Curbside Consultation

Harm Reduction for Patients With Substance Use Disorders

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Case Scenario

S.R., a 27-year-old patient with a history of depression, presents to my clinic with a painful outbreak of genital herpes. During the physical examination, I notice what appear to be track marks on the patient's feet. I mention my concern, and S.R. admits to recently resuming daily heroin and methamphetamine injection drug use with their partner. I offer a referral for treatment, but S.R. declines. What additional options are available for me to help this patient?

Commentary

HARM REDUCTION: BACKGROUND AND APPROACH

Patients engaged in high-risk activities are often ambivalent about changing their behavior.[1] Harm reduction is an approach that focuses on limiting harm and improving quality of life for patients who persist with high-risk behaviors; the foundations of harm reduction are pragmatism and compassion. The approach encompasses a range of evidence-based practices that decrease risk for patients and the community.[2] For health professionals, harm reduction is not only a set of evidence-based interventions, but it also conveys respect for personal autonomy that empowers patients to take responsibility for their behavioral changes.[2] Acknowledging the complexity of high-risk behavior and using a supportive, practical approach to address the situation can decrease friction between the patient and physician and build trusting therapeutic relationships that can pay off in often unexpected ways.

Patients engaged in high-risk behaviors, including substance use, are often stigmatized and mistreated in the medical system.[3] When patients are treated poorly, they have worse outcomes, making behavioral change even more difficult.[4] When physicians measure success in small steps that reduce harm, patients can experience positive emotions that make subsequent behavioral change more likely.[5] For patients with substance use disorders, the leading harm-reduction interventions target prevention of overdose and infection and also reproductive issues. By embracing harm reduction, physicians can offer interventions and resources that are not contingent on abstaining from substance use. *Table 1* provides resources that physicians can use to implement harm-reduction interventions with their patients.

OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION

Overdose is the leading cause of death among people who use nonprescribed opioids.[6] Naloxone has been approved by the U.S. Food and Drug Administration (FDA) for reversal of opioid overdoses since the early 1970s, but communities have only recently embraced overdose education and naloxone distribution programs. All 50 states and the District of Columbia now have naloxone access laws that expand where and how naloxone can be obtained and used.[7] Observational studies have demonstrated that overdose education and take-home naloxone kits decrease overdose-related deaths.[8] Naloxone distribution is particularly important in communities with rapidly rising overdose rates[9] or on reentry into the community after incarceration, when overdose rates are particularly high.[10] In addition to decreasing overdose-related deaths, prescribing naloxone to patients with high-risk behaviors is an act of caring. As one physician described it, "I expected the decreases in deaths from overdose—but I hadn't thought about how this simple act of prescribing potentially lifesaving treatment has opened up other important conversations that have allowed me to provide better, safer and more compassionate care to my patients."[11]

MEDICATIONS FOR OPIOID USE DISORDER

Many patients with opioid use disorder (OUD) decline a generic offer of treatment. Some patients are not ready to change their use patterns; others have experienced detoxification and abstinence-based counseling that have not been helpful. In a large retrospective analysis of outcomes for patients with OUD, only buprenorphine and methadone decreased opioid overdoses and reduced serious

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aafp.org. Materials are edited to retain confidentiality.

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opioid-related acute care use. Conversely, inpatient detoxification, residential services, intensive and nonintensive behavioral health interventions, and naltrexone did not.[12]

All patients with moderate or severe OUD should be offered medications for treatment.[13] However, in a 2017 study, 60% of residential treatment centers did not offer any FDA-approved medications for OUD.[14] Both buprenorphine and methadone maintenance are harm-reduction strategies that improve treatment retention, suppress illicit opioid use, decrease deaths from overdose, and decrease all-cause mortality.[15] Methadone has superior evidence for retention in treatment, but it can be prescribed only in federally licensed outpatient treatment programs, limiting the scope of this intervention.[16] Buprenorphine, however, can be prescribed by waivered family physicians; an article from *American Family Physician* provides guidance for buprenorphine use.[17] Recent changes have streamlined the process to obtain a waiver.[18] Extended-release naltrexone is another treatment option, although an opioid-free period is required that can delay and complicate starting the medication.[19]

Until all treatment settings offer a full range of medications for OUD, it is difficult to assess whether more intensive treatment in residential settings or use of behavioral health interventions offers additional benefit to treatment in a primary care setting. One role of a family physician is to help patients navigate a health system that does not always offer optimal care. In addition to offering medications for OUD in the clinic, physicians should be knowledgeable about which community partners offer evidence-based treatments.

NEEDLE AND SYRINGE PROGRAMS, HEPATITIS C, AND HIV

Sharing needles and syringes is the main risk factor for infection with HIV and acute hepatitis C virus among people who inject drugs.[20] It is also a risk factor for other infections such as subacute bacterial endocarditis and septicemia. Needle and syringe programs provide sterile equipment to people who inject drugs to reduce the number of injections with used equipment.[21] These programs reduce transmission of HIV in people who inject drugs, and when paired with buprenorphine or methadone therapy, needle and syringe programs may reduce the risk of hepatitis C infection.[22] Needle and syringe programs often serve as an important point of entry for people who inject drugs to receive other harm-reduction services, including HIV and hepatitis C virus testing, referrals for substance use treatment, overdose education and naloxone distribution, and condom distribution.[21] Despite extensive evidence showing that needle and syringe programs do not increase drug use or crime,[23,24] a lack of funding and political support remains a barrier to expanding services. Similar gaps in funding and support may hamper the mainstreaming of supervised injection sites, widely accepted in Europe and Canada, to ensure injection safety, proper disposal of needles, and entry points for those wishing to pursue addiction treatment.

TABLE 1

Resources for Harm Reduction in Patients With Substance Use Disorders

National Harm Reduction Coalition	National harm reduction advocacy organization https://harmreduction.org/
North American Syringe Exchange Network	Search for syringe exchange programs by location https://nextdistro.org/resources-collection/2020/2/4/north-american-syringe-exchange-network
SAMHSA: Behavioral Health Treatment Services Locator	Search for treatment facilities for substance use disorder and/or mental health problems by location https://findtreatment.samhsa.gov/
SAMHSA: Become a Buprenorphine Waivered Practitioner	Learn how to obtain a waiver to prescribe buprenorphine for the treatment of opioid use disorder https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

SAMHSA = Substance Abuse and Mental Health Services Administration.

LONG-ACTING REVERSIBLE CONTRACEPTION AS HARM REDUCTION

Approximately 45% of all pregnancies are unintended among women of reproductive age.[25] This rate is nearly doubled in women with substance use disorders.[26,27] Women with substance use disorders are 25% less likely to use contraception and are more likely to use contraception methods with higher failure rates. Among women with substance use disorders, around 60% reported condom use (18% failure rate), whereas only 8% used more effective methods, including intrauterine devices and contraceptive implants (less than 1% failure rate).[27,28]

In 2015, the American College of Obstetricians and Gynecologists recommended long-acting reversible contraceptives as first-line contraception for all women.[29] These contraceptives decrease unintended pregnancy and have the highest continuation rates of all contraceptives.[29] Discussion of reproductive goals is an important component of the harm-reduction conversation for people with substance use disorders, and long-acting reversible contraceptives should be easily accessible for those who do not desire pregnancy.

FUTURE OF HARM REDUCTION

Family physicians are ideally suited to address high-risk behaviors and ambivalence in patients with substance use disorders. The combination of motivational interviewing and harm reduction can decrease risk, improve the therapeutic relationship, and prevent physicians from feeling

helpless when patients who are engaging in high-risk behaviors are not ready to change. Offering treatments that are not contingent on the ability to modify high-risk behaviors can be an important step in countering the mistreatment and stigma that patients with substance use disorders experience inside and outside the medical system.

Case Resolution

As a physician, you should first address S.R.'s genital herpes, the original reason for coming to your clinic. In response to S.R.'s substance use, you could say, "I want you to know that I care about you and hear that you are not ready to stop using heroin and methamphetamines. I will continue to be here for you as your physician whether you are using drugs or not. Let's talk about some other things we can do together to reduce your health risks." You can offer long-acting reversible contraception; testing for HIV, hepatitis C, and sexually transmitted infections; and referral to a syringe exchange program if one is available in the community. You can prescribe naloxone; if your clinic has partnered with local public health organizations to distribute naloxone, S.R. could leave with a naloxone kit and training on how to use it. You should counsel your patient on a range of treatment options for substance use disorder, including buprenorphine that you can prescribe in the clinic. S.R. says that they will think about it because buprenorphine has helped a few people they know. S.R. thanks you for being kind and agrees to come back in a few weeks to follow up.

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