Harm Reduction and Substance Use Treatment

April 22, 2024

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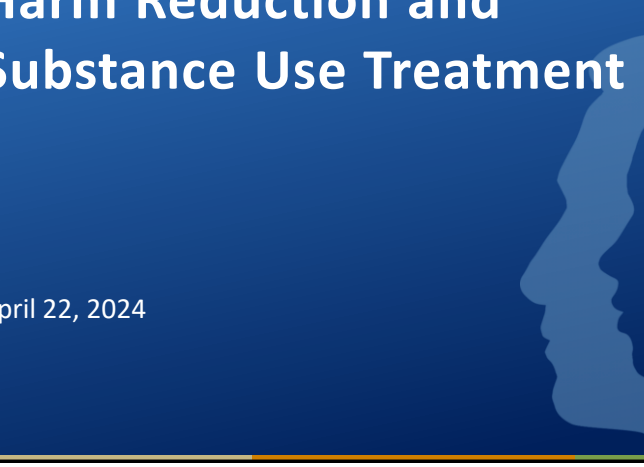

Substance Abuse and Mental Health Services Administration. (2022). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

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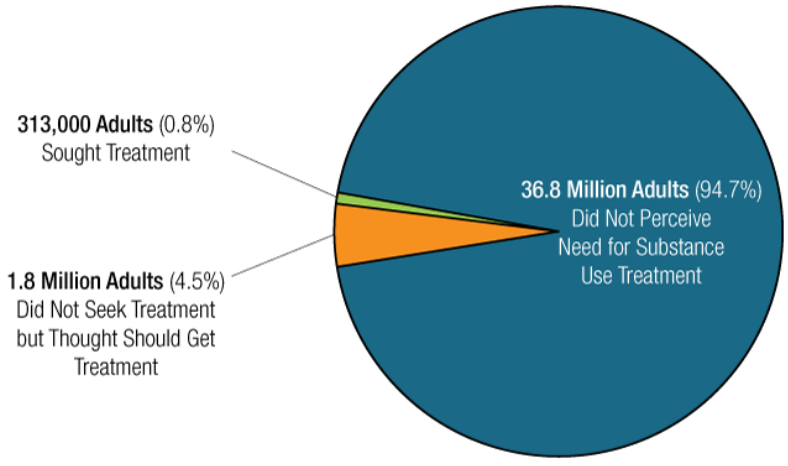

39.7 Million Adults with a Substance Use Disorder Who Did Not Receive Substance Use Treatment

Substance Abuse and Mental Health Services Administration. (2023). *Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health* (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

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Stages of Change

Precontemplation → Contemplation → Preparation → Action → Recovery Maintenance

Harm reduction programs

- Initial engagement
- Harm reduction supplies
- Skills development to reduce risks
- Linkage to health care and social services
- Outreach: street teams
- Low-threshold medications for addiction treatment

Recovery is Possible!
- Of those in the U.S. with a history of substance use disorder, 75% are in recovery

Harm Reduction is Essential
- Harm reduction is practiced all across health care settings and services
- In the context of the worst overdose crisis in history, harm reduction reduces mortality risks, increases treatment access and access to other health and social services, and supports recovery

Treatment programs

- Biopsychosocial treatment for substance use (including medication services, individual and group therapy)
- Linkage to other medical and social services
- Crisis care

Aligning Services with Readiness is Essential

- Addiction is chronic and recurrent, and not all people are at the same stage of readiness to change.
- Only focusing on individuals in some stages of change as opposed to ALL stages of change limits service reach and impact → We need the widest service net possible

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Harm Reduction Services

Harm Reduction Supplies Access

Syringe Exchange & Disposal

Naloxone and Test Strips

Medications for Addiction Treatment

Drop-In Centers

Linkage to Ho using Services

Pharmacy Access

Referrals for Needed Services

- GOAL → Meeting people where they are, both figuratively and literally
  - While brick and mortar locations are needed, mobile services that go out to people who are unlikely to go to brick and mortar locations are also needed

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A Continuum of Substance Use Interventions

Youth Development & Health Promotion
- Programs at school- and community-level

Drug Use Prevention
- Universal, selected, and indicated prevention

Harm Reduction → Currently largely serves people who are using drugs and not yet interested in SUD treatment
- Low threshold services proven to reduce morbidity and mortality, including outreach, overdose prevention (naloxone and fentanyl test strip distribution, etc), syringe exchange, peer services, linkages to SUD treatment and other needed services, etc.

SUD Treatment & Recovery → Currently largely serves people who are ready for abstinence
- Involves a spectrum of settings: opioid treatment programs, outpatient, intensive outpatient, residential, inpatient, withdrawal management, Recovery Services, Recovery Bridge Housing, field-based services, care coordination and navigation, etc.

Surveillance of drug use and its community impact

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Principles of Harm Reduction

- Acceptance
- Understanding that some ways of using drugs are clearly safer than others.
- Individual and community life and well-being is the criteria for successful interventions and policies.
- Non-judgmental, non-coercive provision of services and resources
- Drug users and those with a history of drug use should have a real voice in the creation of programs and policies designed to serve them
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use
- Recognition the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities
- Does not minimize or ignore the real and harm and danger

harm reduction COALITION

http://harmreduction.org

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SAMHSA Six Pillars of Harm Reduction

- Led by people who use drugs and with lived experience of drug use
- Embraces the inherent value of people
- Commits to deep community engagement and community building
- Promotes equity, rights, and reparative social justice
- Offers most accessible and noncoercive support
- Focuses on any positive change, as defined by the person

http://www.samhsa.gov/find-help/harm-reduction/framework

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SAMHSA Core Practice Areas for Harm Reduction

- Safer Practices
- Safer Settings
- Safer Access to Healthcare
- Safer Transitions to Care
- Sustainable Workforce and Field
- Sustainable Infrastructure

http://www.samhsa.gov/find-help/harm-reduction/framework

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Syringe Services Programs

- Syringe services programs are a key component of overdose prevention strategies, because they can facilitate access to and uptake of services and interventions for reducing overdose, enhancing health and wellbeing, and improving public health and public safety
- Receipt of syringe services is associated with enrollment in treatment (3x-5x when compared with people who use drugs who don't receive syringe services)

http://www.cdc.gov/drugoverdose/featured-topics/evidence-based-strategies.html
http://pubmed.ncbi.nlm.nih.gov/10609594

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What Does The Data Say About Harm Reduction?

- Harm reduction approaches greatly reduce morbidity and mortality associated with risky health behaviors.
- Needle-exchange programs have shown mean annual decreases in HIV seroprevalence compared with those areas that have not introduced needle-exchange programs.
- Access to and use of methadone maintenance programs are strongly related to decreased mortality, both from natural causes and overdoses, which suggests that these programs have an impact on overall sociomedical health
- Supervised injecting facilities, which have been successfully implemented in Europe and Canada, play an important role.

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What Does The Data Say About Harm Reduction?

Syringe Service Programs

- Decades of evidence to support their benefits ranging from preventing HIV, HCV, & soft tissue infections to supporting the most marginalized people
- Needs based, low threshold access
- Point of entry into healthcare and treatment services

*Harm reduction programs **do not** exacerbate individual and community drug use*

Harm reduction interventions are best implemented when integrated within a broader public health response, including steps to facilitate healthier living and safer social environments

Slide Credit: Amanda Cowan

Ti L, Kerr T. The impact of harm reduction on HIV and illicit drug use. Harm Reduct J. 2014 Feb 21;11:7. doi: 10.1186/1477-7517-11-7. PMID: 24559062; PMCID: PMC3936850. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3936850

Hedrich, D., Hartnoll, R. (2015). Harm Reduction Interventions. In: el-Guebaly, N., Carrà, G., Galanter, M. (eds) Textbook of Addiction Treatment: International Perspectives. Springer, Milano. http://doi.org/10.1007/978-88-470-5322-9_133

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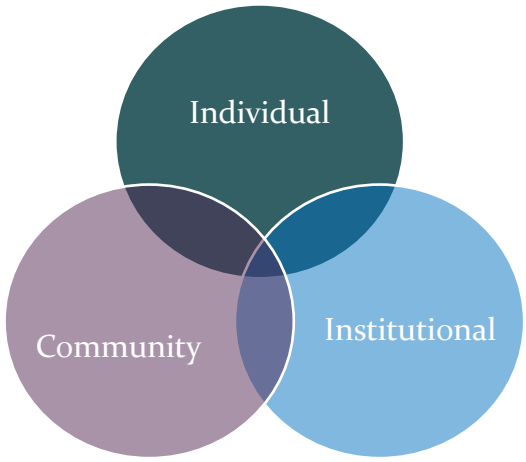
Domains of Harm Reduction



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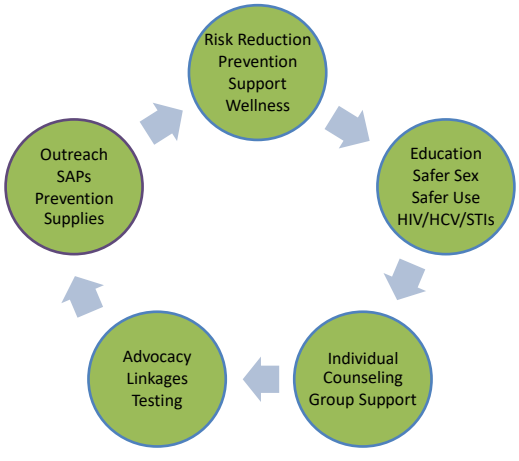
What Harm Reduction Looks Like



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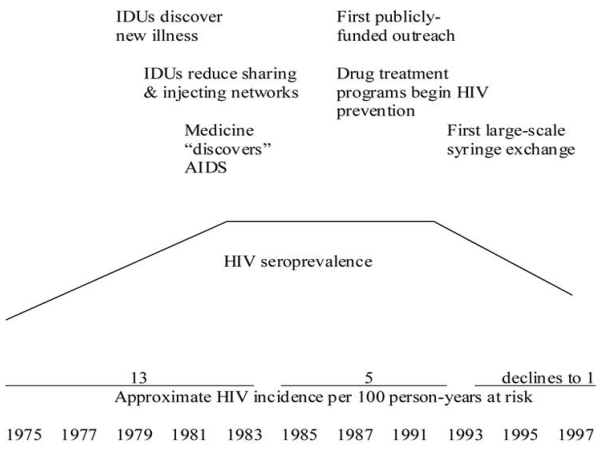
History of Harm Reduction



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History of Harm Reduction

- 1920's- British system and Rolleston report
- 1960's- 1980's- The Dutch model, users union and syringe exchange
- Late 1980's- Liverpool (Mersey) Harm Reduction model & grassroots US activists start pursuing HR models
- 1990's- Canada- HIV/AIDS & SUD public health model: Dave Purchase, Dan Bigg
- In the United States, HR finds its roots and inspiration from multiple movements and strategies, including-
  - The Black Panther Party's survival programs = Free Breakfast for Children and health clinics
  - In 1972, the Panther's manifesto is updated to include free healthcare for oppressed people
  - The Young Lords' launch of auricular acupuncture program for heroin users in the South Bronx
  - Lincoln Hospital Takeover- Young Lords & Black panther take over – Lincoln Detox Center (Mutulu Shakur; Cointelpro)
  - The women's health movement emerging from 1970s feminist activism and the fight for reproductive health
  - The grassroots and activist response to the AIDS crisis in the 1980s and beyond: Marsha P Johnson/ Sylvia Rivera- STAR formed in late 80's

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Factors and Harms Related to People Who Use Drugs

Physical
- Poor health outcomes
- Violence
- OD

Psychological
- Depression
- Isolation
- Stigma

Social
- Relationship issues
- Lack of community
- Isolation from community

Spiritual
- Isolation
- Not connecting to life

Economic
- $$ to acquire drugs
- Loss of housing
- Loss of or trouble finding jobs

Legal
- Discrimination
- Arrest
- Incarceration

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Stigma

Stigma in thinking
- A perception and bias that people who use drugs are "bad" or "immoral" rather than having a chronic medical condition that requires care and treatment.
- People with SUDs are viewed more negatively than people with physical or psychiatric disabilities (Kulesza et al, 2014).

Stigma in attitudes
- Communicated in tone, attitude, and body language
- Negative attitudes among heath care professionals have been found to adversely affect quality of care and subsequent treatment outcomes (Tsai et al, 2019)

Stigma in language
- Communicated in our choice of words
- Terminology that is often used can suggest SUDs are the result of personal failing/choice
- The term "abuse" is highly associated with negative judgments and punishment

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Impact of Language

The **language we use heavily impacts the way care is received**. Refer to patients using **'person first' language** such as a "person who uses drugs." This acknowledges the person first, rather than identifying them by their drug.

Words Matter. And our decision to use words that de-stigmatize substance use disorder must be intentional.

INSTEAD OF…	USE…	BECAUSE…
Addict User Substance/drug abuser Junkie Alcoholic Drunk Former addict Reformed addict	• Person with opioid use disorder (OUD)/substance use disorder (SUD) or person with opioid addiction • Patient • Person in recovery or long-term recovery **For heavy alcohol use:** • Unhealthy, harmful, or hazardous alcohol use • Person with alcohol use disorder	• Person-first language. • The change shows that a person "has" a problem, rather than "is" the problem. • The terms to avoid elicit negative associations, punitive attitudes, and individual blame.
IV drug user	• Person who injects drugs	• Person-first language.
Habit Relapse	• Substance use disorder • Drug addiction • Return to use/slip	• Inaccurately implies that a person is choosing to use substances or can choose to stop. • "Habit" may undermine the seriousness of the disease.
Clean	**For toxicology screen results:** • Testing negative **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. • Set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.
Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person who uses drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. • May decrease patients' sense of hope and self-efficacy for change.

(Adapted from NIDA Words Matter: Terms to Use and Avoid When Talking About Addiction)

TIPS: Take action and destigmatize (From National Harm Reduction Coalition's Respect to Connect: Undoing Stigma)

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Harm Reduction Mindset in Healthcare

- How we speak
- How we listen
- How we approach

Honoring the Patient

- I am really glad to see you
- How was it getting here for you?
- Listen for ways to support / engage

Addressing Patient's Need

- What would you like to see happen for you with regards to [patient's priority]?

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Better Blending Treatment & Harm Reduction

- **We know recovery is a continuum, but the separation and programmatic divide between treatment and harm reduction services is often wide and needs to be addressed to better match the continuum of SUD services with client experience.**

- **Better integrating treatment and harm reduction services within agencies is both a cultural and operational issue, with the cultural issue being the more challenging to address.**
  - Achieving this goal will require addressing this from both angles and will require agency-level interventions on top of what SAPC focuses on given that agencies have different cultures and agency leadership know their culture best.

- **Ingredients for culture change at the agency-level**
  1. Knowing what we're dealing with – Opening the door for discussions to explore staff thoughts/feelings around this topic (e.g., individual/supervision/staff meetings, office hours, etc.) --> **ESSENTIAL FOCUS!**
  2. Leadership making the end goal clear – Aligning the agency and staff
  3. Evaluating progress – How do we know when treatment and harm reduction service are more integrated?
  4. Adjusting approaches as needed – Our evaluations will allow us to modify our interventions to more effectively achieve this integration

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About SAPC

- The Department of Public Health's Division of Substance Abuse Prevention and Control (DPH-SAPC) oversees the most diverse and comprehensive continuum of SUD services in California.

SUBSTANCE ABUSE SERVICE HELPLINE 24/7 1.844.804.7500

CENS Client Engagement and Navigation Services

CORECenter Connecting to Opportunities for Recovery and Engagement

- SAPC is committed to innovative, equitable, and quality-focused substance use **prevention**, **harm reduction**, **treatment**, and **recovery services**.

DPH-SAPC Contracted Provider Network*

Prevention	Treatment	Harm Reduction	Recovery Bridge Housing
29 provider agencies	86 provider agencies	7 provider agencies	23 provider agencies
133 site locations	394 site locations	12 site locations	123 site locations
69,552 served	33,800 served	10,866 served	3,200 served

*For persons served, all numbers are annual

SAPC Website: ph.lacounty.gov/sapc/

SAPC Strategic Plan - 2023-2028: ph.lacounty.gov/sapc/docs/providers/SAPC-Strategic-Plan-2023-2028.pdf

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Thank You!

SAPC website:
http://publichealth.lacounty.gov/sapc/

SUBSTANCE ABUSE SERVICE HELPLINE
24/7 1.844.804.7500

RecoverLA.org *(try it out on your mobile browser!)*

SAPC's filterable Service & Bed Availability Tool:
https://sapccis.ph.lacounty.gov/sbat/

Harm Reduction Framework

SAMHSA
Substance Abuse and Mental Health Services Administration

Electronic Access and Copies

Products may be downloaded at https://www.samhsa.gov/find-help/harm-reduction/framework

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Originating Office

Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

Contents

Harm Reduction Framework for People Who Use Drugs (PWUD)

The Biden-Harris Administration has identified harm reduction as a federal drug policy priority. The White House Office of National Drug Control Policy (ONDCP), in the 2022 National Drug Control Strategy, notes that harm reduction is a public health approach designed to advance policies and programs in collaboration with people who use drugs (PWUD) and is supported by decades of evidence. Harm reduction strategies are shown to substantially reduce HIV and hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety, and increase by five-fold the likelihood of a person who injects drugs to initiate substance use disorder treatment.[1, 2, 3] In line with this, harm reduction is one of the four strategic priorities of the U.S. Department of Health and Human Services (HHS) Overdose Prevention Strategy developed to address the overdose public health emergency.[4]

In December 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) convened the first-ever federal Harm Reduction Summit, in partnership with the Centers for Disease Control and Prevention (CDC) and ONDCP. The Summit brought together more than 100 experts representing prevention, treatment, recovery, and harm reduction perspectives. Most importantly, Summit attendees included people with lived experience with substance use to help inform SAMHSA's policies, programs, and practices as they relate to harm reduction. Additional partners included community members, advocates, harm reductionists, providers, funders, and others who are affected by these issues.

SAMHSA's Harm Reduction Framework is one outcome of the Summit. This Framework is historic, as the first document to comprehensively outline harm reduction and discuss its role throughout HHS.

The Framework was developed and written in partnership with the Harm Reduction Steering Committee, composed of harm reduction leaders in the field from across the country. This group represents a broad array of backgrounds and experience, with most having lived experience of drug use. The Steering Committee synthesized findings from the Summit — including a definition of harm reduction, pillars and principles supporting that definition, and core practices that SAMHSA can support. The Framework is adapted from the Committee's final report.

This Framework will inform SAMHSA's harm reduction activities moving forward, as well as related policies, programs, and practices. SAMHSA's aim is to integrate harm reduction activities and approaches across its organizational Centers and initiatives, and to do so in a manner that draws on evidence-based practice and principles — while also maintaining sustained dialogue with harm reductionists and people who use drugs (PWUD). The Framework will also inform SAMHSA's thinking about opportunities to work with other federal, state, tribal, and local partners toward advancing harm reduction approaches, services, and programs.

> SAMHSA defines harm reduction as *a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower PWUD and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them.*

Brief History and Background of Harm Reduction

Harm reduction has a long history in the United States. The field itself and harm reduction practice emerged decades ago, as direct community action and mutual aid in response to effects of the "War on Drugs," an early and incomplete scientific understanding of substance use and substance use disorders, and government inaction to swiftly respond to the growing HIV/AIDS epidemic.[5]

In 1982, CDC published findings that the human immunodeficiency virus (HIV) is transmissible through the intravenous use of drugs.[6] By 1983, PWUD began the distribution of sterile syringes to limit the transmission of HIV/AIDS.[7] After the 1988 restriction on federal funding for the purchase of syringes for needle and syringe exchange programs, PWUD and allies who operated syringe services programs (SSPs) across the country began to organize their work.[8] In 1992, the first Harm Reduction Working Group meeting in the United States was held in San Francisco to create a unified definition of harm reduction. A major outcome of the group was the establishment of the National Harm Reduction Coalition.[9]

Since the first Harm Reduction Working Group meeting in 1992, harm reduction has grown in scope and in practice. PWUD have innovated and sustained the movement despite criminalization of many harm reduction interventions and lack of financial and social support.

An important example is the advent of community naloxone distribution, which began in 1996.[10] From 1996 through June 2014, 136 organizations reported distributing naloxone to 152,283 laypersons. Of the 109 organizations who collect reversal data, 26,463 overdose reversals were reported.[11] Although the number of organizations distributing naloxone has doubled and since 2013 has included organizations other than SSPs, in 2014, SSPs still accounted for 80 percent of the distribution effort to PWUD, as well as 80 percent of overdose reversals.[12]

In 2019, SSPs distributed 702,232 doses of naloxone to 230,506 people in communities across the country.[13] Studies have shown that communities may experience up to a 46 percent reduction in opioid overdose mortality when more than 100 people who are likely to observe or experience an overdose per 100,000 population are enrolled into an Overdose Education and Naloxone Distribution (OEND) program.[14] In addition, SSPs are associated with an estimated 50 percent reduction in HIV and hepatitis C incidence.[15,16] When combined with medications that treat opioid use disorder (also known as medications for opioid use disorder or MOUD), hepatitis C virus and HIV transmission is reduced by more than two-thirds.[17] The last few decades have solidified the evidence-based practices and individuals have become specialized subject matter experts in the field of harm reduction.

Addressing Health Inequities

In the spirit of Executive Order 13985,[18] SAMHSA is in the process of reviewing its policies to examine the intended and unintended impacts of its programs, policies, and procedures; incorporating racial justice and health equity into its policy goals; and advancing equitable support for Black, Latino, American Indian and Alaskan Native persons, Asian Americans, Native Hawaiians, and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely impacted by persistent poverty or inequality. This is proactively undertaken to address past and present inequities.[18] Integrating harm reduction principles and approaches throughout the agency is one strategy for advancing that commitment.

Deficient social determinants of health and structural inequalities contribute to and exacerbate substance use, substance use disorder, and mental illness, and can and do have a profound impact on some populations. Most notably, persons who have a history of familial, community or racial trauma may be particularly in need of compassionate services to support their pathways to improved health outcomes. Community practitioners and behavioral health providers must be culturally responsive and attentive to health equity to effectively improve individual and population level health. For this to be accomplished, community trust and buy-in must be earned, and that begins with truth and reconciliation of a community's shared traumatic history and the structural racism that perpetuates inequities. On this foundation, trust and meaningful relationships can develop.[19]

"Formally acknowledging a community's shared traumatic history is a fundamental step in preparing for and planning community engagement (CE) efforts that address health inequities."[19]

This work is undertaken in partnership with SAMHSA's Office of Behavioral Health Equity, which describes the work as: "Advancing health equity involves ensuring that everyone has a fair and just opportunity to be as healthy as possible. This also applies not only to behavioral health, but in conjunction with quality services, this involves addressing social determinants, such as employment and housing stability, insurance status, proximity to services, culturally responsive care — all of which have an impact on behavioral health outcomes."[20]

Framework Overview

Harm reduction is practical in its understanding and acceptance that drug use and other behaviors that carry risk exist — and responds in a compassionate and life-preserving manner. Harm reduction seeks to reduce the harmful impacts of stigma, mistreatment, discrimination, and harsh punishment of PWUD, especially those who are Black, Indigenous, and other People of Color.[21] Building community partnerships with harm reduction organizations can positively shape beliefs and attitudes, reduce stigma, and ensure the well-being of the community at large.[22]

Harm reduction also accounts for the intersection of drug use, other stigmatized behaviors, and people's health. Fundamentally, a harm reduction approach meets people where they are, engaging with them and providing support.[23]

Harm reduction opens the door to more options for PWUD, for whom traditional treatment approaches are inaccessible, ineffective, or inappropriate — and who want to make safer, healthier choices with their life and health. Access to harm reduction services is consistently shown to improve individual and community outcomes. By viewing substance use on a continuum, incremental change can be made, allowing for risk reduction to better suit a person's own individual goals and motivations.

Most importantly, harm reduction approaches save lives.

The SAMHSA definition of harm reduction contains **six pillars, 12 principles, and six core practice areas** that give life to harm reduction approaches, initiatives, programs, and services. The pillars are essential building blocks that are the foundation of what makes harm reduction effective. The pillars are further divided into supporting principles that are the specific concepts and ideals supporting each pillar. The SAMHSA Framework also describes the core components of community-based harm reduction programs.

Framing Harm Reduction

SAMHSA conceptualizes harm reduction as being a set of services, an approach, and a type of organization. Harm reduction has, at times, been reduced to a singular service or group of services, when in fact, its application goes well beyond this. Harm reduction as an approach — with supporting principles and pillars that can be applied to a variety of contexts — includes the provision of evidence-based treatment. An organization or an individual healthcare practitioner may not consider themselves as primarily providing harm reduction services but may adopt and apply practices and principles outlined in this Framework — to enhance the services they offer and engage with PWUD in a manner informed by these principles. Any organization who works with PWUD can benefit from the integration of harm reduction as an approach.

Harm reduction is also part of the continuum of care and a comprehensive strategy that includes prevention, treatment, recovery, and health promotion. All of these elements are necessary — and people weigh them differently in different situations, at different points in their lives, and relative to a wide range of substances and behaviors.

Prevention, in particular primary prevention, seeks to prevent problems before they start. That means preventing exposure to substances (or screening and intervening with early misuse), reducing risk factors, and strengthening protective factors at the individual, relationship, community, and society levels. Prevention also seeks to stop or delay the progression of substance use to a substance use disorder, as well as prevent other harms associated with substance use.

Harm reduction recognizes the complex relationship people may have with substances, starting from first use, through the many possible intervention points from there. Harm reduction does not minimize the inherent harms associated with drug use and acknowledges that reducing harm can take different forms for different people at different points, including with the use of medications to treat substance use disorders. Harm reduction is also inclusive of abstinence as a chosen pathway but not inclusive of abstinence as a coerced pathway.

Harm reduction services must adhere to the harm reduction approach to maintain fidelity to the evidence base and lead to better outcomes. This is exemplified by the concept of Community-Based Harm Reduction Programs (CHRPs) described in this Framework.

Pillars of Harm Reduction

Table 1 summarizes the six pillars of harm reduction. Harm reduction initiatives, programs, or services should include these elements.

Table 1. Six Pillars of Harm Reduction

Harm Reduction...	
1. Is led by people who use drugs (PWUD) and with lived experience of drug use	Work is led by PWUD and those with lived and living experience of drug use. Harm reduction interventions that are evidence based have been innovated and largely implemented by PWUD. Through shared decision-making, people with lived experience are empowered to take an active role in the engagement process and have better outcomes.[24] Put simply, the effectiveness of harm reduction programs is based on the buy-in and leadership of the people they seek to serve. Organizations providing harm reduction services should have a formal mechanism to meaningfully include the voices of people with lived experience in the design, implementation, and evaluation of those services.[25] Adopting at least two of the following specific mechanisms of inclusion is mission critical: employment of people with lived experience in both intervention and administrative roles, advisory boards of PWUD, and the consultation of CHRPs or any other peer-led organizations. It is important to note that while people in recovery and people who formerly used drugs have valuable experience, centering the perspectives of people who currently use drugs (and the intersectionality with other historically marginalized individuals) and have a working understanding of the current, dynamic, and rapidly changing landscape of drug use in a particular community in which an organization is working, is essential to successful engagement and outcomes. This is exemplified in the provision of OEND Programs.[26]
2. Embraces the inherent value of people	All individuals have inherent value and are treated with dignity, respect, and positive regard. Harm reduction initiatives, programs, and services are trauma informed, and never patronize nor pathologize PWUD, nor their communities. They acknowledge that substance use happens, and the reasons a person uses drugs are nuanced and complex. This includes people who use drugs to alleviate symptoms of an existing medical condition.

Harm Reduction...(Cont.)	
3. Commits to deep community engagement and community building	All communities that are impacted by systemic harms are leading and directing program planning, implementation, and evaluation. Funding agencies and funded programs support and sustain community cultural practices, and value community wisdom and expertise. Agencies and programs develop through community-led initiatives focused on geographically specific, culturally based models that integrate language revitalization, cultural programming, and Indigenous care with dominant-society healthcare approaches.
4. Promotes equity, rights, and reparative social justice	All aspects of the work incorporate an awareness of (and actively work to eliminate) inequity related to race, class, language, sexual orientation, and gender-based power differentials. Pro-health and pro-social practices that have worked well for specific cultural and/or geographic communities are aligned with organizing and mobilizing, providing direct services, and supporting mutual aid among PWUD. CHRPs are often the best-placed organizations to respond to communities or individuals on racial justice and health equity issues, and provide services for Black, Latino, American Indian and Alaska Native persons, Asian Americans, Native Hawaiians, and Pacific Islanders, and other persons of color; members of religious minorities; LGBTQI+ persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely impacted by persistent poverty or inequality.
5. Offers most accessible and noncoercive support	All harm reduction services have the lowest requirements for access. Participation in services is always voluntary, confidential (or anonymous), self-directed, and free from threats, force, and the concept of compliance. Any data collection requires informed consent and participants should not be denied services for not providing information. This means using low-threshold evaluation and data collection systems to measure the effectiveness of harm reduction programs.
6. Focuses on any positive change, as defined by the person	All harm reduction services are driven by person-centered positive change in the individual's quality of life. Harm reduction initiatives, programs, and services recognize that positive change means moving towards more connectedness to the community, family, and a more healthful state, as the individual defines it. There are many pathways to wellness; substance use recovery is only one of them. Abstinence is neither required nor discouraged.

Supporting Principles

The pillars are supported and reinforced by 12 core principles that guide the work. As with the pillars, the principles are vital. Programs that do not incorporate all 12 principles risk violating the spirit of harm reduction.

Table 2. Principles of Harm Reduction

Supporting Principles	Principle Description
Respect autonomy	Each individual is different. It is important to meet people where they are, and for people to lead their own individual journey. Harm reduction approaches, initiatives, programs, and services value and support the dignity, personal freedom, autonomy, self-determination, voice, and decision making of PWUD.
Practice acceptance and hospitality	Love, trust, and connection are important in harm reduction work. Harm reduction approaches, initiatives, programs, and services hold space for people who are at greatest risk for marginalization and discrimination. These elements emphasize trusting relationships and meaningful connections and understand that this is an important way to motivate people to find personal success and to feel less isolated.
Provide support	Harm reduction approaches, initiatives, programs, and services provide information and support without judgment, in a manner that is non-punitive, compassionate, humanistic, and empathetic. Peer-led services enhance and support individual positive change and recovery; and peer-led leadership leads to better outcomes.
Connect with community	Positive connections with community, including family members (biological or chosen) are an important part of well-being. Community members often assist loved ones with safety, risk reduction, or overdose response. When possible, harm reduction initiatives, programs, and services support families in expanding and deepening their strategies for love and support; and include families in services, with the explicit permission of the individual.
Provide many pathways to well-being across the continuum of health and social care	Harm reduction can and should happen across the full continuum of health and social care, meeting whole-person health and social needs. In networking with other providers, harm reduction initiatives, programs, and services work to build relationships and trust with health and social care partners that embrace supporting principles. To help achieve this, organizations practicing harm reduction utilize education and encourage policies that facilitate interconnectedness between all parties.

Supporting Principles	Principle Description...(Cont.)
Value practice-based evidence and on-the-ground experience	Structural racism and other forms of discrimination have limited the development and inclusion of research on what works in underserved communities. Harm reduction initiatives, programs, and services understand these limitations and use community wisdom and practice-based evidence as additional sources of knowledge.
Cultivate relationships	Relationships are of central importance to harm reduction. Harm reduction approaches, initiatives, programs, and services are relational, not transactional, and work to establish and support quality relationships between individuals, families, and communities.
Assist, not direct	Harm reduction approaches, initiatives, programs, and services support people on their journey towards positive change, as they define it. Support is based on what PWUD identify as their needs and goals (not what programs think they need), offering people tools to thrive.
Promote safety	Harm reduction approaches, initiatives, programs, and services actively promote safety **as defined by the people they serve.** These efforts also acknowledge the impact that law enforcement can have on PWUD (particularly in historically criminalized and marginalized communities) and provide services accordingly.
Engage first	Each community has different cultural strengths, resources, challenges, and needs. Harm reduction approaches, initiatives, programs, and services are grounded in the most impacted and marginalized communities. It is important that meaningful engagement and shared decision making begins in the design phase of programming. Equally important is bringing to the table as many individuals and organizations as possible who understand harm reduction and who have meaningful relationships with the affected communities.
Prioritize listening	Each community has its own unique story that can be the foundation for harm reduction work. When we listen deeply, we learn what matters. Harm reductionists engage in ***active listening*** — the act of inviting people to express themselves completely, recognizing the listener's inherent biases, with the intent to fully absorb and process what the speaker is saying.
Work toward systems change	Harm reduction approaches, initiatives, programs, and services recognize that trauma; social determinants of health, such as access to healthcare, housing, and employment; inequitable policies; lack of prevention and early intervention strategies; and social support have all had a responsibility in systemic harm.

Core Practice Areas

Core practices are effective methods for harm reduction that reflect community understanding, experience, strengths, and needs. There are six core practice areas: (1) safer practices; (2) safer settings; (3) safer access to healthcare; (4) safer transitions to care; (5) sustainable workforce and field; and (6) sustainable infrastructure.

While not an exhaustive list, Table 3 provides key strategies and links to resources.

Anyone in the United States can access free, direct technical assistance (in any of the core practice areas) from SAMHSA and CDC. SAMHSA's harm reduction webpage offers resources, including allowable expenses for its grants that support harm reduction activities.

Table 3. Core Practice Areas

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)
Safer Practices: Education and support describing how to reduce risk; provision of risk reduction supplies and materials	
Needs Based Syringe Services Programs (SSPs) — also referred to as syringe exchange programs (SEPs) and needle exchange programs (NEPs),* including secondary exchange.[1,17,19,22,26,27,28,29]	CDC Syringe Services Programs Technical Package SAMHSA TIP 33 Treatment for Stimulant Use Disorders SAMHSA TIP 63 Medications for Opioid Use Disorder
Safer smoking supplies/ distribution to reduce infectious disease transmission.* [29,30,31] *As permitted by law. No federal funding is used directly or through subsequent reimbursement of grantees to purchase pipes. Grants include explicit prohibitions of federal funds to be used to purchase drug paraphernalia.	CDC Stimulant Guide
Overdose education, overdose detection services, and naloxone distribution.[10,13,26,29,32]	CDC Lifesaving Naloxone Guide SAMHSA What is Naloxone? SAMHSA TIP 63 Medications for Opioid Use Disorder SAMHSA Opioid-Overdose Reduction Continuum of Care Approach (ORCCA) Practice Guide 2023 Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide 2023

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Drug-checking education, fentanyl test strips, xylazine test strips and other assay test strips, FTIR spectrometers, and other drug-checking technology at community drug-checking sites.[33,34]	CDC MMWR: Rapid Analysis of Drugs: A Pilot Surveillance System to Detect Changes in the Illicit Drug Supply to Guide Timely Harm Reduction Responses Overdose Data to Action: Surveillance Strategies | Drug Overdose | CDC Injury Center SAMHSA Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips
Integrated reproductive health education, services and supplies, and sexually transmitted infection screening, prevention, and treatment.[35,36,37,38]	SAMHSA TIP 33 Treatment for Stimulant Use Disorders
Onsite access or immediate accessible referral to basic wound care supplies and services in the community.[38]	Wound Care & Medical Triage for People Who Use Drugs and the Programs That Serve Them | NASTAD CDC Syringe Services Program Technical Package
Safer Settings: Access to safe environments to live, find respite, practice safer use, and receive supports that are trauma-informed and stigma-free	
Day centers and social spaces that offer harm reduction services, are low barrier, and are led and maintained by the communities they serve.[39]	SAMHSA Peer Support Services in Crisis Care
Access to safe and secure housing.[33,40]	SAMHSA Homeless & Housing Resource Center
Public health programs as alternatives to arrest and any legal system involvement.[20,41]	SAMHSA Criminal and Juvenile Justice Resources
Hybrid recovery community organizations providing peer-delivered harm reduction and recovery support services.[42]	Peer Recovery Center of Excellence

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Safer Access to Healthcare: Ensuring access to person-centered and non-stigmatizing healthcare that is trauma informed, including FDA-approved medications	
Low-barrier treatment services that offer a whole-person approach and rapid re-initiation, if needed.[43]	SAMHSA Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings
Flexible provision of services that offer medication starts at first visit or at home, choice of medications, and individualized dosages.[44]	SAMHSA Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings
Healthcare settings and providers are directly informed by harm reduction principles, pillars, and the people they serve.[45,46,47]	SAMHSA Engaging Community Coalitions to Decrease Opioid Overdose Deaths Practice Guide 2023
Nonpunitive care that consistently offers the standard of care in a nonstigmatizing, nonjudgmental manner and does not refuse healthcare based on stigma or personal beliefs about PWUD.[48]	Overcoming Stigma, Ending Discrimination
Mobile access and take-home methadone medication.[49,50,51,52]	SAMHSA Methadone Take-Home Flexibilities Extension Guidance
Mobile buprenorphine services, including telehealth options for initiation and continuity of care.[53,54,55,56]	SAMHSA The Physical Evaluation of Patients Who Will Be Treated with Buprenorphine at Opioid Treatment Programs
Access to new paradigms of care, including treatment specific to the use of all drugs and/or each drug.[57,58]	SAMHSA Treating Concurrent Substance Use Among Adults
Onsite or quick referral, low-barrier oral health services that are informed by lived experience of substance use.[59]	Oral Health, Mental Health and Substance Use Treatment

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Safer Transitions to Care: Connections and access to harm-reduction-informed and trauma-informed care and services	
Health hubs for PWUD/ integrated HIV, viral hepatitis, and healthcare services.[26,38,60,61,62,63,64]	Center of Excellence for Integrated Health Solutions CDC HIV Risk Reduction Tool
Expand telehealth, while also addressing low technology literacy and enhancing access in languages other than English.[54]	SAMHSA Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders SAMHSA Culturally Competent LEP and Low-literacy Services
Warm hand-off to and from emergency department programs — with low-barrier MOUD initiation and post- overdose services.[38,65]	SAMHSA Connecting Communities to Substance Use Services: Practical Tools for First Responders ACA Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings
Medication access and treatment on-demand (abstinence not required).[26,66,67,68]	SAMHSA Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings CDC Linking People with Opioid Use Disorder to Medication Treatment
Onsite or immediate referral to accessible nutritional assistance, clothing, temporary shelter, and housing.[65]	SAMHSA Homeless & Housing Resource Center SAMHSA Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness
Seamless coordination of care for individuals leaving carceral settings and treatment settings that do not offer medications, because people are at greatly heightened risk for overdose fatality when back in the community.[65]	SAMHSA GAINS Center ACA Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings SAMHSA Best Practices for Successful Reentry from Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders

Examples of Practices	Supporting Resources and Evidence (Research- and Practice-based)...(Cont.)
Sustainable Workforce and Field: Resources for maintaining a skilled, well-supported, and appropriately managed workforce and for sustaining community-based programs	
Organizational leadership from people with living and lived experience.[26]	ASPE Methods and Emerging Strategies to Engage People with Lived Experience SAMHSA Participation Guidelines for Individuals with Lived Experience and Family NHRC Peer Delivered Syringe Exchange (PDSE) Toolkit SAMHSA TIP 64: Incorporating Peer Support into Substance Use Disorder Treatment Services
Living wages and essential benefits for harm reduction workers.[69,70]	SAMHSA National Model Standards for Peer Support Certification
Wellness services and support for harm reduction staff and volunteers without mandated abstinence.[39,71]	SAMHSA National Model Standards for Peer Support Certification
Training and technical assistance for community-based providers.[38]	SAMHSA Practitioner Training
Include harm reduction expertise and lived expertise in the selection process of reviewers for harm reduction grants and other competitive processes.[72]	SAMHSA Grant Review Process
Sustainable Infrastructure: Resources for building and maintaining a revitalized and community-led infrastructure to support harm reduction best practices and the needs of PWUD	
Hire and appropriately compensate PWUD to inform policy at agencies that serve PWUD.[73]	SAMHSA National Model Standards for Peer Support Certification
Co-leadership of PWUD in organizational partnership in research.[74]	SAMHSA National Model Standards for Peer Support Certification
Promote education on the value of harm reduction services.[26,75, 76,77,78,79]	CDC/SAMHSA National Harm Reduction Technical Assistance Center SAMHSA Harm Reduction SAMHSA National Model Standards for Peer Support Certification

Community-Based Harm Reduction Programs (CHRPs)

While integrating harm reduction (as an approach and as services) into a wide variety of settings is beneficial to the people who are served and impacted by them, SAMHSA is committed to supporting harm reduction organizations that are by and for their community — as they are mission critical for connecting to our communities' most marginalized individuals.

CHRPs describe harm reduction organizations where people with lived and living experience lead the planning and oversight, program development and evaluation, and resource/funding allocation for an organization's harm reduction initiatives, programs, and services. CHRPs also offer the core practice areas, as permitted by law. Harm reduction activities may be integrated into a comprehensive, person-centered program of care that includes treatment services that meet the specific needs of the community in which the program is housed.

In addition to programs being consistent with all aforementioned principles and pillars, CHRPs should include people with lived experience as co-investigators in any research project. Boards, staff, and team members should be at least 51 percent those with lived experience. CHRPs demonstrate meaningful connection to PWUD in their community, especially to communities most marginalized, and provide lowest-barrier, core harm reduction practices.

Conclusion

The Harm Reduction Summit was a groundbreaking event that engaged a diversity of perspectives across the fields of prevention, treatment, recovery, and harm reduction. More than 100 participants attended the Summit, representing the private sector, community-based organizations, health care, faith-based organizations, academia, researchers, funders, law enforcement, and leaders from federal, state, local, and tribal governments.

The subsequent Steering Committee synthesized and refined the Summit findings, providing guidance for this Framework. Moving forward, this Framework will inform SAMHSA's harm reduction activities, as well as related policies, programs, and practices. SAMHSA's aim is to integrate harm reduction activities and approaches across its organizational Centers and initiatives, and to do so in a manner that draws on evidence-based practice and principles — while also maintaining sustained dialog with harm reductionists and PWUD.

SAMHSA is committed to continued collaboration with PWUD and the field to put this Framework into practice, support and expand harm reduction approaches and services, and ultimately save lives.

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Substance Abuse and Mental Health
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ADVISORY: LOW BARRIER MODELS OF CARE FOR SUBSTANCE USE DISORDERS

Introduction

Despite robust evidence demonstrating the effectiveness of medications and psychosocial treatment interventions for substance use disorders (SUDs), less than 10 percent of people who need treatment have sustained access to care. In 2021, only 22.1 percent of people with a past year opioid use disorder (OUD) reported receiving medications for the treatment of their opioid misuse, and only 6.3 percent of people with a past year illicit drug or alcohol use disorder reported receiving any substance use treatment.[1] SUDs continue to pose a significant public health challenge. Most people who could benefit from treatment do not receive it due to systemic barriers and access issues which are even greater for historically underserved communities.

Low barrier care is a model for treatment that seeks to minimize the demands placed on clients and makes services readily available and easily accessible. It also promotes a non-judgmental, welcoming, and accepting environment. In this way, low barrier models of care meet people where they are, providing culturally responsive and trauma informed care that is tailored to the unique circumstances and challenges that each person faces.[2,3] This facilitates engagement in treatment: one recent study of a low barrier bridge clinic serving individuals with opioid, alcohol, stimulant, sedative/hypnotic, and cannabis use disorders, found that 70 percent of clients were engaged in treatment, which is higher than national averages.[4] Another study of low barrier buprenorphine offered at a syringe services program revealed a nearly three-fold increase in buprenorphine use (from 33 to 96 percent) and substantial declines in the use of other opioids (from 90 to 41 percent) between clients' first and sixth visits.[5] Other research reveals that low-barrier care is cost-effective, reducing the need for emergency department visits and hospitalizations.[6]

Key Messages

- Low barrier care reduces requirements and restrictions that may limit access to care and increases access to treatment for individuals with substance use disorders. This approach meets individuals where they are and helps provide culturally sensitive care tailored to the unique circumstances and challenges that each person faces.
- Research demonstrates the potential effectiveness of low barrier care in improving treatment engagement and outcomes for individuals with substance use disorders.[4] Low barrier care can reduce the use of harmful substances and lower the need for emergency department visits and hospitalizations.
- Some approaches to substance use disorder treatment may be perceived by people who use drugs as punitive, leading to stigmatization and limited treatment engagement. Low barrier care provides a non-judgmental, welcoming, and accepting environment that encourages individuals to seek help without fear of stigma or discrimination.
- Policymakers and stakeholders must work to identify and address any inhibitors to low barrier care, including funding and reimbursement, workforce development, and regulatory policies.
- Low barrier care can increase access to treatment and improve recovery-based outcomes for individuals and communities affected by substance use disorders.[6]

This Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory outlines the principles and components of low barrier care and how low barrier care may be leveraged to overcome substantial gaps in access, while also engaging individuals in treatment. Low barrier care for SUDs is a critical way to address the overdose epidemic and other substance use challenges. By removing barriers to care and providing evidence-based services in a non-judgmental, welcoming, and accepting environment, low barrier models of care can help to improve recovery-based outcomes for individuals and communities affected by substance use and use disorders. [2]

Principles and Components of Low Barrier Models of Care

Low barrier models of care promote engagement and retention by placing the patient at the center of planning and decision making. Accordingly, low barrier models include flexible scheduling and walk-in services, a non-punitive approach to ongoing substance use, decreased stigma about SUD compared to traditional care settings, and incorporation of patient goals and choice into medication decisions. The following principles and components of low barrier care highlight a patient-centered approach to care that meets the person where they are and engages them in treatment in a compassionate and person-centered manner.

Principles

1. **Person-centered care:** Treatment works best when the focus is on how to empower each client to achieve their goals. This requires being present to the individual, asking about, listening to, and respecting clients' experiences, wishes, and autonomy, as well as providing individualized care to meet their needs. Cultivating a culture of person-centered empowerment within organizations and systems is especially needed given the pervasive stigma against people with SUDs. In the context of low barrier care for SUDs, it is crucial to support a client's preferences for short-term versus long-term medication use (e.g., withdrawal management) as part of a patient-centered approach to treatment. This includes providing psychosocial education so that individuals understand the risks and benefits of their decisions. Respecting individual autonomy and through a shared decision-making and informed consent process can enhance treatment adherence, promote a sense of autonomy, and improve overall outcomes. Long-term medication use may offer stability and continuous support for clients, whereas short-term use can be instrumental in managing withdrawal symptoms and initiating the recovery process. By ensuring effective informed consent via shared decision-making and tailoring treatment plans to align with clients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to a more successful and sustainable recovery.[13]

EXAMPLE: New York Harm Reduction Educators

New York Harm Reduction Educators (NYHRE), serving Manhattan and the Bronx in New York City, prioritizes meeting people where they are and supporting clients in their self-defined recovery process. NYHRE offers case management, naloxone, syringe access, and other supports and services regardless of whether clients continue using drugs or express interest in medication. NYHRE is increasing the number of hours that medication prescribers are available and incorporating additional services for co-occurring mental disorders to better serve their population.

2. **Harm reduction and meeting the person where they are:** Harm reduction, a cornerstone of the Department of Health and Human Services' Overdose Prevention Strategy,[1] is a practical and transformative approach that incorporates public health strategies – including prevention, risk reduction, and health promotion- to people who use drugs, so that they

might live healthy and purpose-filled lives. What that looks like can vary for each client. For example, abstinence from all substances may not be a feasible or desired goal for every client at a given point in time. Other behavior changes – including reductions in substance use and engaging in less risky substance use practices – can meaningfully improve health outcomes and can be appropriate treatment goals. Similarly, recovery is determined by the person. It is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. In a low barrier setting, services and interventions are provided in a non-judgmental, welcoming, and accepting environment, which is designed to encourage individuals to seek help without fear of stigma or discrimination.[7] Low barrier care recognizes that recovery is a journey that is unique to each individual, and therefore, emphasizes the need to provide interventions that are tailored to the unique needs and circumstances of each person.[8]

3. **Flexibility in service provision:** Low barrier models of care prioritize patient-centered care and adapt to the individual's specific needs, preferences, and circumstances by offering walk-in services, providing multiple levels of care within a single program, and using evidence-based practices to support a variety of recovery goals.[9,10]
4. **Provision of comprehensive services:** Low barrier care models often incorporate a whole health approach that encompass a range of medical, behavioral, and social services to address the multifaceted needs of individuals with SUDs, including access to medications for opioid use disorder (MOUD) and medications for alcohol use disorder (AUD), counseling, case management, peer support, mental health care, education, housing support, mental health screening and referral or co-occurring enhanced treatment, and vocational services.[9] The provision of these services may be performed onsite, or through referrals.
5. **Culturally responsive and inclusive care:** The burden of SUDs has been disproportionately experienced by people from racially and ethnically marginalized communities. Addressing these disparities requires proactive and community-involved efforts to improve access to care for communities that have been underserved, including mitigation of the upstream factors that reinforce inequities in health status, healthcare access, healthcare quality, and health outcomes. Low barrier care also emphasizes diversity, striving to provide care sensitive to the unique needs and experiences of each individual, including those belonging to marginalized populations, such as people of color, rural communities, lesbian, gay, bisexual, transgender, questioning, intersex and asexual (LGBTQIA+) individuals, people with disabilities, and those experiencing homelessness.[11,12]
6. **Recognize the impact of trauma:** Many individuals with an SUD have experienced trauma at some point in their lives. Trauma-informed care can improve patient engagement, treatment adherence, and health outcomes as it recognizes the long-lasting, negative impacts of trauma. Key principles of a trauma-informed approach include attention to (1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment, voice, and choice, and (6) cultural, historical, and gender issues.[13]

Components of Low Barrier Models of Care

In low barrier models of care, providers accommodate clients' preferences to the maximum extent possible while also working collaboratively with clients to determine recovery goals, recognizing that recovery is unique to the person. Key elements of low barrier models are availability, flexibility, responsiveness, a collaborative approach to the needs and interests of the individual, as well as promoting a culture of learning and evaluation.

Available and Accessible

Embedding SUD treatment, related services and supports across the healthcare system is critical to improving treatment engagement. Relatedly, socioeconomic factors can make it difficult for some clients to access treatment (e.g., unreliable transportation, employment, childcare responsibilities, prior authorizations). These are key considerations to increasing access to treatment for the entire population with SUDs and can be actualized through the use of telehealth technology, integrated care platforms and mobile medical units.

This model would ensure that:

- Treatment is available outside of specialty SUD settings, including in emergency departments, primary care, specialty health care (e.g., obstetrics/gynecology), syringe services programs, crisis stabilization facilities, and mobile units.[14,15]
- Other clinical (e.g., primary care, mental health care) and non-clinical services (e.g., syringe access, peer support services, case management) are incorporated into specialty SUD treatment settings.[16]
- Individuals can receive services on the same day without an appointment.[6,14]
- Clinics have extended hours of operation.[16]
- Telehealth and in-person services are available.[17] This is especially important for individuals in remote or underserved areas, eliminating transportation barriers.

EXAMPLE: Meharry Addiction Clinic

Meharry Addiction Clinic (MAC), part of the Meharry Medical College and located in North Nashville, TN, emphasizes the importance of building strong relationships between staff and clients, and community and providing person-centered care. MAC does not discharge clients for ongoing substance use and they provide harm reduction services – naloxone, fentanyl test strips, and syringe access – to all clients with OUD. To reduce barriers to their services, MAC is implementing a mobile addiction clinic and increasing their outreach to emergency departments, faith-based organizations, and Black community members.

Flexible

Low-barrier models adapt to the individual's specific needs, preferences, and circumstances, offering walk-in services, providing multiple levels of care within a single program, and using evidence-based practices to support a variety of recovery goals. Rigid requirements and expectations imposed on clients can deter them from seeking, initiating, or sustaining treatment.

- Treatment engagement conditions or preconditions should not be placed on the patient. This includes requirements that individuals receive multiple services simultaneously; demonstrate complete adherence with scheduled intake appointments; complete additional testing prior to starting medication or receiving dose increases; receive treatment for co-occurring conditions (e.g., mental disorders); or provide consent to co-occurring treatment providers before SUD treatment initiation are required conditions of treatment.[18,19]
- Medication is provided at the first visit if the patient chooses. Additionally, the provision of medication is not contingent on a positive urinary drug screen or active withdrawal.[14,20]
- Home initiation of medications is offered.[14,17]
- Various formulations of medications are offered.[14]
- Medication dosage and duration of therapy are individualized.[16]

- Medication is rapidly re-initiated if person chooses when there is a short-term treatment disruption.[14]
- If desired by the individual, counseling can teach new ways to make healthy choices and handle stress. While counseling should be offered to patients, the provision of medication should not be contingent upon participation or engagement in a set counseling schedule.
- The use of toxicology results to prioritize client safety, rather than punishment, helps to establish trust, promote transparency, and facilitate a more effective therapeutic alliance, ultimately enhancing treatment outcomes and mitigating potential adverse outcomes. In other words, the results of tests are not used to restrict services.

Responsive

Recovery is a highly personal process that occurs via many pathways. Each person with a SUD will have a different approach to cultivating and sustaining recovery. People with SUDs benefit from comprehensive services to support them on their path to recovery, and low barrier care does not preclude offering a full range of services to the individual in a person-centered manner. Indeed, practitioners in low barrier settings play a vital role in providing a full continuum of support, which includes community-based services, family support, and peer support, all of which ensure those with SUDs have access to whole person care.[16]

- Visit frequency is based on clinical stability, not an organization-wide schedule (except for interventions that employ specific visit schedules by design, such as contingency management).[14]
- Ongoing substance use, whether by self-report or demonstrated through specimen testing, does not automatically lead to treatment discontinuation or a reduction in medication dose.[14,16]
- Being prescribed medications for mental health conditions does not automatically preclude MOUD, nor should programs mandate those receiving MOUD provide consent to release information to their mental health prescriber as a contingency of continued SUD treatment.
- Providers support clients in determining their recovery goals based on what feels right for them, including medication choice.[16]
- Reducing substance use and harm mitigation are considered acceptable goals.[14,16]
- Peer services or nonclinical professionals with lived experience in recovery from SUD are available to support people on their recovery journeys by providing education about how to care for and strengthen recovery, help advocate for people in recovery, share resources, and provide mentorship.
- Providers should work with patients and their care team to determine what services are needed to support their growth in the four domains of recovery (health, home, purpose, and community).[21]
- Families should be involved based on the wishes of the individual.
- Clinic staff use outreach and follow-ups to encourage treatment adherence and attendance.[22]

Collaborative

To address the complex needs of individuals with SUD, low barrier care programs often partner with other community organizations, including:

- Primary care providers;[23]

- Mental health services;[24]
- Housing agencies;[25]
- Social services;
- Transportation services;
- Offices of employment; and
- Peer support networks.[26]

Engaged in learning and quality improvement.

Adequate training and education of healthcare providers and staff members in low barrier care principles, evidence-based treatment practices, signs and symptoms of co-occurring disorders, recovery-oriented care, and harm reduction strategies are crucial to delivering effective care for people with SUDs.[20] It is also important to foster program evaluation and feedback mechanisms, as these underlie quality improvement activities.[27] Implementing these strategies can involve:

- Enhancing knowledge about the latest evidence-based interventions for SUDs, including medications, counseling, and recovery support services.[20,28]
- Providing information on the principles and benefits of harm reduction approaches, such as overdose prevention, and syringe services programs.[29]
- Offering cultural competence training to better understand and address the diverse needs of clients from various cultural, racial, and ethnic backgrounds, as well as the LGBTQIA+ community.[30]
- Encouraging continuing education and professional development opportunities for staff and providers, including conferences, webinars, and workshops related to SUDs and low barrier care.
- Collecting and analyzing data on treatment outcomes, client satisfaction, and accessibility of services, using standardized measures and tools.[31]
- Incorporating feedback from clients, staff, and community partners to identify strengths and weaknesses of the low barrier care model and to inform service improvements.[32]
- Conducting regular reviews of clinical practices and policies to ensure alignment with the latest research evidence and best practices in the field.[33]
- Establishing a culture of continuous quality improvement, where staff and providers are encouraged to learn from successes and challenges, and to adapt and innovate in their approaches to care.[34]

These components facilitate a comprehensive, integrated approach to care, while also enhancing the effectiveness of treatment and support services. In this way, comprehensive implementation of low barrier care requires systemic policy and practice transformation at every level. SAMHSA is committed to supporting the treatment provider and harm reduction communities in achieving this transformation.

Exhibit 1: A Comparison of Low-Barrier and High-Barrier Care

Barrier Level	Requirements and Approach [35,36,37,38,39,40]	Requirements and Approach (medication only)	Availability [41,42,43,44,45]
Low Barrier Care	• No service engagement conditions or preconditions. • Visit frequency based on clinical stability. • Ongoing substance use does not automatically result in treatment discontinuation. • Client's individual recovery goals prioritized. • Reduction in substance use and engaging in less risky substance use as acceptable goals.	• Medication at first visit. • Home initiation permitted. • Various medication formulations offered. • Individualized medication dosage. • Rapid re-initiation of medication after short-term disruption.	• Treatment available in non-specialty SUD settings. • Other clinical and non-clinical services incorporated into SUD treatment settings. • Same-day treatment availability, no appointment required. • Extended hours of operation. • Telehealth and in-person services available.
High Barrier Care	• Requirements for current or previous engagement with specific services. • Visit frequency based on a rigid, pre-determined schedule. • Treatment discontinuation due to ongoing substance abuse. • Treatment goals imposed. • Abstinence as the primary goal for all clients, all the time.	• Two or more visits before medication. • Clinic initiation required. • Limited medication formulation options. • Uniform maximum dosage. • Induction required to restart medication.	• Treatment only available at specialty SUD programs. • Non-integrated or limited-service offerings. • One or more day wait to initiate treatment, appointment required. • Traditional hours of operation. • Services only available in-person.

This table was adapted from a table developed by Jakubowski and Fox.[35]

A Brief Implementation Example

Implementing low barrier models of care into primary care settings, including Federally Qualified Health Centers (FQHCs), involves a comprehensive approach that addresses the various components of patient-centered care, including availability, flexibility, responsiveness, collaboration, and a culture of learning. Below, are some important examples of required elements in promoting low barrier models of care in primary care settings:

- **Establish a multidisciplinary care team**: Assemble a team of healthcare professionals, including physicians, nurses, counselors, marriage and family therapists, social workers, and peer support specialists, to provide comprehensive care to patients with substance use disorders.[46]

- **Integrate SUD screening and assessment**: Incorporate routine SUD screening and assessment into primary care settings using validated tools, such as the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST).[47]
- **Involve people with lived experience**: Meaningfully engage people in recovery and family members in the planning, delivery, and evaluation of services. Include people in recovery in leadership and board roles.
- **Train primary care providers**: Provide training and education for primary care providers on the fundamentals of addiction medicine, evidence-based treatment options, and the use of medications for SUD, such as buprenorphine.[48]
- **Develop collaborative care protocols**: Establish protocols that outline communication and coordination processes among primary care providers, behavioral health specialists, and other community-based service providers.[49]
- **Offer flexible treatment options**: Provide various treatment options, including medications, counseling, and harm reduction services, which cater to the individual needs and preferences of patients with SUDs.[50]
- **Eliminate service engagement preconditions**: Ensure that treatment initiation is not contingent on factors such as strict adherence to scheduled appointments or the requirement to receive treatment for co-occurring conditions before initiating SUD treatment.[50]
- **Address stigma**: Provide ongoing education and training to staff members to challenge misconceptions about addiction and promote empathy and understanding towards individuals with SUDs. This can help reduce stigma and create a welcoming, non-judgmental environment.[51]
- **Establish referral networks**: Develop strong partnerships with local mental health, social services, and housing organizations to facilitate access to additional support and resources for patients, thereby fostering a comprehensive continuum of care.[48]
- **Evaluate and continuously improve**: Regularly assess the effectiveness of the low barrier care model through the collection and analysis of patient outcomes, satisfaction, and engagement data. Use the insights gained to refine and enhance service delivery.[49]

Through careful implementation of these steps, primary care settings can successfully implement low barrier models of care, fostering an accessible and patient-centered environment for individuals with SUDs.

Providing Comprehensive Patient-Centered Care: Treating The "Whole Person" Through Low Barrier Care

People with SUDs benefit from comprehensive services to support them on their path to recovery, and low barrier care does not preclude offering a full range of services to the individual in a person-centered manner. Indeed, practitioners in low barrier settings play a vital role in ensuring that those with SUDs are offered "whole person" care. This can include addressing concerns that the individual may have about their physical and mental health, financial, or housing needs. Practitioners should consider the following issues when caring for individuals.

- **Treatment decisions are person-centered.** In the context of low barrier care for substance use disorders, it is crucial to support a client's preferences for long-term versus short-term medication use (e.g., withdrawal management) as part of a patient-centered approach to

treatment. By ensuring effective informed consent and tailoring treatment plans to align with clients' unique needs and preferences, healthcare providers can foster a therapeutic alliance, optimize treatment efficacy, and ultimately contribute to more successful and sustainable recovery trajectories. For more information on treating opioid use disorders, see SAMHSA's TIP 63 - Medications for Opioid Use Disorder (https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002). Information on treating stimulant use disorders can be found in TIP 33, available at https://store.samhsa.gov/product/treatment-for-stimulant-use-disorders/PEP21-02-01-004. Information on treating alcohol use disorder is available at: https://store.samhsa.gov/product/prescribing-pharmacotherapies-patients-with-alcohol-use-disorder/pep20-02-02-015. Information on treating co-occurring disorders can be found in TIP 42, available at: https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004?referer=from_search_result.

- **The use of telehealth expands access.** Audio-only and/or audio-visual telehealth technologies can be helpful in reaching individuals in remote settings, or connecting to those people who are reluctant to receive care in physical settings. A growing amount of research has demonstrated the effectiveness of using telehealth in treating OUD with medications. More information about telehealth and treating substance use disorders can be found in SAMHSA's evidence-based guide on 'Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders', available at: https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders.
- **Biological specimen testing is not punitive.** In low barrier care for substance use disorders, the use of biological specimen test results, obtained after appropriate patient education and consent, holds significant value for informing clinical decision-making with respect to client safety, as opposed to punitive applications. By providing objective data on a client's substance use patterns, these tests can guide healthcare providers in adjusting treatment strategies, ensuring appropriate interventions, and monitoring client progress, all while considering the individual's unique needs and risk factors. Utilizing test results to prioritize client safety helps to establish trust, promote transparency, and facilitate a more effective therapeutic alliance, ultimately enhancing treatment outcomes and mitigating potential adverse consequences associated with substance use disorders. Further information about biological specimen testing can be found at: https://store.samhsa.gov/product/TAP-32-Clinical-Drug-Testing-Primary-Care/SMA12-4668.
- **Counseling can help people enhance their coping skills.** If desired by the individual, counseling can teach new ways to make healthy choices and handle stress. The provision of medications for treatment should not be contingent on participation in counseling, but it should be offered as indicated. This is because the combination of counseling and medications has been shown to be of significant benefit to the individual. Practitioners can help patients locate services using SAMHSA's Behavioral Health Treatment Services Locator (https://www.samhsa.gov/find-help/treatment).
- **Peer workers**, or nonclinical professionals with lived experience in behavior change and recovery from SUD, can support people on their recovery journeys. Peer workers support people in or seeking recovery from SUDs by providing education about triggers that can lead to recurrence, advocating for people in recovery, sharing resources, teaching skill-building, and mentoring. For more information about peer workers, see https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.

- **People seeking care may also have other health issues**. Practitioners should work with clients to ensure access to additional health services as needed. Indeed, those with SUDs may have physical or mental health conditions that they wish to be addressed. For more information about referral centers in your local area, see https://findtreatment.gov/.
- **Additional Supports**. Additional supports such as family therapy and vocational counseling should be offered to the patient with the understanding that such services may not be accepted immediately, and that engagement might be sporadic. For more information on employment and recovery, see https://store.samhsa.gov/product/Substance-Use-Disorders-Recovery-with-a-Focus-on-Employment/PEP21-PL-Guide-6. Additional information on family therapy can be found at https://store.samhsa.gov/product/importance-family-therapy-substance-use-disorder-treatment/pep20-02-02-016.
- **Caring for people with SUDs is empowering** for the provider and patient. Expanding skills and knowledge through learning about medications to treat SUDs, prescribing buprenorphine to patients with OUD, and engaging with other resources provides a practical way to help a growing number of individuals. In December 2022, the requirement to obtain a special waiver to prescribe buprenorphine was lifted. Now, where state law allows, any practitioner with a valid state license and DEA registration to prescribe Schedule III medications may prescribe buprenorphine. This expands opportunities to provide care and the ability to provide low barrier treatment to those with OUD across different settings. For more information on removal of the Data-Waiver, see https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement.

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Centers for Disease Control and Prevention

Summary of Information on The Safety and Effectiveness of Syringe Services Programs (SSPs)

Background

The nation is currently experiencing an opioid crisis involving the misuse of prescription opioid pain relievers as well as heroin and fentanyl.[1,2] The increase in substance use, including stimulant use, has resulted in concomitant increases in injection drug use across the country.[3] This has caused not only large increases in overdose deaths,[4] but also tens of thousands of viral hepatitis infections annually[5] and is threatening recent progress made in HIV prevention.[6] The most effective way for individuals who inject drugs to avoid infections related to unsafe injection drug use is to stop injecting.[7,8] However, many people are unable or unwilling to do so, or they have little or no access to effective treatment. Approximately 3.7 million Americans report having injected a drug in the past year.[9] In 2019, 14.3% of high school students reported using opioids without a prescription and 1.6% reported having ever injected drugs.[10]

Syringe services programs (SSPs) are proven and effective community-based prevention programs that can provide a range of services, including access to and disposal of sterile syringes and injection equipment, vaccination, testing, and linkage to infectious disease care and substance use treatment. [8, 11] SSPs reach people who inject drugs, an often hidden and marginalized population. Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.[11,12] Research shows that new users of SSPs are five times more likely to enter drug treatment and about three times more likely to stop using drugs than those who don't use the programs.[13] SSPs that provide naloxone also help decrease opioid overdose deaths. SSPs protect the public and first responders by facilitating the safe disposal of used needles and syringes.

Appropriations language from Congress in fiscal years 2016-2018 permits use of funds from the Department of Health and Human Services (HHS), under certain circumstances, to support SSPs with the exception that funds may not be used to purchase needles or syringes.[14] State, local, tribal, or territorial health departments must first consult with CDC and provide evidence that their jurisdiction is experiencing or at risk for significant increases in hepatitis infections or an HIV outbreak due to injection drug use.[15] CDC has developed guidance and consults with state, local, or tribal and territorial health departments on determining if they have adequately demonstrated need according to federal law. Decisions about use of SSPs to prevent disease transmission and support the health and engagement of people who inject drugs are made at the state and local level.

Prevention of Infectious Diseases

Viral hepatitis, HIV, and other blood-borne pathogens can spread through injection drug use if people use needles, syringes, or other injection materials that were previously used by someone who had one of these infections. Unsafe injection can also lead to other serious health problems, such as skin infections, abscesses and endocarditis. The best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of infection and prevent outbreaks.

During the last decade, the United States has seen an increase in injection drug use — primarily the injection of opioids. Outbreaks of hepatitis C, hepatitis B and HIV infections have been correlated with these injection patterns and trends.[16,17] The majority of new hepatitis C virus (HCV) infections are due to injection drug use, and the nation has seen a 4.9-fold increase in

reported cases of HCV from 2010 to 2019.[5] New HCV virus infections are increasing most rapidly among young people, with the greatest incidence among individuals aged 20-39 years.

Until recently, CDC had observed a steady decline since the mid-1990s in HIV diagnoses attributable to injection drug use. However, recent data show progress has stalled. Notably, new HIV infections among people who inject drugs increased 12% from 2014 to 2019.[18] The estimated lifetime cost of treating one person living with HIV is near $510,000.[19] Hospitalization in the US due to substance- use related infections alone costs over $700 million annually.[20] In the United States, the estimated cost of providing health care services for people living with chronic HCV infection is $15 billion annually.[21] SSPs can help reduce these healthcare costs by preventing viral hepatitis, HIV, endocarditis and other infections.

SSPs are a tool that can help reduce transmission of viral hepatitis, HIV, and other blood-borne infections. SSPs are associated with an approximately 50% reduction in HIV and HCV incidence.[11] When combined with medications that treat opioid dependence (also known as medications for opioid use disorder [MOUD] or medication-assisted treatment) HIV and HCV transmission is reduced by more than two-thirds.[22,23]

Linkage to Substance Use Treatment, Naloxone, and Other Healthcare Services

Syringe services programs serve as a bridge to other health services including, HCV and HIV diagnosis and treatment and MOUD for substance use.[24] The majority of SSPs offer referrals to MAT,[25] and people who inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP.[13,26,27] SSPs facilitate entry into treatment for substance use disorders by people who inject drugs.[26,28] People who use SSPs show high readiness to reduce or stop their drug use.[29] There is also evidence that people who inject drugs who work with a nurse at an SSP or other community-based venue are more likely to access primary care than those who don't,[36] also increasing access to MAT.[30] Many comprehensive community-based SSPs offer a range of preventative services including vaccination, infectious disease testing, and linkage to healthcare services.

Syringe services programs can reduce overdose deaths by teaching people who inject drugs how to prevent and respond to a drug overdose, providing them training on how to use naloxone, a medication used to reverse overdose, and providing naloxone to them. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[31,32] SSPs have partnered with law enforcement, providing naloxone to local police departments to help them keep their communities safer.[33]

Public Safety

Syringe services programs can benefit communities and public safety by reducing needlestick injuries and overdose deaths, without increasing illegal injection of drugs or criminal activity. Studies show that SSPs protect first responders and the public by providing safe needle disposal and reducing community presence of needles.[34–38] As many as one in every three officers may be stuck by a used needle during his or her career.[39] Needle stick injuries are among the most concerning and stressful events experienced by law officers.[40,41] A study compared the prevalence of improperly disposed of syringes and self-reported disposal practices in a city with SSPs (San Francisco) to a city without SSPs (Miami) and found eight times as many improperly disposed of syringes in Miami, the city without SSPs.[34] People who inject drugs in San Francisco also reported higher rates of safe disposal practices than those in Miami. Data from CDC's National HIV Behavioral Surveillance system in 2015 showed that the more syringes distributed at SSPs per people who inject drugs in a geographic region, the more likely people who inject drugs in that region were to report safe disposal of used syringes.[42]

Evidence demonstrates that SSPs do not increase illegal drug use or crime.[43,44] Studies in Baltimore[44] and New York City[43] have found no difference in crime rates between areas with and areas without SSPs. In Baltimore, trends in arrests were examined before and after a SSP was opened and found that there was not a significant increase in crime rates. The study in New York City assessed whether proximity to an SSP was associated with experiencing violence in an inner-city neighborhood and found no association.

SSP Implementation

Not all SSPs are alike. Programs differ in size, scope, geographic location, and delivery venue (e.g., mobile vs. fixed sites). Community acceptance and legality also impact program success. Prior to establishing an SSP, it is important for public health agencies (or others) to assess the needs of potential clients, their families, key stakeholders, law enforcement, and the community at large.

The decision to incorporate SSPs as part of a comprehensive prevention program is made at the state and local level. Laws vary by state and can either increase or reduce access to SSPs. CDC created a guidance document to aid state and local health departments in managing HIV and hepatitis C outbreaks among people who inject drugs, which provides best practices to consider when establishing an SSP.[45] Conducting a needs assessment prior to the establishment of an SSP, developing evaluation tools, and careful planning of the operational tasks can increase the chances the SSP will be successful in a community. CDC supported the development of a technical package that provides evidence of the effectiveness of strategies and approaches for supporting successful planning, design, implementation, and sustainability of syringe services programs.[46]

HHS guidance states that SSPs should be part of a comprehensive service program that includes, as appropriate,[47]

- Provision of sterile needles, syringes, and other drug preparation equipment (purchased with non-federal funds) and disposal services.
- Education and counseling to reduce sexual, injection and overdose risks.
- Provision of condoms to reduce risk of sexual transmission of viral hepatitis, HIV or other sexually transmitted diseases.
- Provision of HIV, viral hepatitis, STD and tuberculosis screening.
- Provision of naloxone to reverse opioid overdoses.
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention, treatment, and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.
- Referral and linkage to hepatitis A virus (HAV) and hepatitis B virus vaccination.
- Referral and linkage to and provision of substance use disorder treatment, including MAT for opioid use disorder, which combines drug therapy (e.g., methadone, buprenorphine, or naltrexone) with counseling and behavioral therapy.
- Referral to medical care, mental health services, and other support services.

Emerging Issues

In addition to the concerning increases in hepatitis and HIV rates, CDC has also identified additional emerging infectious disease risks related to injection drug use, including increases in methicillin-resistant Staphylococcus aureus (MRSA) infection rates, which increased 124% between 2011 and 2016 among people who inject drugs.48 In addition, people who inject drugs are 16 times as likely as other people to develop invasive MRSA infections.

Rates of endocarditis, a life-threatening infection of the heart valves that can occur in people who inject drugs, has also increased. For example, in North Carolina alone, the rate of hospital discharge diagnoses for endocarditis related to drug dependence increased more than 12-fold from 2010 to 2015, with unadjusted hospital costs increasing from $1.1 million in 2010 to over $22 million in 2015.[49] Identifying and responding to these emerging infectious disease threats is critical to alleviate the subsequent harms of opioid misuse and abuse. These infections have been linked to frequency of injecting and to syringe sharing.[50] SSPs may help reduce bacterial infections by providing sterile injection equipment and linkage to substance use treatment.

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