FIP STATEMENT OF POLICY AND CALL TO ACTION

The role of pharmacists in preventing and reducing harm associated with psychoactive substances

Executive summary

This Statement of Policy outlines the role of pharmacists in preventing and reducing harm associated with the non-medicinal use of psychoactive substances. It recognises substance use disorder (SUD) as a significant public health challenge that contributes to morbidity, mortality, and social disadvantage, and acknowledges that prevention, early intervention, treatment support and evidence-informed harm reduction are essential components of an effective response.

As highly accessible healthcare professionals, pharmacists are uniquely positioned to contribute across the continuum of care through prevention-focused services, early identification of substance-related risks, patient education, referral to appropriate treatment pathways, and support for harm reduction interventions. The policy adopts a person-centred, public health approach grounded in principles of social justice, human rights, and non-discriminatory care, recognising that substance-related harms are influenced by broader social, economic, and environmental determinants.

The statement emphasises three key priorities:

1. discouraging the non-medicinal use of psychoactive substances obtained through medical pathways;
2. preventing the development of SUD, including those arising from inappropriate prescribing or medicine use; and
3. supporting the prevention, early identification, and management of SUD.

It also highlights pharmacists' roles in overdose prevention, treatment support, public health promotion, advocacy for vulnerable populations and collaboration within interdisciplinary care networks.

The statement calls on governments, professional organisations, educational institutions, health system funders, pharmaceutical manufacturers, and pharmacists themselves to strengthen workforce capability, remove unnecessary barriers to care, support sustainable service delivery, and promote integrated, patient-centred approaches that improve health outcomes and reduce harms associated with psychoactive substance use.

Introduction

This Statement of Policy sets out the role of pharmacists in preventing and reducing harm associated with the non-medicinal use of psychoactive substances and replaces the 2018 Statement of Policy on "The role of pharmacists in reducing harm associated with drugs of abuse".[1]

FIP STATEMENT OF POLICY AND CALL T O ACTION

The role of pharmacists in preventing and reducing harm associated with psychoactive substances

Psychoactive substances are defined as natural or synthetic substances that affect the central nervous system and may alter perception, mood, cognition, or behaviour.[2, 3] Production, distribution, sale, medicinal, and non-medicinal use of many psychoactive substances are regulated under national legislation and international drug control conventions. Legislation is intended to limit their manufacturing, distribution, cultivation and use to legitimate medicinal and scientific purposes, or in limited circumstances, as adult consumer products.[4] Use outside these legally sanctioned channels may therefore be considered illicit.

Non-medicinal use refers broadly to the use of psychoactive substances outside authorised medical use, or in a manner inconsistent with prescribing instructions, clinical guidance or evidence-based therapeutic purposes. This includes the misuse of prescription medicines other than as prescribed, including use for non-therapeutic purposes, use by individuals for whom the medicine was not prescribed, or use in a manner or for a duration inconsistent with clinical guidance.[2] It also includes the use of fraudulent prescriptions to obtain prescription-only medicines.

SUD refers to a recognised group of health conditions characterised by impaired control over substance use, increasing priority given to substance use over other activities, and continued use despite harmful consequences. [2] SUDs may be associated with problematic intoxication, withdrawal, or substance-induced mental and physical health conditions. SUD has also been defined as a problematic pattern of substance use leading to clinically significant impairment, risky use, and, where relevant, pharmacological features such as tolerance and withdrawal.[5] SUDs may have an iatrogenic origin due to health professionals utilising psychoactive substances outside of accepted evidence-based modalities. This may include the use of doses outside of accepted ranges; lengthy treatment periods; lack of timely review and modification of treatment; and reliance exclusively on medicines for conditions in which treatment guidelines and evidence support allied health or supportive therapies.[6] When untreated, SUDs are associated with increased morbidity and mortality, and impairment in personal, social, educational, and occupational functioning. Harm reduction is underpinned by principles of social justice and human rights. It emphasises practical and evidence-informed approaches that reduce harm and promote wellbeing by engaging with people in a respectful, non-judgemental, and non-discriminatory manner, without coercion or the requirement to cease use of psychoactive substances as a condition of treatment or support.[7]

Harm reduction refers to evidence-informed policies, programmes, and practices aimed at minimising the negative health, social, and legal impacts associated with the non-medicinal use of psychoactive substances.[7]

The statement focuses on the non-medicinal use of psychoactive substances and the harms associated with such use, including misuse of prescription medicines, diversion, and the use of controlled substances obtained outside healthcare systems. It does not address the therapeutic use of medicines, nor substances such as alcohol or nicotine, which are covered by separate public health and regulatory frameworks.

The statement adopts a prevention-first, person-centred public health approach that prioritises prevention, early identification, counselling, and referral as foundational strategies, alongside treatment support and evidence-informed harm reduction. It recognises that substance use and substance-related harm are influenced by broader social, economic, and environmental determinants and that

effective responses require coordinated interdisciplinary approaches involving pharmacists, physicians, nurses, social workers and other relevant professionals.

Within this framework, the statement addresses three principal areas of pharmacy practice:

1. discouraging the non-medicinal use of psychoactive substances obtained via a medical pathway,
2. preventing the development of SUD due to iatrogenic or autogenic causes; and
3. supporting the prevention, early identification, and management of SUD.

The statement acknowledges the wide variation in legal frameworks, scopes of practice and service delivery models across nations and regions. It provides evidence-informed guidance intended to support implementation in diverse settings while avoiding an overly prescriptive approach. Implementation should consider disparities in regulatory capacity, workforce training, access to specialist referral pathways, and sociocultural perceptions of substance use across jurisdictions, particularly in resource-limited settings.

Background

The available literature, together with the experiences of pharmacists and their professional organisations across countries and practice settings, supports the role of pharmacists in preventing and reducing harm associated with the non-medicinal use of psychoactive substances. As highly accessible health professionals, pharmacists are well positioned to actively and effectively contribute to the prevention, early identification, referral, treatment support and harm reduction, particularly within community and primary care settings.

The nature and extent of pharmacist involvement will depend on national legislation, regulatory frameworks and local health system structures, and should be implemented in collaboration with other health professionals through appropriate care pathways.[8] Pharmacist-delivered services should be embedded within integrated care pathways that include primary care, mental health services, addiction medicine, emergency care, infectious disease services, social care and community organisations. Pharmacists can facilitate equitable access to harm reduction for their patients through mindful consideration of their own beliefs and attitudes towards the consumption of psychoactive substances by patients, therefore reducing the risk of stigma and reducing barriers to care.

Within a broader public health framework, pharmacists may contribute through the following activities:

1. Prevention and early identification, including public health education, brief interventions, medicines review to identify patterns of risky or inappropriate use, safety planning for overdose risk, and referral to medical, mental health and specialised SUD services through established care pathways.[9] Early identification may also involve the use of validated screening approaches such as the Screening, Brief Intervention and Referral to Treatment (SBIRT) tool.[10] Pharmacists may also use other structured tools, such as the WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), to identify individuals at increased risk and facilitate referral to appropriate interdisciplinary services.[11] Implementation should be adapted to national capacities, including available time, training, remuneration mechanisms and referral infrastructure.

2. Harm reduction advice and services, including education on safer use, awareness and response to overdose, vaccination (where allowed), and the prevention of infectious diseases. Where permitted, pharmacists and pharmacies may provide harm reduction services such as sterile injecting equipment, low dead-space syringes, alcohol swabs, sterile water, tourniquets, wound care supplies, and other equipment designed to reduce harms associated with non-medicinal use of psychoactive substances. The scope and delivery of these services should be determined by national legal frameworks, public health priorities, workforce capacity and societal context. Many such services have evolved beyond traditional "exchange programmes" into broader equipment-provision services.[8] Such extended services may involve, depending on national context, either direct provision by pharmacies or referral and collaboration with specialised services, analytical services to check substances being used and support for safe consumption services or overdose prevention centres.[12-14]

3. Treatment support, including opioid agonist therapy and medication-assisted treatment programmes. Pharmacists may contribute through supervised administration, adherence support, patient counselling, and, where authorised, collaborative prescribing or dose adjustment.[15]

4. Overdose prevention, including opioid antagonists such as naloxone and, where permitted, pharmacist-initiated provision. Reducing unnecessary regulatory barriers to naloxone access, alongside appropriate training and safeguards, has demonstrated public health benefits.[16] Efforts to improve naloxone access should also address affordability, supply chain resilience, public awareness, and workforce training to ensure equitable implementation.

5. Broader health promotion and patient support services, including sexual and reproductive health services, testing and treatment of sexually transmissible infections and hepatitis viruses, pre-exposure prophylaxis, and the authorised supply of hormonal and non-hormonal contraceptives, where permitted.

6. Advocacy for vulnerable populations, including in prisons, refugee settings, during transition periods, and other contexts where individuals may experience barriers to accessing prevention, treatment, and harm reduction services, including measures to maintain pharmacies as safe and trusted healthcare environments for patients, staff and communities. Particular attention should be given to equity of access for underserved populations, including people experiencing homelessness, people in custodial settings, migrants, refugees, adolescents and young adults, women, people with mental health conditions, and people living in rural or remote areas.

7. Development of interprofessional relationships and referral pathways for individuals at risk of, or experiencing, SUD, who need treatment beyond the scope of what the pharmacist can provide.

Education and training are essential enabling conditions for safe and effective pharmacist involvement across prevention, harm reduction and treatment support. Competency-based programmes should address the clinical pharmacology and toxicology of psychoactive substances, SUDs, identification of high-risk patterns and

combinations, communication with vulnerable populations, stigma reduction, brief intervention skills, referral pathways, advocacy competencies, cultural competencies, the psychosocial model of SUD, and the management of challenging interactions. Continuing professional development and, where appropriate, recognition of advanced practice, should be promoted.

Implementation of pharmacist-led prevention, harm reduction, and treatment support services should be supported by quality assurance, monitoring, and evaluation, including indicators related to service uptake, referral success, patient safety, overdose events prevented, and cost-effectiveness. These measures can inform sustainable funding models and continuous improvement of services.[17]

Appropriate legal frameworks and protection, professional guidance, and workplace protections are also essential to safeguard pharmacists' well-being and security when delivering these services, including support for de-escalation, incident management, and access to professional support resources.

AGAINST THIS BACKGROUND, FIP RECOMMENDS THAT AND CALLS FOR ACTION BY STAKEHOLDERS TO:

Governments and policymakers

1. Engage with pharmacists and their professional associations to identify any barriers and maximise pharmacists' contributions to nationally appropriate harm reduction services, including through collaborative practice arrangements that support screening, brief interventions, referral and follow-up within integrated care pathways.
2. Support the inclusion of prevention-focused services within these models, recognising the public health value of early intervention by engaging with end-user and consumer representatives in policy and programme development and co-design.
3. In collaboration with pharmacy professional associations and relevant specialised societies (e.g., psychiatric associations, substance use disorder medicine groups, antidoping agencies and national drug authorities), support the development of certified training programmes addressing prevention, harm reduction and treatment support, and integrate these within continuing professional development (CPD) systems with competency-based support and recognition.
4. Reduce unnecessary regulatory barriers to pharmacist provision of opioid antagonists such as naloxone.
5. Where appropriate, introduce or adapt regulatory frameworks that enable pharmacists to provide low-threshold interventions (e.g., naloxone provision without prescription), while ensuring appropriate pharmacovigilance and safety monitoring, and
6. Facilitate access to shared digital patient records for pharmacists to support them to reduce harm from adult non-medicinal use of drugs.

Professional pharmacy organisations

1. Advocate with policymakers and health authorities for the resources, training, legal clarity and workplace protections required to support pharmacists in delivering prevention, treatment support and harm reduction services.
2. Support the development and implementation of nationally appropriate pharmacist-delivered services, including prevention

initiatives, harm reduction programmes, treatment support services and overdose prevention interventions, and
3. Engage with people with lived experience and relevant community organisations to inform the development and improvement of services delivered by pharmacists and pharmacies, ensuring that these services remain patient-centred and responsive to community needs.

Pharmacy academic institutions and education providers

1. Collaborate with member organisations, pharmacists and people with lived experience to develop education and workforce development opportunities addressing prevention, harm reduction and treatment support.
2. Promote and implement the inclusion of harm reduction and substance use disorder management within early-career competency frameworks and pharmacy education curricula, and
3. Contribute evidence to the field through evidence-based educational research, including active monitoring of experimental policy initiatives which seek to reduce harm from non-medicinal use of drugs; to build an evidence base which would either support the policy continuing, encourage policy makers to change course or to develop the policy to mitigate any unintended consequences.

Pharmacists:

1. Strengthen prevention-oriented services, including early identification of substance-related risks, brief interventions, and referral to appropriate care pathways.
2. Participate in education and training programmes that support competency development in prevention, harm reduction, and treatment support.
3. Contribute to the development and use of measurable quality and outcome indicators for pharmacist services in this domain to demonstrate impact, support reimbursement, and improve patient and community outcomes.
4. Identify patterns of misuse, diversion, iatrogenic origin and high-risk combinations of medicines through digital health technologies in medication safety and monitoring, such as electronic prescription monitoring systems, which are increasingly used in many countries to reduce inappropriate use of controlled medicines and support early interventions.
5. Where appropriate, engage with policymakers and health authorities around prescriptive authority to initiate, monitor, and adjust medications for substance use disorder treatment.
6. Engage with patients, service users, and people with lived experience to better understand their needs and experiences and to inform the design and delivery of pharmacist-led services, and
7. As SUDs are frequently associated with mental health conditions, pharmacists should establish and make use of integrated care pathways through collaboration between pharmacists, mental health professionals and mental health services.

Payers and health system funders:

1. Support sustainable service delivery by ensuring appropriate remuneration for pharmacist-provided services related to prevention,

early identification, appropriate intervention, referral, counselling and harm reduction across relevant practice settings.

Pharmaceutical manufacturers:

1. Support the development and availability of safer product designs that reduce harms associated with non-medicinal use (e.g., low dead-space syringes and related harm reduction equipment) and diversion-resistant pharmaceutical formulations of psychoactive substances; and
2. Support the development of appropriate dosage forms and delivery devices that enable safe administration of opioid antagonists such as naloxone by non-specialist users.

AGAINST THIS BACKGROUND, FIP COMMITS TO:

Continue to advocate for a considered, pharmacy-inclusive, evidence-informed approach to the development of public policy on the issue of non-medicinal use of psychoactive substances. This advocacy should explicitly include:

1. Harm prevention, workforce development through standardised training and competency, ethical clarity regarding pharmacists' roles, and the promotion of evaluation frameworks to measure outcomes and guide best practice.
2. Fair remuneration of harm reduction services provided by pharmacists;
3. Promoting the global adoption of the recommendations from the statement, and
4. Work with international organisations, such as the United Nations (UN), World Health Organization (WHO), patient organisations, and others, to collaborate and intensify efforts towards patient safety and harm reduction, including continuing professional education opportunities.

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