



AMA Journal of Ethics®

July 2024, Volume 26, Number 7: 562-571

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

How Should Harm Reduction Be Included in Care Continua for Patients With Opioid Use Disorder?

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Abstract

Practices and interventions that aim to slow progression or reduce negative consequences of substance use are harm reduction strategies. Often described as a form of tertiary prevention, harm reduction is key to caring well for people who use drugs. Evidence-based harm reduction interventions include naloxone and syringe service programs. Improving equitable outcomes for those with opioid use disorder (OUD) requires access to the continuum of evidence-based OUD care, including harm reduction interventions, as well as dismantling policies that undermine mental health and substance use disorder treatment continuity, housing stability, and education and employment opportunities.

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Background

Harm reduction, often described as a form of tertiary prevention, represents a set of practices that aim to reduce the negative consequences of substance use by adopting patient-centered approaches that are nonpunitive, nonjudgmental, and practical.^{1,2} Its origins in the United States date back to the **HIV epidemic of the 1980s**, when transmission rates were high among people who injected drugs, which led activists, people who use drugs, and their allies to implement syringe exchange programs beginning in the late 1980s.^{3,4} This approach was politically controversial and illegal in many states at the time and would not be federally supported for decades.^{4,5} Currently, some harm reduction approaches, such as naloxone distribution (now available in all 50 states)⁶ and syringe service programs, are becoming more accepted in the United States as a result of HIV outbreaks in rural settings such as Scott County, Indiana⁷; the national hepatitis C virus epidemic⁸; and the ongoing opioid overdose crisis.^{9,10} However, harm reduction efforts still face major barriers due to a combination of stigma, preferences for punitive approaches to substance use, and policy and legal-moral objections.¹¹ Political opposition to harm reduction interventions also impacts willingness to adopt harm

reduction-inspired, evidence-based interventions for addressing opioid use disorder (OUD).

A professional duty to offer comprehensive evidence-based health care to all those who use drugs within the context of the ongoing opioid overdose crisis, inequitable opioid-associated outcomes in low-income and minoritized communities, and underlying contributors to multiple health challenges require physicians caring for people who use drugs and policy makers to (1) include harm reduction in the continuum of services for people who use substances; (2) embrace evidence-based policies and practices, including harm reduction approaches in health care systems and public health; (3) develop strategies to address underlying social determinants of health (SDoH); and (4) address health inequities in outcomes related to OUD treatment and opioid overdoses.

Harm Reduction Services

From an ethical standpoint, an important component of the success of harm reduction programs has been their focus on the autonomy and consent of people who use drugs. What in the medical field might be considered person-centered care has been key to the behavior changes and health benefits associated with harm reduction strategies. People who use drugs vary in their interest in engaging in treatment services, so providing a continuum of options (ranging from residential treatment to outpatient, low-barrier buprenorphine and syringe services programs or overdose prevention sites) is essential for improving health outcomes for all people who use drugs. Without a full range of interventions for OUD, individuals may be dissuaded from participating in health care, with avoidable adverse health outcomes. For instance, patient-directed discharge is more common among people who have substance use disorders (SUDs) than other populations,¹² yet harm reduction practices could reduce patient-directed discharge among people with OUD, given the discrimination experienced by people who use drugs in hospital settings,¹³ by actively managing opioid withdrawal symptoms,¹⁴ consistently prescribing evidence-based medications for opioid use disorder (MOUD),¹⁵ providing naloxone upon discharge from inpatient settings, and improving systems for care continuity as patients transition through health care and community settings.¹⁶

During the COVID-19 pandemic, the regulations for MOUD were loosened. The changes included permitting telehealth prescribing of controlled substances, wider buprenorphine prescribing authority based on a telehealth evaluation, and more flexibility in methadone dosing and take-home protocols.^{17,18} These types of person-centered care approaches that are informed by harm reduction practices could be critical to expanding the availability of highly effective medications to the many patients who need them. Implementation of better payment schemes for MOUD is also helpful in making it more widely available.¹⁹ Codifying approaches that safely maximize access to MOUD (including low-barrier access), naloxone, and other harm reduction approaches are likely to have significant impacts on patient outcomes and population health.²⁰

Adopt Evidence-Based Policies and Programs

From a tertiary prevention standpoint, evidence demonstrating reduced morbidity and mortality outcomes from harm reduction interventions²¹ is compelling enough to support expansion of evidence-based policy interventions across the country. The Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the Office of National Drug Control Policy convened stakeholders to develop a harm reduction framework to help guide policies, programs, and practices at SAMHSA. The Harm Reduction Framework²² acknowledges that

structural inequities and SDoH contribute to substance use and SUDs. While SAMHSA's identified core practice areas focus on specific services related to reducing harms at the individual level,²² it is critical that national harm reduction efforts have a broader focus and address the underlying structural factors and policies that actively cause harm to people who use drugs.

Policies and programs need to be based on evidence of reduced morbidity and mortality; and when reliable evidence of benefit of innovative practices exists, integrating, scaling, and spreading these practices to achieve improved health outcomes is necessary. Examples include community-based naloxone programs, which are associated with decreased opioid mortality,^{23,24} and syringe service programs, which are associated with reduced transmission of HIV and hepatitis C, as well as reduced soft tissue skin infections.^{25,26} While adoption of interventions that have been shown to reduce morbidity and mortality seems a straightforward policy choice, even when harm reduction approaches have strong supporting evidence, uptake has taken decades.²⁷ New harm reduction practices and policies are emerging quickly, such as drug-checking programs,²⁸ overdose prevention sites,²⁹ and decriminalization of personal substance possession.³⁰ Research evaluating these measures will be critical to understanding their impacts on morbidity and mortality, as well as their impact on community health. Conversely, when research identifies existing practices or policies that are causing harm, steps must be taken to modify or eliminate those practices or policies. Examples of policies associated with harm include prohibiting MOUD in jails and prisons, criminalizing possession of drug use equipment (which has long been known to increase infectious pathogen transmission, including of HIV and hepatitis C virus),²⁵ and closing syringe services programs.³¹

Structural Determinants of Health

Naloxone distribution and syringe service programs are critically important and effective interventions, but they are also downstream approaches that do not directly address the risk factors associated with the development of OUD. A prevention framework additionally encourages a focus on primary prevention interventions that address risk factors associated with a health condition and thereby aim to prevent the development of that condition. SDoH, by contrast, address factors such as access to food, education, housing, affordable health care, job security, and social inclusion that provide a foundation for achieving well-being³² by moving even more upstream to what is known as primordial prevention.¹ Addressing upstream factors such as these could reduce the development of OUD, therefore also reducing its associated morbidity and mortality.^{1,2} SDoH that are associated with the development of OUD include adverse childhood experiences (ACEs),³³ limited access to educational and job opportunities, lack of affordable housing, lack of available mental health services, racism, and lack of health insurance. For example, broad exposure to ACEs is associated with a 4- to 12-fold increase in the risk of substance use, depression, or suicide attempt in adulthood.³³ Preventing ACEs is one strategy that could reduce opioid morbidity and mortality; known evidence-based interventions include community-level strategies, such as strengthening economic supports for families (eg, universal basic income³⁴) and supporting positive parenting and resiliency to protect against adversity.^{2,35}

In addition to impacting the risk of opioid use and development of OUD, SDoH also affect an individual's ability to recover from OUD. SAMHSA describes the 4 major dimensions of recovery as health, home, purpose, and community.³⁶ Ensuring access to health care and housing is a necessary step in supporting individuals with OUD. An

excellent example is the Housing First approach, which provides permanent supportive housing to those experiencing homelessness and SUD without a requirement of abstinence, unlike the standard treatment-first approach that requires people to first engage in treatment and to be substance use free before they are eligible for housing. Compared to treatment-first models, Housing First programs reduced homelessness by 88% and, in patients living with HIV, decreased emergency department visits by 41%, hospitalizations by 36%, and mortality by 37% within 2 years or less in most studies.³⁷ Moreover, among individuals who were chronically homeless with severe alcohol problems, housing first was associated with a decrease in total costs (including costs associated with jail bookings, days incarcerated, and substance use and health care services) at 6 months relative to wait-list controls.³⁸ Housing First programs, however, have faced political barriers, including stigma and perceived high costs associated with program implementation. Typically, strategies are funded by a specific sector (eg, housing, health care, or carceral settings), neglecting the interconnected nature of OUD impacts that transcend these silos. This oversight can lead to insufficient investment in innovative cross-sector strategies.

Strategies to Reduce Inequity

Implementing strategies to reduce inequity is imperative. Although community naloxone distribution and MOUD have gained national acceptance and increased funding, inequities in access exist. For example, a recent study found that among Medicare beneficiaries who experienced an opioid-related emergency department visit or hospitalization, White patients were more likely to receive buprenorphine treatment and naloxone than Black or Hispanic patients.³⁹ Another study found that, among Medicaid participants diagnosed with OUD, Black enrollees were less likely than White enrollees to start MOUD, and incarceration in county jail was associated with lower likelihood of initiating MOUD within 180 days of an OUD diagnosis.⁴⁰ Community-based studies similarly show inequitable uptake of naloxone, including in receipt of naloxone training and possession of naloxone among Black and Latinx compared to White people who use illicit opioids.⁴¹ These examples demonstrate the failure of current strategies to adequately address inequity in receipt of evidence-based services.

In addition to disparities in access to evidence-based services, there are also significant disparities in how the War on Drugs has been implemented, with disproportionate impact on Black and Latino communities.⁴² The Controlled Substances Act of 1970,⁴³ which established the current drug scheduling system, was motivated by the Nixon Administration's desire to target countercultural movements and racial minorities.⁴⁴ This punitive approach to drug policy, focused on criminalization and tough-on-crime policies, has been disproportionately enforced in Black and Latino communities—thereby perpetuating stigma—and failed to effectively address public health concerns. Despite similar rates of substance use compared to White people, Black people are more likely to face arrest, prosecution, conviction, and incarceration for drug-related offenses and, once convicted, face harsher criminal penalties.⁴⁵ Harsh criminal penalties and fear-based education campaigns have had little impact on reducing drug supply or demand, while **incarcerating individuals with SUD** is traumatizing and actively increases harm to these individuals.⁴⁶ Additionally, drug-related felony charges limit individuals' future housing, educational, and employment opportunities,⁴⁷ making their path to recovery even more challenging.

The combined forces of the War on Drugs, stigma against people who use illicit substances, and structural inequalities have created the conditions for multiple health

crises and epidemics among people who use drugs. Stigma affects risk behaviors, help seeking, remaining in care, availability of services, and willingness to invest in nonpunitive approaches to substance use-related health problems.^{48,49,50} Prohibition and stigma interact with existing structural inequalities to increase health harms and impede efforts to improve health outcomes among people who use drugs. Poverty, structural violence, and structural racism all contribute to health risk in this population.⁵¹

Conclusion

Harm reduction should be embraced as a core component of the continuum of services required for an effective response to the opioid overdose epidemic. Harm reduction interventions, such as syringe services, naloxone distribution, Housing First models, and low-barrier MOUD, are evidence based and should be funded and expanded nationally, with an eye toward **reducing inequities**. Programs and policies that are not effective or that contradict best practice standards should be dismantled.

To be effective at reducing harms, efforts should focus on not only the late-stage sequelae of OUD but also the structural factors that predispose people to developing OUD in the first place. Factors such as access to physical and behavioral health care, educational and job opportunities, and housing are all critical, as is a greater focus on reducing ACEs and other forms of community trauma.

Physicians have significant influence in advancing harm reduction services for individuals who use substances and in advocating for policies and programs that tackle SDoH. Within clinical practice, it is crucial for physicians to integrate harm reduction measures, thereby ensuring patients' access to a nonstigmatizing continuum of OUD care. This care includes prescribing naloxone and low-barrier MOUD as a routine part of outpatient and inpatient medical care, as well as establishing referral pathways to connect patients with community-based resources like syringe services and drug-checking programs. Additionally, physicians must be trained in treating SUDs, as such training has been found to increase physicians' perceived preparedness for and comfort in treating SUDs.^{52,53} At the policy level, by voicing concerns and advocating for structural interventions, physicians can contribute to broader initiatives that address societal contributors to the ongoing opioid overdose mortality crisis and associated inequities.

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Citation

AMA J Ethics. 2024;26(7):E562-571.

DOI

10.1001/amajethics.2024.562.

Conflict of Interest Disclosure

Dr Livingston is the medical director of an Oregon coordinated care organization, and her work involves substance use disorder coverage policy and programs for Medicaid members. Drs Bluthenthal and Salisbury-Afshar 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.