
- <sup>xx</sup> Mitchell, P., Samsel, S., Curtin, K. M., Price, A., Turner, D., Tramp, R., ... & Lewis, D. (2022). Geographic disparities in access to Medication for Opioid Use Disorder across US census tracts based on treatment utilization behavior. *Social Science & Medicine*, 302, 114992.
- <sup>xxi</sup> Centers for Medicare and Medicaid Services (CMS). (2022). Office of Minority Health. [Opioid Data Snapshot- January 2022 \(cms.gov\)](#)
- <sup>xxii</sup> Aronowitz, Behrends, Lowenstein, Schackman, Weiner. (2022). University of Pennsylvania. [Lowering the Barriers to Medication Treatment for People with Opioid Use Disorder \(upenn.edu\)](#)
- <sup>xxiii</sup> Aronowitz, Behrends, Lowenstein, Schackman, Weiner. (2022). University of Pennsylvania. [Lowering the Barriers to Medication Treatment for People with Opioid Use Disorder \(upenn.edu\)](#)
- <sup>xxiiii</sup> *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*. Substance Abuse and Mental Health Services Administration; 2021. Publication No. PEP21-07-01-003, NSDUH Series H-56. <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFRRPDFWHTMLFiles2020/2020NSDUHFRR1PDFW102121.pdf>
- <sup>xxv</sup> National Institute of Mental Health. Substance Use and Co-occurring Mental Disorders. (2023). [NIMH » Substance Use and Co-Occurring Mental Disorders \(nih.gov\)](#)
- <sup>xxvi</sup> National Institute of Mental Health. Substance Use and Co-occurring Mental Disorders. (2023). [NIMH » Substance Use and Co-Occurring Mental Disorders \(nih.gov\)](#)
- <sup>xxvii</sup> Addiction Medicine Toolkit. Center for Disease Control and Prevention. Updated March 2, 2022. <https://www.cdc.gov/opioids/addiction-medicine/index.html>
- <sup>xxviii</sup> Empathy: Talking to Patients About Substance Use Disorder. Centers for Disease Control and Prevention. Center for Disease Control and Prevention. Updated July 7, 2022. <https://www.cdc.gov/opioids/addiction-medicine/conversation-starters/talking-to-patients.html>
- <sup>xxix</sup> Motivational Interviewing to Help Your Patients Seek Treatment. Center for Disease Control and Prevention. Updated July 7, 2022. <https://www.cdc.gov/opioids/addiction-medicine/conversation-starters/motivational-interviewing.html>
- <sup>xxx</sup> Remove Stigma: Talk with Your Patients About Substance Use Disorder. Center for Disease Control and Prevention. Updated July 7, 2022. <https://www.cdc.gov/opioids/addiction-medicine/conversation-starters/remove-stigma.html>
- <sup>xxxi</sup> Harm Reduction. Substance Abuse and Mental Health Services Administration. Updated June 6, 2022. <https://www.samhsa.gov/find-help/harm-reduction>
- <sup>xxxii</sup> Razaghizad A, Windle SB, Filion KB, et al. The Effect of Overdose Education and Naloxone Distribution: An Umbrella Review of Systematic Reviews. *Am J Public Health*. 2021;111(8):1516-1517. doi:10.2105/AJPH.2021.306306a.
- <sup>xxxiii</sup> Lambdin BH, Bluthenthal RN, Wenger LD, et al. Overdose Education and Naloxone Distribution Within Syringe Service Programs - United States, 2019. *MMWR Morb Mortal Wkly Rep*. 2020;69(33):1117-1121. Published 2020 Aug 21. doi:10.15585/mmwr.mm6933a2; Wheeler E, Jones TS, Gilbert MK, Davidson PJ; Centers for Disease Control and Prevention (CDC). Opioid Overdose Prevention Programs Providing Naloxone to Laypersons - United States, 2014. *MMWR Morb Mortal Wkly Rep*. 2015;64(23):631-635.; Enteen L, Bauer J, McLean R, et al. Overdose prevention and naloxone prescription for opioid users in San Francisco. *J Urban Health*. 2010;87(6):931-941. doi:10.1007/s11524-010-9495-8; Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*. 2013;346:f174. Published 2013 Jan 30. doi:10.1136/bmj.f174
- <sup>xxxiiii</sup> Carrol JJ, Green TC, Noonan, RK. *Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States* Center for Disease Control and Prevention; 2018. <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>



- <sup>xxxiv</sup> Nolte, K., Romo, E., Stopka, T. J., Drew, A., Dowd, P., Del Toro-Mejias, L., ... & Friedmann, P. D. (2022). "I've been to more of my friends' funerals than I've been to my friends' weddings": Witnessing and responding to overdose in rural Northern New England. *The Journal of Rural Health*.
- <sup>xxxv</sup> Platt, L., Minozzi, S., Reed, J., Vickerman, P., Hagan, H., French, C., ... & Maher, L. (2017). Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database of Systematic Reviews*, (9). doi: 10.1002/14651858.CD012021.pub2; Fraser, H., Zibbell, J., Hoerger, T., Hariri, S., Vellozzi, C., Martin, N. K., ... & Vickerman, P. (2018). Scaling-up HCV prevention and treatment interventions in rural United States—model projections for tackling an increasing epidemic. *Addiction*, 113(1), 173-182.
- <sup>xxxvi</sup> Summary of Information on The Safety and Effectiveness of Syringe Services Programs (SSPs). Center for Disease Control and Prevention. Updated May 23, 2019. <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>.
- <sup>xxxvii</sup> Summary of Information on The Safety and Effectiveness of Syringe Services Programs (SSPs). Center for Disease Control and Prevention. Updated May 23, 2019. <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>.
- <sup>xxxviii</sup> Bornstein, K.J., Coye, A.E., St. Onge, J.E. et al. Hospital admissions among people who inject opioids following syringe services program implementation. *Harm Reduct J* 17, 30 (2020). <https://doi.org/10.1186/s12954-020-00376-1>; Lambdin BH, Bluthenthal RN, Wenger LD, et al. Overdose Education and Naloxone Distribution Within Syringe Service Programs - United States, 2019. *MMWR Morb Mortal Wkly Rep*. 2020;69(33):1117-1121. Published 2020 Aug 21. doi:10.15585/mmwr.mm6933a2.
- <sup>xxxix</sup> Statement of Policy: Harm Reduction. National Association of County and City Health Officials. Updated April 2022. <https://www.naccho.org/uploads/downloadable-resources/05-09-Harm-Reduction.pdf>
- <sup>xl</sup> Goldman, J.E., Wayne, K.M., Periera, K.A. et al. Perspectives on rapid fentanyl test strips as a harm reduction practice among young adults who use drugs: a qualitative study. *Harm Reduct J* 16, 3 (2019). <https://doi.org/10.1186/s12954-018-0276-0>; Peiper, N.C., Clarke, S.D., Vincent, L.B. et al. Fentanyl test strips as an opioid overdose prevention strategy: Findings from a syringe services program in the Southeastern United States. *Int. J. Drug Policy*. 63 (2019). <https://doi.org/10.1016/j.drugpo.2018.08.007>.
- <sup>xli</sup> Overview of Supervised Consumption Services in the United States. National Harm Reduction Coalition. Updated August 31, 2020. <https://harmreduction.org/issues/supervised-consumption-services/overview-united-states/>
- <sup>xlii</sup> Sherman, S. G., Hunter, K., & Rouhani, S. (2017). Safe drug consumption spaces: a strategy for Baltimore City. Abell Report, 29(7).
- <sup>xliii</sup> Sherman, S. G., Hunter, K., & Rouhani, S. (2017). Safe drug consumption spaces: a strategy for Baltimore City. Abell Report, 29(7).
- <sup>xliv</sup> Overview of Medications for Opioid Use Disorder (MOUD). Providers Clinical Support System. <https://pcssnow.org/medications-for-opioid-use-disorder/>
- <sup>xlv</sup> Methadone. Substance Abuse and Mental Health Services Administration. Updated June 23, 2022. <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone>
- <sup>xlvi</sup> Wakeman S.E., Laroche M.R., Ameli O. et al. Comparative effectiveness of different treatment pathways for opioid use disorder. *JAMA Netw Open*. 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622.
- <sup>xlvii</sup> Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; 2019. <https://www.ncbi.nlm.nih.gov/books/NBK541393/>; Kelty, E., & Hulse, G. (2017). Fatal and non-fatal opioid overdose in opioid dependent patients treated with methadone, buprenorphine or implant naltrexone. *International Journal of Drug Policy*, 46, 54-60.; Saucier, R., Wolfe, D., & Dasgupta, N. (2018). Review of case narratives from fatal overdoses associated with injectable naltrexone for opioid dependence. *Drug Safety*, 41(10), 981-988.; Kelty, E., & Hulse, G. (2017). Fatal and non-fatal opioid overdose in opioid dependent patients treated with methadone, buprenorphine or implant naltrexone. *International Journal of Drug Policy*, 46, 54-60.
- <sup>xlviii</sup> Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; 2019. <https://www.ncbi.nlm.nih.gov/books/NBK541393/>.
- <sup>xlix</sup> Stein MD, Herman DS, Bailey GL, et al. Chronic pain and depression among primary care patients treated with buprenorphine. *J Gen Intern Med*. 2015;30(7):935-941. doi:10.1007/s11606-015-3212-y
- <sup>l</sup> Overview of Medications for Opioid Use Disorder (MOUD). Providers Clinical Support System. <https://pcssnow.org/medications-for-opioid-use-disorder/>
- <sup>li</sup> Naltrexone. Substance Abuse and Mental Health Services Administration. Updated April 21, 2022. <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone>

