CLINICAL GUIDELINES PROGRAM
NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV • HCV • STIs • SUBSTANCE USE • LGBTQ+ HEALTH

Substance Use Harm Reduction in Medical Care

Updates, Authorship, and Related Resources

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Committee: Substance Use Guidelines Committee

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All Recommendations

☑ ALL RECOMMENDATIONS: SUBSTANCE USE HARM REDUCTION IN MEDICAL CARE

Implementing Substance Use Harm Reduction

- For patients who use substances, whether or not they are engaged in SUD treatment, clinicians should continue to offer medical care, including HCV and HIV screening and treatment, HIV PrEP, and HIV PEP, as indicated. (A3)
- Clinicians should offer or refer for harm reduction counseling and services, including counseling on safer substance use. (A3)
- To assist in harm reduction and treatment planning, clinicians should ask patients about all of the substances they use, methods of use, use networks, and the role and effects of substance use in their daily lives. (A3)
- Clinicians should collaborate with patients to set specific harm reduction/treatment goals, recognizing that goals other than full abstinence, such as reduced or safer use, are acceptable. (A3)
- To reduce harms associated with drug injection, clinicians should refer patients to an NYS Authorized Syringe Exchange Site and advise patients against sharing and reusing equipment given the associated risks. (A2)

Opioid Overdose Prevention

- Clinicians should educate patients on the risks of drug overdose, especially fentanyl overdose, discuss risk reduction strategies, and counsel patients to:
  - Assume that all illicitly manufactured opioids contain fentanyl or other high-potency synthetic opioids and that stimulants and counterfeit pills may contain these agents. (A3)

☑ ALL RECOMMENDATIONS: SUBSTANCE USE HARM REDUCTION IN MEDICAL CARE

  - When possible, test drugs with fentanyl and xylazine test strips or other drug-checking systems [a]. (A3)
  - Try to avoid using drugs alone [b]. (A3)
  - Start with a small amount when using any drug. (A3)
  - Carry NLX, learn how to use it to reverse an opioid overdose, and encourage friends and contacts to do the same. (A2)
- Clinicians should offer or refer patients to a local or online resource for fentanyl and xylazine test strips and instructions on their use. (B3)
- Clinicians should ensure that patients have access to NLX: prescribe the 4 mg NLX nasal spray formulation with refills or refer the patient to a local or online resource [c]. (A2)

Pharmacologic Treatment

- When indicated, clinicians should offer pharmacologic treatment for patients with an SUD [d]. (A3)
  - See NYSDOH AI guidelines Treatment of Opioid Use Disorder and Treatment of Alcohol Use Disorder.
- Clinicians should continue to prescribe SUD treatment for patients who continue or resume use. (A3)

Avoiding Substance Use-Associated Discrimination

- 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 2: Changing the Language of Substance Use). (A2)

Abbreviations: HCV, hepatitis C virus; NLX, naloxone; PEP, post-exposure prophylaxis; PrEP, pre-exposure prophylaxis; SUD, substance use disorder.

Notes:

a. See MATTERS > Harm Reduction to order fentanyl and xylazine test strips (for an individual or organization).
b. Suggest, for instance, that individuals might arrange for someone to check in on them or may use phone- or web-based apps, such as Never Use Alone Inc. (877-696-1996).
c. See Box 1: Harm Reduction Resources in New York State (January 2025).
d. Office-based services; medically managed, monitored, or supervised withdrawal and stabilization; outpatient services; opioid treatment programs (e.g., methadone programs); and residential treatment. For information on treatment availability in New York State, see the OASAS Treatment Availability Dashboard.

Purpose of This Guideline

This guideline on harm reduction was developed by the New York State Department of Health AIDS Institute (NYSDOH AI) to guide primary care clinicians and other clinical practitioners in integrating harm reduction principles into the treatment and care of adults with substance use and substance use disorders (SUDs).

Goals

By providing evidence-based guidelines on treatment of substance use and SUDs, the NYSDOH AI and the Substance Use Guidelines Committee aim to increase the availability of treatment in general medical settings. With this guideline, the committee aims to promulgate a harm reduction approach to medical care of patients who use substances or have SUDs and to:

- Promote adoption of practical harm reduction strategies to reduce the negative consequences associated with drug and alcohol use.
- Increase awareness and use of NYSDOH and local/regional harm reduction resources.
- Support healthcare clinicians in recognizing and addressing the effects of stigma, which can pose a barrier to individuals seeking substance use treatment and harm reduction services.

Role of primary care clinicians: Primary care clinicians in New York State play an essential role in identifying substance use in patients, counseling patients about risky substance use, and expanding access to evidence-based treatment. SUDs are chronic conditions that can be successfully managed in primary care or other outpatient settings.

In the clinical context, harm reduction is an approach based on the use of practical strategies 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 National Harm Reduction Coalition). A harm reduction approach promotes positive changes beyond abstinence, which may include reducing substance use and using safely to reduce disease acquisition and transmission, and emphasizes the avoidance of coercion, discrimination, and bias in the clinical care of people with SUDs.

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 SUD. The recommendations are based on emerging evidence and the extensive clinical experience of this committee.

Racial and Ethnic Disparities

Studies conducted before the COVID-19 pandemic documented racial or ethnic disparities in access to evidence-based opioid use disorder (OUD) treatment [Goedel, et al. 2020; Lagisetty, et al. 2019] and opioid overdose mortality rates [Friedman, et al. 2022; Larochelle, et al. 2021]. These disparities in access to treatment and mortality appear to have worsened during the COVID-19 pandemic [Kariisa, et al. 2022; Nguyen, et al. 2022; Khatri, et al. 2021].

Because people of color experience a disproportionate level of harm associated with substance use and repercussions related to use, it is essential to expand access to evidence-based harm reduction services and treatment for people of color who use substances. Clinicians can work directly with patients and their families and regular social contacts to provide naloxone and other harm reduction services when indicated and refer patients to appropriate community-based organizations for further support.

Harm Reduction During the COVID-19 Pandemic

The COVID-19 pandemic had devastating consequences for people who use substances, with unprecedented increases in overdose deaths [CDC(b) 2024; Kouimtsidis, et al. 2021; Krawczyk, et al. 2021]. In the United States, in the 12 months ending in April 2021, the Centers for Disease Control and Prevention reported 75,673 opioid-related overdose deaths compared with 56,064 deaths in the preceding 12-month period [CDC 2021]. In 2019, 2,939 overdose deaths (14.9 per 100,000 population) occurred among New York State residents, which is nearly triple the rate in 2010 [NYSDOH 2021]. Preliminary 2020 data indicate the rate continues to increase; in New York State (excluding New York City), there were 2,521 (22.5 per 100,000 population) opioid-related deaths [NYSDOH 2022].

New harm reduction interventions were implemented in response to COVID-19. For example, under the federal COVID Public Health Emergency (PHE), telemedicine was used to initiate medication for OUD treatment, thus expanding and protecting access to evidence-based treatment [Jones, et al. 2022; Tofighi, et al. 2022; Wang, et al. 2021]. The ability to initiate and continue medication for OUD treatment via telehealth after the conclusion of the COVID PHE remains unclear at this time; PHE exemptions for telehealth have been extended through 2025 while new regulations are under review. Other harm reduction services implemented in response to the pandemic include home and mail-order delivery programs for naloxone distribution and syringe exchange.

Trauma-Informed Care

Trauma is more common among people with an SUD [Bartholow and Huffman 2021; Karsberg, et al. 2021; Zarse, et al. 2019], and this population is more likely to experience trauma in healthcare settings [Aronowitz and Meisel 2022; Simon, et al. 2020]. The effect of trauma on the health and well-being of individuals and communities is gaining visibility and attention [Center for Youth Wellness 2024; Robert Wood Johnson Foundation 2024; CDC 2023]. Trauma results from an event, series of events, or set of circumstances that is experienced (or perceived) by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being [SAMHSA 2014]. Historical trauma refers to cumulative traumatic experience and associated harms extending over an individual life span and across generations. In a trauma-informed approach, clinicians recognize the signs of trauma and avoid retraumatizing patients.

◊ RESOURCES

- Substance Abuse and Mental Health Services Administration: Trauma-Informed Care in Behavioral Health Services (TIP 57)
- Centers for Disease Control and Prevention: Trauma-Informed Care Learning Series
- New York State Trauma-Informed Network & Resource Center
- Center for Health Care Strategies: Trauma-Informed Care Implementation Resource Center

Implementing Substance Use Harm Reduction

☑ RECOMMENDATIONS

Implementing Substance Use Harm Reduction

- For patients who use substances, whether or not they are engaged in SUD treatment, clinicians should continue to offer medical care, including HCV and HIV screening and treatment, HIV PrEP, and HIV PEP, as indicated. (A3)
- Clinicians should offer or refer for harm reduction counseling and services, including counseling on safer substance use. (A3)
- To assist in harm reduction and treatment planning, clinicians should ask patients about all of the substances they use, methods of use, use networks, and the role and effects of substance use in their daily lives. (A3)
- Clinicians should collaborate with patients to set specific harm reduction/treatment goals, recognizing that goals other than full abstinence, such as reduced or safer use, are acceptable. (A3)
- To reduce harms associated with drug injection, clinicians should refer patients to an NYS Authorized Syringe Exchange Site and advise patients against sharing and reusing equipment given the associated risks. (A2)

Opioid Overdose Prevention

- Clinicians should educate patients on the risks of drug overdose, especially fentanyl overdose, discuss risk reduction strategies, and counsel patients to:
  - Assume that all illicitly manufactured opioids contain fentanyl or other high-potency synthetic opioids and that stimulants and counterfeit pills may contain these agents. (A3)
  - When possible, test drugs with fentanyl and xylazine test strips or other drug-checking systems [a]. (A3)
  - Try to avoid using drugs alone [b]. (A3)
  - Start with a small amount when using any drug. (A3)
  - Carry NLX, learn how to use it to reverse an opioid overdose, and encourage friends and contacts to do the same. (A2)
- Clinicians should offer or refer patients to a local or online resource for fentanyl and xylazine test strips and instructions on their use. (B3)
- Clinicians should ensure that patients have access to NLX: prescribe the 4 mg NLX nasal spray formulation with refills or refer the patient to a local or online resource [c]. (A2)

Pharmacologic Treatment

- When indicated, clinicians should offer pharmacologic treatment for patients with an SUD [d]. (A3)
  - See NYSDOH AI guidelines Treatment of Opioid Use Disorder and Treatment of Alcohol Use Disorder.
- Clinicians should continue to prescribe SUD treatment for patients who continue or resume use. (A3)

Abbreviations: HCV, hepatitis C virus; NLX, naloxone; PEP, post-exposure prophylaxis; PrEP, pre-exposure prophylaxis; SUD, substance use disorder.

Notes:

a. See MATTERS > Harm Reduction to order fentanyl and xylazine test strips (for an individual or organization).
b. Suggest, for instance, that individuals might arrange for someone to check in on them or may use phone- or web-based apps, such as Never Use Alone Inc. (877-696-1996).
c. See Box 1: Harm Reduction Resources in New York State (January 2025).
d. Office-based services; medically managed, monitored, or supervised withdrawal and stabilization; outpatient services; opioid treatment programs (e.g., methadone programs); and residential treatment. For information on treatment availability in New York State, see the OASAS Treatment Availability Dashboard.

Harm Reduction Approach

Substance use or SUDs, whether treated or not, do not preclude delivery of primary care services. Regardless of a patient's desire to engage in treatment for substance use as part of their medical care, every clinic visit is an opportunity to provide primary care with attention to screening for sexually transmitted and injection drug use-associated diseases, including HIV and HCV, vaccinations, and sexual health services. See NYSDOH AI guidelines:

- HIV Testing
- Hepatitis C Virus Screening, Testing, and Diagnosis in Adults
- PrEP to Prevent HIV and Promote Sexual Health
- PEP to Prevent HIV Infection

Working with a patient who uses substances to implement an appropriate harm reduction/treatment plan involves balancing many factors, and choice 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.

Harm reduction/treatment goals: Traditionally, SUD treatment providers have considered abstinence the primary goal of treatment, but this approach is evolving. Changing the pattern of or reducing substance use has measurable health benefits and contributes to increased function, even if the individual continues to use substances [Charlet and Heinz 2017; Lea, et al. 2017; Collins(a), et al. 2015; Collins(b), et al. 2015; Gjersing and Bretteville-Jensen 2013]. See ASAM: Engagement and Retention of Nonabstinent Patients in Substance Use Treatment: Clinical Consideration for Addiction Treatment Providers.

For some individuals with a SUD, the use of other substances can reduce the 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 [Chye, et al. 2019; Socías, et al. 2017]. Choosing cannabis may be a harm reduction strategy for some patients who use opioids because fewer risks are associated with cannabis use.

One example of harm reduction counseling is to review any potential interactions between the substance(s) a patient uses and medications taken for other conditions and dispel misinformation about drug-drug interactions [Kalichman(a), et al. 2022]. In studies among individuals with HIV, intentional nonadherence to ART is associated with the belief that alcohol and other drugs interact with ART medications [Kalichman(a), et al. 2022; Kalichman(b), et al. 2022; El-Krab and Kalichman 2021]. If no significant interactions exist, patients should be encouraged to take all medications as prescribed even when using substances.

Based on individual patient needs and priorities and available clinical resources, clinicians should offer or refer patients for harm reduction services. Services may include primary or specialty medical care, education and counseling on safer drug use, development of an overdose safety plan including access to NLX, provision of sterile drug use equipment, provision of fentanyl and xylazine test strips or other options for drug checking, and referrals to social support resources.

Sterile syringes and needles and other drug equipment: Harm reduction includes the 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(a) 2024]. 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 per 100 person-years from 4 per 100 person-years [Des Jarlais and Carrieri 2016]. Syringe exchange has also been associated with reductions in HCV transmission [Saab, et al. 2018; Des Jarlais, et al. 2005]. Unsterile injection equipment is associated with soft tissue infections, including methicillin-resistant *Staphylococcus aureus* (MRSA), *Candida albicans*, and *Staphylococcus aureus* [Hartnett, et al. 2019]. It is also important for individuals who use drugs to have access to safe and sterile supplies beyond syringes, including alcohol swabs, ascorbic acid, sterile water, sterile cookers, sterile filters, tourniquets, straight stems, push sticks, brass screens, bowl pipes, mouthpieces, foil, paper straws, and benzalkonium wipes.

→ KEY POINTS

- Xylazine, a nonopioid sedative used in animals, has increasingly been found in the nonprescription drug supply, frequently mixed with fentanyl.
- Known as "tranq" or "tranq dope" when combined with heroin or fentanyl, xylazine has severe central nervous system depressant effects, and use may cause skin and soft tissue wounds, including ulceration.
- For more information and harm reduction strategies, see the NYSDOH fact sheet Xylazine: What Clinicians Need to Know.
- Counsel patients to test drugs for xylazine. Online sources for xylazine test strips include MATTERS (for New York State residents and programs, no charge) and BTNX; on-site drug testing is available at some NYSDOH Drug User Health Hubs.

Opioid Overdose Prevention

Clinicians should provide patient education on the risks of overdose and discuss strategies to reduce overdose risk. See Box 1, below, for resources in New York State and the NYSDOH resource Your health and life matter. Build a safety plan.

Fentanyl: Fentanyl, a synthetic opioid, is a common and often unidentified additive to heroin and other drugs such as cocaine, methamphetamine, and counterfeit pills that look like various opioid analgesics and benzodiazepines [Colon-Berezin, et al. 2019]. Because fentanyl is much more potent than heroin, it increases the likelihood of a fatal opioid overdose. Clinicians should advise individuals who use drugs, both opioids and other drugs, on how to avoid an overdose: assume all products sold as heroin or other opioids will contain fentanyl and that stimulants and counterfeit pills may contain fentanyl, check drugs before use with a fentanyl test strip, avoid using alone, start with a small amount, carry NLX to reverse opioid overdoses, and avoid mixing drugs. If patients do use alone, counsel them to arrange for someone to check in with them; check-ins can be scheduled using phone- and web-based apps, such as Never Use Alone Inc.

→ KEY POINTS

- Individuals who use stimulants may be exposed to fentanyl or other high-potency synthetic opioids through concurrent use of opioids or through illicitly manufactured stimulants that contain these agents.
- Advise patients that all illicitly manufactured opioids will contain synthetic opioids and nonprescription stimulants and counterfeit pills may contain these agents.
- Offer NLX, fentanyl and xylazine test strips, and other harm reduction strategies to patients who use nonprescription stimulants.

Drug checking: Testing drugs with specialized equipment at a test site or with fentanyl test strips provides the chemical content of drugs before use. Some NYSDOH Drug User Health Hubs offer drug checking with on-site gas chromatography-mass spectrometry machines that separate and detect chemical compounds.

Fentanyl test strips may promote safer use practices because individuals who are aware that drugs contain fentanyl may opt to use a smaller amount, change the mode of administration, or not use. Clinicians should discuss fentanyl test strips with patients who use opioids and other substances, such as methamphetamines, because of the prevalence of fentanyl in the nonprescription drug supply.

False-positive results erroneously showing the presence of fentanyl can occur when substances have been cut with high levels of diphenhydramine, methamphetamine, or 3,4-methylenedioxy-methamphetamine (MDMA) [Lockwood, et al. 2021]. Clinicians should counsel patients on how to use fentanyl test strips correctly, particularly when testing methamphetamines; if dilution is not performed correctly when testing methamphetamines, false-positive results may result. For more information on using fentanyl test strips, see NYC Health How to Test Your Drugs Using Fentanyl Test Strips.

Naloxone: Clinicians should prescribe or ensure access to NLX for individuals at risk of experiencing or witnessing an opioid overdose. As an opioid antagonist, NLX displaces other opioids from opioid receptors but does not cause opioid effects and does not have the potential for misuse. Clinicians should also encourage patients' family members, friends, or other regular contacts to have NLX on hand and be trained to use it for reversing opioid overdose. The nasal spray formulation of NLX ("Narcan") can be administered by laypeople and bystanders to reverse an opioid overdose safely and effectively. In New York State, intranasal NLX is covered by Medicaid, and the NYSDOH Naloxone Co-payment Assistance Program (see Box 1, below) covers a portion of the cost for patients with private insurance who have a copay for NLX. NLX is also distributed free of charge and regardless of insurance status by NYSDOH-Registered Opioid Overdose Prevention Programs.

The nasal spray formulation of NLX is typically prescribed and administered as a 4 mg dose. In 2021, the U.S. Food and Drug Administration (FDA) approved an 8 mg dose of NLX nasal spray and a 5 mg prefilled syringe of NLX for intramuscular or subcutaneous injection to treat opioid overdose, but few clinical data are available that clarify when a higher dose or alternative administration method is indicated [FDA 2021]. A recent study of NLX 4 mg or 8 mg administration by New York State police first responders found that the same number of doses were administered regardless of formulation [Payne, et al. 2024]. In this study, there was no dose-related difference in survival, but the 8 mg dose was associated with more than twice the risk of withdrawal symptoms than the 4 mg dose. Ninety-nine percent of persons who received NLX, regardless of dose, survived.

The use of stimulants, either alone or in combination with other substances including opioids, has been increasing [Han, et al. 2021], and no FDA-approved pharmacologic treatment is available specifically for stimulant use disorder. Individuals who use

stimulants may be unknowingly exposed to fentanyl. As such, it is essential to offer NLX, fentanyl test strips, and other harm reduction strategies to patients who use nonprescription stimulants.

Overdose prevention centers (or sites): In December 2021, the first overdose prevention centers (OPCs) in the United States were opened in New York City. As of January 2025, staff at the 2 New York City sites have reversed 1,696 overdoses, and a total of 5,804 individuals have used the sites; see OnPoint NYC.

OPCs, also known as "supervised injection facilities" or "supervised consumption sites" have been opened in 11 countries and are increasingly recognized as an evidence-based and cost-effective harm reduction intervention [Samuels, et al. 2022]. At an OPC, people can use drugs that they have obtained elsewhere under medical supervision. Sterile injection supplies are available, and staff are trained to monitor for overdose and administer oxygen, NLX, and other first-response care as needed. Additional medical and social services may be offered, including referrals to SUD treatment or other indicated services [ICER 2021]. Notably, an opinion study in the United States showed higher levels of support for "overdose prevention sites" than "supervised consumption sites" (45% vs. 29%), suggesting that using the term OPS (or OPC) may be preferred to foster public support [Valencia, et al. 2021; Kennedy, et al. 2019; Barry, et al. 2018].

No fatal overdose has been reported in an OPC. Evidence demonstrates that OPCs are associated with improved outcomes, including reductions in overdose mortality [ICER 2021; Levengood, et al. 2021; Kral, et al. 2020; Kennedy, et al. 2019], injection-related infections [Valencia, et al. 2021], and injection risk behaviors, without increasing crime in the surrounding communities.

Box 1: Harm Reduction Resources in New York State (January 2025)	
Naloxone (NLX)	• Clinicians can prescribe NLX as a 4 mg or 8 mg nasal spray with refills for patients at risk of experiencing or witnessing an overdose [a]. NLX is also available in a prefilled syringe for injection. • NLX may be purchased OTC as a 3 mg or 4 mg nasal spray • Naloxone is covered by state Medicaid. Coverage among private insurers varies due to the OTC status of some products. To use insurance for OTC NLX in a retail store, patients must go to the store pharmacy, not the check-out line. • All pharmacies in New York State may dispense NLX without a patient-specific prescription to individuals who are at risk of an overdose or their family members or friends. • The NYSDOH Naloxone Co-payment Assistance Program (N-CAP) covers up to $40.00 of any co-payment for NLX obtained through insurance. • NYSDOH-Registered Opioid Overdose Prevention Programs, which include syringe exchange and drug treatment programs and the New York State Department of Corrections and Community Supervision, distribute free NLX. • **Mail-order:** NLX is available through NEXT Distro and MATTERS (for New York State residents and programs, no charge) • **Resources:** – OASAS Harm Reduction: Virtual Opioid Overdose Rescue Training – NYC Health: Overdose Prevention Resources for Providers – National Harm Reduction Coalition: Understanding Naloxone – PrescribeToPrevent.org
Sterile needles and syringes	• Clinicians can prescribe sterile needles and syringes with refills [b]. • Licensed pharmacies, healthcare facilities, and healthcare providers can sell or furnish hypodermic needles or syringes to individuals aged ≥18 years without a patient-specific prescription; see NYSDOH Expanded Syringe Access Program: Overview of the Law and Regulations. • **Syringe exchange sites:** As of January 2025, there are more than 30 syringe exchange programs in New York State; see NYS Authorized Syringe Exchange Sites. – Some sites offer individual and peer harm and risk reduction counseling; HIV, STI, and hepatitis counseling, screening, and testing; behavioral interventions; mental health counseling; opioid overdose prevention training; safety planning; aftercare for overdose; and care management. Syringe exchange sites can also evaluate individuals aged <18 years to determine whether syringes are needed. • **Second-tier syringe exchange programs (STSEP):** Service providers, including community-based organizations, local health departments, accredited hospitals, and other accredited medical facilities, who have registered with New York State and added harm reduction services and supplies to existing services; see NYS Authorized Syringe Exchange Sites. Harm reduction services include client-centered education, counseling, and provision of sterile syringes and sharps containers. For more information, contact the NYSDOH Office of Drug User Health.

Box 1: Harm Reduction Resources in New York State (January 2025)	
Drug checking	**Drug checking service:** • NYSDOH Drug Checking • NYC Health Alcohol and Drug Use Services **Fentanyl test strips:** • Clinicians cannot prescribe fentanyl test strips, but programs can purchase the strips for distribution, and federal funds can be used for the purchase. • Online sources include MATTERS (for New York State residents and programs, no charge), DanceSafe, and BTNX. Some NYS Authorized Syringe Exchange Sites may provide fentanyl test strips and other drug-checking systems. • See NYC Health: How to Test Your Drugs Using Fentanyl Test Strips **Xylazine test strips:** • Clinicians cannot prescribe xylazine test strips, but programs can purchase the strips for distribution, and federal funds can be used for the purchase. • Online sources include MATTERS (for New York State residents and programs, no charge) and BTNX.
Drug User Health Hubs	These New York State locations provide healthcare, mental health services, and pharmacologic treatment tailored to meet the needs of people who use drugs, especially those who inject drugs. Services may be provided on-site or through facilitated linkage to culturally competent care and treatment services. See NYSDOH Drug User Health.
Abbreviations: MATTERS, Medication for Addiction Treatment & Electronic Referrals; OASAS, Office of Addiction Services and Supports; OTC, over-the-counter; STI, sexually transmitted infection. **Notes:** a. New York State Medicaid allows 11 refills. b. New York State Medicaid allows 5 refills.	

Pharmacologic Treatment for Substance Use Disorder

A range of effective pharmacologic treatments is available for several SUDs, including alcohol [Jonas, et al. 2014; Rösner, et al. 2010; Overman, et al. 2003], tobacco [Anthenelli, et al. 2016; Piper, et al. 2009], and opioid use disorders [Lee, et al. 2018; Mattick, et al. 2014]. Clinicians should discuss with patients the pharmacologic treatments and different treatment settings available and help them understand the benefits and risks. In New York State, most drug treatment programs licensed by the Office of Addiction Services and Supports are mandated to provide pharmacotherapy when indicated [OASAS 2022]. Some patients may misunderstand or have biases against pharmacologic treatment, so it may be helpful to continue these discussions over time.

Because the patient may benefit from treatment, clinicians should not deny or discontinue SUD treatment if a patient continues to or returns to use [Gjersing and Bretteville-Jensen 2013]. In 2017, the FDA 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 continuing medications.

SUD is a chronic health condition that requires long-term management, including pharmacologic treatment [Saitz, et al. 2013], which should be continued for as long as it is beneficial to the patient. Patients may opt to discontinue medication, but clinicians should encourage resumption without suggesting or implying that discontinuation of pharmacologic treatment is the preferred approach.

→ KEY POINT

- If the criminal justice system, child welfare services, or other similar entities discontinue an individual's OUD treatment plan, clinicians can advocate for continuation of their patient's pharmacologic treatment plan.

Individualized follow-up during outpatient SUD 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 according to individual needs (e.g., change in dose of pharmacologic treatment, addition of support services).
- As patients 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 SUD 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 complicate diagnosis and treatment, local and national resources are available for consultation and referral. For opioid-related issues, see Providers Clinical Support System or NYSDOH AI Provider Directory.

Avoiding Substance Use-Associated Discrimination

☑ RECOMMENDATIONS

Avoiding Substance Use-Associated Discrimination

- 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 2: Changing the Language of Substance Use). (A2)

Stigma in the Healthcare Setting

Substance use-related stigma may prevent individuals from seeking or receiving treatment and harm reduction services [Tsai, et al. 2019]. In particular, people who use substances during pregnancy face significant stigma and may fear accessing medical care or other services as a result [Schiff, et al. 2022; Wakeman, et al. 2021]. Stigma among clinicians against people who use substances has been well documented [Stone, et al. 2021; Tsai, et al. 2019; van Boekel, et al. 2013]. Clinician bias has been associated with health disparities and can have profoundly negative effects [FitzGerald and Hurst 2017; Hall, et al. 2015]. In particular, the stigma associated with substance use may increase the risk of overdose, although the exact mechanism for this association is not well defined. In 1 study, enacted stigma (discrimination) was associated with an increased risk of opioid overdose but internalized stigma was not. This finding may suggest that enacted stigma could contribute to risk behaviors, such as using quickly or in multiple locations to avoid detection [Latkin, et al. 2019; Cruz, et al. 2018].

It is often challenging for clinicians to recognize and set aside personal biases and to address biases with peers and colleagues. 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 [Avery, et al. 2019; van Boekel, et al. 2013; Livingston, et al. 2012]. Individuals who use substances may also be stigmatized by assumptions about substance use and criminal behavior. For more information, see the resources listed below.

◊ RESOURCES

- 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):18m02382.
- 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):472-79.
- Avoiding Unintended Bias: Strategies for Providing More Equitable Health Care, Van Ryn M. *Minn Med* 2016;99(2):40-43, 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, and to help colleagues and staff adopt neutral language (see Box 2, 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 and Westerhoff 2010]. Patients may choose to use stigmatizing words in describing themselves, but clinicians and staff should strive to use language that is respectful of the individual and easy to understand.

Box 2: Changing the Language of Substance Use [a,b]	
Neutral Term	**Stigmatizing Term**
Substance use	Substance abuse
Use of nonprescription medication or drug	Illicit drug use
Pharmacologic treatment	Medication-assisted treatment
A person who uses drugs, alcohol, or substances	Drug addict, drug abuser, alcoholic, junkie, crackhead, tweaker, etc.
A person who formerly used drugs or alcohol	A person who got clean
Negative or positive toxicology results	Clean or dirty toxicology results
A recurrence of use or return to use	Relapse

Notes:

a. For additional terms and definitions, see Addictionary.
b. For discussion on stigmatizing information disseminated in the media, see Changing the Narrative.

Legal Protections for Individuals With Substance Use Disorder

The New York State Human Rights Law (NYSHRL) and the American With Disabilities Act (ADA) protect individuals with disabilities from discrimination in the workplace and housing. Under the NYSHRL and ADA, individuals taking prescribed medical treatment for SUD and those in recovery from SUD are considered disabled; for patients with OUD, see The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery. The NYSHRL and the ADA *exclude* from protection individuals who are currently using illegal drugs.

Employers and housing providers are prohibited from discriminating against individuals with disabilities under the NYSHRL. Employers are prohibited from denying a job opportunity to a qualified individual, terminating an employee because of a disability, and making inquiries about an individual's disability, which includes questions about prescribed medical care for SUD. Employers are to provide reasonable accommodations to assist disabled people in performing their job functions. It is unlawful for housing providers to refuse to house or discriminate against a tenant because they are taking medical treatment for SUD or are in recovery from SUD.

Information about these protections and enforcement of the NYSHRL can be found at the New York State Division of Human Rights.

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Supplement: Guideline Development and Recommendation Ratings

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Developer	New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program
Funding source	NYSDOH AI
Program manager	Clinical Guidelines Program, Johns Hopkins University School of Medicine, Division of Infectious Diseases. See Program Leadership and Staff.
Mission	To produce and disseminate evidence-based, state-of-the-art clinical practice guidelines that establish uniform standards of care for practitioners who provide prevention or treatment of HIV, viral hepatitis, other sexually transmitted infections, and substance use disorders for adults throughout New York State in the wide array of settings in which those services are delivered.
Expert committees	The NYSDOH AI Medical Director invites and appoints committees of clinical and public health experts from throughout New York State to ensure that the guidelines are practical, immediately applicable, and meet the needs of care providers and stakeholders in all major regions of New York State, all relevant clinical practice settings, key New York State agencies, and community service organizations.
Committee structure	• Leadership: AI-appointed chair, vice chair(s), chair emeritus, clinical specialist(s), JHU Guidelines Program Director, AI Medical Director, AI Clinical Consultant, AVAC community advisor • Contributing members • Guideline writing groups: Lead author, coauthors if applicable, and all committee leaders
Disclosure and management of conflicts of interest	• Annual disclosure of financial relationships with commercial entities for the 12 months prior and upcoming is required of all individuals who work with the guidelines program, and includes disclosure for partners or spouses and primary professional affiliation. • The NYSDOH AI assesses all reported financial relationships to determine the potential for undue influence on guideline recommendations and, when indicated, denies participation in the program or formulates a plan to manage potential conflicts. Disclosures are listed for each committee member.
Evidence collection and review	• Literature search and review strategy is defined by the guideline lead author based on the defined scope of a new guideline or update. • A comprehensive literature search and review is conducted for a new guideline or an extensive update using PubMed, other pertinent databases of peer-reviewed literature, and relevant conference abstracts to establish the evidence base for guideline recommendations. • A targeted search and review to identify recently published evidence is conducted for guidelines published within the previous 3 years. • Title, abstract, and article reviews are performed by the lead author. The JHU editorial team collates evidence and creates and maintains an evidence table for each guideline.
Recommendation development	• The lead author drafts recommendations to address the defined scope of the guideline based on available published data. • Writing group members review the draft recommendations and evidence and deliberate to revise, refine, and reach consensus on all recommendations. • When published data are not available, support for a recommendation may be based on the committee's expert opinion. • The writing group assigns a 2-part rating to each recommendation to indicate the strength of the recommendation and quality of the supporting evidence. The group reviews the evidence, deliberates, and may revise recommendations when required to reach consensus.

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Review and approval process	• Following writing group approval, draft guidelines are reviewed by all contributors, program liaisons, and a volunteer reviewer from the AI Community Advisory Committee. • Recommendations must be approved by two-thirds of the full committee. If necessary to achieve consensus, the full committee is invited to deliberate, review the evidence, and revise recommendations. • Final approval by the committee chair and the NYSDOH AI Medical Director is required for publication.
External reviews	• External review of each guideline is invited at the developer's discretion. • External reviewers recognized for their experience and expertise review guidelines for accuracy, balance, clarity, and practicality and provide feedback.
Update process	• JHU editorial staff ensure that each guideline is reviewed and determined to be current upon the 3-year anniversary of publication; guidelines that provide clinical recommendations in rapidly changing areas of practice may be reviewed annually. Published literature is surveilled to identify new evidence that may prompt changes to existing recommendations or development of new recommendations. • If changes in the standard of care, newly published studies, new drug approval, new drug-related warning, or a public health emergency indicate the need for immediate change to published guidelines, committee leadership will make recommendations and immediate updates and will invite full committee review as indicated.

Table S2: Recommendation Ratings and Definitions		
Strength	**Quality of Evidence**	
A: Strong B: Moderate C: Optional	1	Based on published results of at least 1 randomized clinical trial with clinical outcomes or validated laboratory endpoints.
	*	Based on either a self-evident conclusion; conclusive, published, in vitro data; or well-established practice that cannot be tested because ethics would preclude a clinical trial.
	2	Based on published results of at least 1 well-designed, nonrandomized clinical trial or observational cohort study with long-term clinical outcomes.
	2†	Extrapolated from published results of well-designed studies (including nonrandomized clinical trials) conducted in populations other than those specifically addressed by a recommendation. The source(s) of the extrapolated evidence and the rationale for the extrapolation are provided in the guideline text. One example would be results of studies conducted predominantly in a subpopulation (e.g., one gender) that the committee determines to be generalizable to the population under consideration in the guideline.
	3	Based on committee expert opinion, with rationale provided in the guideline text.