



AMA Journal of Ethics®

July 2024, Volume 26, Number 7: E509-511

FROM THE EDITOR

Why Harm Reduction and Equity Are Ethical Imperatives in Opioid Use Disorder Care

Jeremy Weleff, DO

Evidence-based harm reduction practices for opioid use disorder (OUD)—such as syringe services programs,¹ among others—hold promise to help advance approaches to thinking of comprehensive OUD care as a human right, but successful implementation of harm reduction interventions in the United States has been hampered by increasingly heated politicization of addiction care and a long history of a patchwork of federal and state laws that create gaps for many.^{2,3,4} From the middle of the 20th century and into America’s seemingly endless so-called War on Drugs, the addition of more regulations have increased the **difficulty of accessing treatment** and care for those who use opioids and other drugs. From the relegation of methadone treatment to opioid treatment programs in the 1970s⁵ (unlike other countries such as Canada, Australia, and the United Kingdom that allow for general prescribing or dispensing⁶) to the federal “crack house statute” of 1986,⁷ the vestiges of these laws continue to contribute to a rigid and slow response to effective implementation of best practices to reduce mortality and morbidity from opioid use. This uniquely American model of OUD care that now exists and has produced a record number of deaths as of June 2023⁸ is the result of discriminatory laws against those who use drugs that began at the turn of the century during America’s earlier opioid epidemics.⁹

Given this legislative history, tertiary prevention strategies for OUD, which include naloxone distribution, syringe services programs, drug testing and checking, safe consumption sites, and safe/safer supply programs, have faced public and executive branch resistance in the United States.^{10,11} These **harm reduction strategies**, which are fundamentally situated in a perspective that upholds respect for bodily autonomy, freedom of choice, and person-centered care, continue to be included in international practice guidelines for OUD.¹² These strategies have never been more needed, as recent waves of the opioid epidemic have been characterized by a rapidly changing and dangerous drug supply made up of illicitly manufactured, high-potency opioids and by supply-side drivers that contribute to an unpredictable drug supply.¹³

It wasn’t until the COVID-19 pandemic that the United States made some of its largest steps in decades toward more equitable and evidence-based OUD care. During the pandemic, methadone prescribing laws were loosened to allow for more take-home doses,¹⁴ laws that limited the prescribing of buprenorphine were removed,¹⁵ and the first safe consumption site opened in New York City.^{16,17} These steps, which should be

celebrated and more closely align the United States with international and evidence-based practices, are hopefully the first of many toward advancing equity in OUD care. This issue of the *AMA Journal of Ethics* examines many of these advances, as well as barriers to OUD care that produce systemic inequities. In so doing, it contributes to the critical conversation on addressing the opioid epidemic earnestly and fully to ensure access to the full spectrum of evidence-based interventions for all individuals, regardless of race, ethnicity, gender, or socioeconomic status.

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Jeremy Weleff, DO is an addiction psychiatrist at Yale School of Medicine in New Haven, Connecticut. He completed psychiatry residency training at the Cleveland Clinic and subsequent addiction psychiatry and public psychiatry fellowships at Yale School of Medicine. His research interests include how homelessness, addiction, and structural determinants of health interface with psychiatry, justice, and society.

Citation

AMA J Ethics. 2024;26(7):E509-511.

DOI

10.1001/amajethics.2024.509.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.