

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-24

Subject: Supporting Harm Reduction

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Referred to: Reference Committee B

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1 INTRODUCTION

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3 At the June 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates  
4 (HOD), Resolution 204 entitled, “Supporting Harm Reduction,” was introduced by the Medical Student  
5 Section and called on the AMA to:

- 6  
7 • Advocate for the removal of buprenorphine from the misdemeanor crime of  
8 possession of a narcotic;  
9 • Support any efforts to decriminalize the possession of non-prescribed  
10 buprenorphine; and  
11 • Amend the 4<sup>th</sup> and 6<sup>th</sup> resolves of Policy D-95.987 by addition and deletion to  
12 read as follows:

13 4. Our AMA will advocate for and encourage state and county medical  
14 societies to advocate for harm reduction policies that provide civil and  
15 criminal immunity for the possession, distribution, and use of “drug  
16 paraphernalia” designed for harm reduction from drug use, including but  
17 not limited to drug contamination testing, safer smoking, and injection  
18 drug preparation, use and disposal supplies.

19  
20 6. Our AMA will advocate for ~~supports efforts to~~ increased access to and  
21 decriminalization of fentanyl test strip, and other drug checking supplies,  
22 and safer smoking kits for purposes of harm reduction.

23  
24 The HOD discussed the strong evidence base supporting buprenorphine as a treatment for opioid use  
25 disorder (OUD), the uncertainty surrounding the facts of buprenorphine “diversion,” and the significant  
26 concerns about the meaning and practice of “safer smoking.” Ultimately, the HOD referred the resolution  
27 to the Board of Trustees for study. In response, this board report provides background information;  
28 discusses the different issues raised by the resolution; presents AMA policy; and makes policy  
29 recommendations.

30  
31 BACKGROUND

32  
33 *Buprenorphine*

34  
35 Buprenorphine is a Schedule III Controlled Substance that the U.S. Drug Enforcement Administration  
36 (DEA) defines as a narcotic for purposes of drug scheduling.<sup>1</sup> The U.S. Food and Drug Administration  
37 (FDA) first approved buprenorphine-containing products in 2002 for the treatment of OUD.

1 Buprenorphine for OUD may be prescribed as a “mono-product,” and some manufacturers combine it  
2 with naloxone (“combination product”) to treat OUD. It may be available as a tablet, sublingual film,  
3 transdermal film, or injection.  
4

5 There is widespread evidence that supports buprenorphine as an evidence-based medication to treat  
6 OUD.<sup>2</sup> Researchers and clinicians commonly promote statements such as, “opioid agonist therapy (OAT)  
7 with methadone or buprenorphine is the gold-standard treatment for OUD.”<sup>3</sup> The U.S. Substance Abuse  
8 and Mental Health Services Administration (SAMHSA) provides multiple resources about  
9 buprenorphine, including clinical and safety information, treating pregnant and postpartum individuals,  
10 potential for misuse, and safety considerations.<sup>4</sup> Because of its evidence-base, AMA advocacy has for  
11 years called for removing all barriers to buprenorphine for the treatment of OUD—including prior  
12 authorization reforms,<sup>5</sup> the x-waiver,<sup>6</sup> telehealth restrictions,<sup>7</sup> and dosage caps.<sup>8</sup>  
13

14 While prescriptions dispensed for medications to treat opioid use disorder (MOUD) have marginally  
15 increased in the past five years from 14.54 million to 16.05 million,<sup>9</sup> there remain millions of Americans  
16 who misuse illicit substances, prescription opioids and/or have untreated substance use disorder.<sup>10</sup> More  
17 than 78 million illicit fentanyl-containing pills and 12,000 pounds of fentanyl powder were seized by the  
18 U.S. Drug Enforcement Administration (DEA) in 2023.<sup>11</sup> The U.S. Centers for Disease Control and  
19 Prevention (CDC) advise that, “Powdered fentanyl looks just like many other drugs. It is commonly  
20 mixed with drugs like heroin, cocaine, and methamphetamine and made into pills that are made to  
21 resemble other prescription opioids.”<sup>12</sup>  
22

### 23 *“Safer Smoking”* 24

25 As a threshold matter, and discussed briefly below, the AMA does not support the concept of “safer  
26 smoking.” The issue of “safer smoking” in relation to the nation’s drug-related overdose and death  
27 epidemic, however, is a harm reduction concept that seeks to reduce the spread of infectious disease as  
28 well as support changes to injection drug use. The types of safer smoking supplies are often, “specific for  
29 each type of drug used, but generally includes a heat resistant pipe or foil, protective mouthpiece, tamp,  
30 screen, and lip protectant, all of which reduce heat-related injuries and infection risk.”<sup>13</sup> In addition to  
31 reducing injection drug use, proponents of safer smoking supplies also point to, “Smoking supplies  
32 distributed by harm reduction programs [that] are clean and safer than improvised items like aluminum  
33 cans, plastic tubes, steel wool, and light bulbs that can break easily or release toxic fumes.”<sup>14</sup> These  
34 supplies are typically considered illicit drug paraphernalia, and “Nearly all states penalize the possession  
35 and distribution of glass pipes and other devices used for smoking or inhaling illegal drugs.”<sup>15</sup>  
36

37 In addition to state law prohibitions against safer smoking supplies, federal law defines a wide variety of  
38 materials as illegal drug paraphernalia, including,  
39

- 40 (1) metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens,
- 41 permanent screens, hashish heads, or punctured metal bowls; (2) water pipes; (3)
- 42 carburetion tubes and devices; (4) smoking and carburetion masks; (5) roach clips:
- 43 meaning objects used to hold burning material, such as a marijuana cigarette, that has
- 44 become too small or too short to be held in the hand; (6) miniature spoons with level
- 45 capacities of one-tenth cubic centimeter or less; (7) chamber pipes; (8) carburetor pipes;
- 46 (9) electric pipes; (10) air-driven pipes; (11) chillums; (12) bongs; (13) ice pipes or
- 47 chillers; (14) wired cigarette papers; or (15) cocaine freebase kits.<sup>16</sup>  
48

49 Every state—except Alaska—has a drug paraphernalia law.<sup>17</sup> While state laws vary considerably, one  
50 distinction is that needles and syringes may still be considered drug paraphernalia, but they are allowed

1 for personal use in most states. Penalties for individuals convicted of possession or use of other drug  
2 paraphernalia can range from misdemeanors to felonies.<sup>18</sup>

## 3 4 DISCUSSION

### 5 6 *Decriminalization of Non-prescribed Possession and Use of Buprenorphine*

7  
8 While penalties vary, possession of non-prescribed buprenorphine—like other non-prescribed controlled  
9 substances—is generally considered a violation of state and/or federal law and can subject an individual  
10 to monetary penalties and/or imprisonment depending on the circumstances.<sup>19</sup> One of the key questions  
11 for this board report, however, is whether the benefits of using non-prescribed buprenorphine in certain  
12 circumstances outweigh the risks. The National Institute on Drug Abuse (NIDA) reports that, “most data  
13 suggest that the majority of buprenorphine and methadone misuse (use without a prescription) is for the  
14 purpose of controlling withdrawal and cravings for other opioids and not to get high.”<sup>20</sup> NIDA also points  
15 out low rates of diversion risk, illicit use, and emergency department visits related to buprenorphine.  
16 Research comparing buprenorphine-involved deaths compared to opioid-involved deaths during the  
17 COVID-19 pandemic found that, “actions to facilitate access to buprenorphine-based treatment for opioid  
18 use disorder during the COVID-19 pandemic were not associated with an increased proportion of  
19 overdose deaths involving buprenorphine; efforts are needed to expand more equitable and culturally  
20 competent access to and provision of buprenorphine-based treatment.”<sup>21</sup> The AMA has argued that  
21 individuals’ lack of access to buprenorphine is due to multiple factors, including stigma, and inadequate  
22 networks of addiction medicine physicians, psychiatrists, primary care and other physicians willing to  
23 prescribe buprenorphine. Access to buprenorphine is particularly problematic for racial and ethnic  
24 minorities.<sup>22</sup> The AMA and the AMA Substance Use and Pain Care Task Force has long urged that all  
25 efforts be taken to increase access to buprenorphine and other medications for opioid use disorder  
26 (MOUD). Decriminalization, however, is an issue of first impression for the AMA.

27  
28 Decriminalization of possession of non-prescribed buprenorphine for personal use already is occurring in  
29 the United States. Vermont became the first state in 2021 to specifically decriminalize possession of  
30 224 milligrams of non-prescribed buprenorphine for personal use.<sup>23</sup> Initially enacted as a two-year pilot,  
31 after positive reviews that the bill helped increase access to buprenorphine among people who use drugs  
32 (PWUD) and also increase access to other forms of treatment, the Vermont Legislature made the  
33 exemption permanent in 2023.<sup>24</sup> Rhode Island also decriminalized buprenorphine in 2021 by amending its  
34 criminal code.<sup>25</sup> Another state example is when Oregon, in 2020, effectively decriminalized a wide range  
35 of drugs for personal use, including Schedule III Controlled Substances.<sup>26</sup> It is not clear whether this has  
36 increased access to buprenorphine in Oregon, but a report from the Oregon Judicial Department did not  
37 cite “buprenorphine” for any of the new “Class E” violations.<sup>27</sup>

38  
39 Multiple studies have found the mortality risk of buprenorphine is low. This includes retrospective  
40 mortality reviews showing how buprenorphine-involved mortality was commonly part of polysubstance  
41 use.<sup>28</sup> In a study of Medicare beneficiaries, “Buprenorphine treatment after nonfatal opioid-involved  
42 overdose was associated with a 62% reduction in the risk of opioid-involved overdose death.”<sup>29</sup> A review  
43 of COVID-19-era opioid-involved overdose deaths found that “buprenorphine was involved in  
44 2.6 percent of opioid-involved overdose deaths during July 2019 to June 2021”—a rate that “did not  
45 increase” even as rates of overdose overall increased.<sup>30</sup> Commentators suggest that while there are some  
46 risks to using non-prescribed buprenorphine, there are many benefits, including overcoming barriers that,  
47 “extend across socioeconomic, bureaucratic, and stigmatizing lines and include unemployment, insurance  
48 status, buprenorphine waiting lists, and most importantly, knowledge and physical access to providers  
49 who can and want to prescribe buprenorphine.”<sup>31</sup> The Board of Trustees acknowledges that use of  
50 nonprescribed buprenorphine carries risks, but views the available evidence as mitigating in support of

1 doing all that is necessary to reduce health inequities and save lives from an opioid-related overdose,  
2 including decriminalizing the personal possession and use of nonprescribed buprenorphine.

3  
4 *“Safer Smoking” as a Harm Reduction Measure*

5  
6 The AMA has supported a broad range of what are generally considered “harm reduction” measures. This  
7 includes support for laws and other policies encouraging prescribing, distribution, and use of naloxone  
8 and other opioid-overdose reversal agents. The AMA also supports broad Good Samaritan protections to  
9 provide civil and criminal protections for individuals at the scene of an overdose event. The AMA further  
10 supports the same protections for individuals who overdose. AMA policy also supports harm reduction  
11 centers (also called overdose prevention sites), as well as the ability for syringe services programs (SSPs)  
12 to provide sterile needles and syringes to help stem the spread of blood borne infectious disease. While  
13 there will always be detractors and stigma, these harm reduction measures have been well-studied and  
14 have been shown to help reduce mortality and improve health outcomes. It is beyond the scope of this  
15 report to detail all the research for these measures, but it is important to highlight that each (to different  
16 degrees) has largely overcome stigma in the medical community. The Board of Trustees acknowledges  
17 that stigma remains a considerable barrier for SSPs and harm reduction centers.

18  
19 Injection drug use continues to be a major public health issue. A Centers for Disease Control and  
20 Prevention (CDC) study found that nearly 3.7 million people in the United States injected drugs in  
21 2018—a 5-fold increase from 2011.<sup>32</sup> The study also found that more than 42 percent of overdose deaths  
22 were from injections. Another CDC report found that, “During 2013–2017, reported methamphetamine,  
23 injection drug, and heroin use increased substantially among women and heterosexual men with [primary  
24 and secondary] syphilis.”<sup>33</sup> Injection drug use may also result in the spread of skin and groin infections,  
25 Hepatitis C, bacterial endocarditis, osteomyelitis, and other preventable health conditions.<sup>34</sup> Prevention of  
26 the spread of blood-borne infectious disease is one of many reasons the AMA strongly supports broad  
27 access to sterile needle and SSPs.

28  
29 AMA support for SSPs, however, has been based on the strong evidence-base for SSPs. We raise the  
30 question, therefore, whether the evidence supports increased use of safer smoking supplies (as defined  
31 above), including decriminalization of such supplies. A 2023 descriptive review of 550 PWUDs found  
32 that there was limited access but high interest in obtaining safer smoking supplies for heroin, crack  
33 cocaine, and methamphetamine.<sup>35</sup> The authors were clear about the study limitations but highlighted other  
34 research suggesting that obtaining safer smoking supplies could reduce injection drug use. A recently  
35 published meta-review of global practices reported that, “Ten studies found that when people who use  
36 drugs were provided with safer smoking materials, they engaged in fewer risky drug use behaviors (e.g.,  
37 pipe sharing, using broken pipes) and showed improved health outcomes.”<sup>36</sup> The authors concluded that,  
38 “safer smoking practices are essential forms of harm reduction,” but that “Additional research is also  
39 needed to evaluate the efficacy of and access to safer smoking services, particularly in the U.S. and other  
40 similar countries, where such practices are being implemented but have not been empirically studied in  
41 the literature.” We agree that more research is necessary.

42  
43 It is also important to emphasize that additional research into the potential benefits of any harm reduction  
44 measure in no way condones or supports the use of illicit drugs or other substances whether through  
45 injection, inhalation, or other routes of administration. The Board of Trustees notes that while reductions  
46 in injection drug use should be considered positive, it is deeply concerning that it may be accompanied by  
47 increases in smoking illicit fentanyl.<sup>37</sup> We agree with comments from addiction psychiatrists such as, “I  
48 do not know that we are at a place where we can say, ‘Hey, maybe you should smoke it instead,’” and “It  
49 would be hard for me to feel confident in recommending that to somebody.”<sup>38</sup> Further, it must be stressed  
50 that there is no such thing as “safer smoking” of fentanyl, cannabis, tobacco or illicit substances, and also  
51 stressed that smoking fentanyl carries significant risks, including overdose and death.<sup>39</sup> Similarly, the

1 Board of Trustees believes that while there may be some evidence showing reduced harms associated  
2 with smoking fentanyl and certain safer smoking supplies as compared to injection use, there is a clear  
3 need for much more research before the AMA spends its resources and puts its public health and science  
4 credibility on the line.

5  
6 *Decriminalization of Fentanyl Test Strips*  
7

8 This resolution also calls for the AMA to support the decriminalization of fentanyl test strips. It is critical  
9 to note that this ask is redundant as AMA policy already effectively accomplishes this. Specifically, our  
10 policy states that, “Our AMA will: advocate for the removal of fentanyl test strips (FTS) and other testing  
11 strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl  
12 or other adulterants from the legal definition of drug paraphernalia.” (Policy D-95.987, “Prevention of  
13 Drug-Related Overdose”) The AMA has advocated for this at the state and federal levels<sup>40</sup> and  
14 encourages all medical societies to support legislation to implement this important policy. In this regard,  
15 we appreciate the opportunity to highlight AMA advocacy and conclude that existing policy (and  
16 subsequent advocacy measures) already meet the intent and purpose of the resolution.  
17

18 **AMA POLICY**  
19

20 Extending AMA policy to support decriminalization of non-prescribed buprenorphine for personal use  
21 would become part of a broad and growing policy base supporting increased access to buprenorphine and  
22 other MOUD. Policies in this family include:  
23

- 24 • Policy H-420.970, “Treatment Versus Criminalization - Physician Role in Drug Addiction During  
25 Pregnancy;”
- 26 • Policy H-95.956, “Harm Reduction Through Addiction Treatment;”
- 27 • Policy H-430.987, “Medications for Opioid Use Disorder in Correctional Facilities;”
- 28 • Policy H-290.962, “Medicaid Substance Use Disorder Coverage;”
- 29 • Policy H-320.941, “Eliminate Fail First Policy in Addiction Treatment;”
- 30 • Policy H-95.944, “Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy;”
- 31 • Policy D-95.955, “Improving Access to Post-Acute Medical Care for Patients with Substance Use  
32 Disorder (SUD);” and
- 33 • Policy D-95.972, “Expanding Access to Buprenorphine for the Treatment of Opioid Use  
34 Disorder.”  
35

36 It bears repeating that the Board of Trustees strongly supports the provision of MOUD to occur within a  
37 medically supervised and physician-led environment. We also recognize that given the innumerable  
38 barriers to such care, combined with the clear benefits of increasing access to buprenorphine, calling for  
39 decriminalization of non-prescribed buprenorphine for personal use is necessary to help reduce harms,  
40 including overdose and death.  
41

42 AMA policy already supports efforts to increase access to a broad range of harm reduction initiatives:  
43

44 Our AMA will advocate for and encourage state and county medical societies to advocate  
45 for harm reduction policies that provide civil and criminal immunity for the possession,  
46 distribution, and use of “drug paraphernalia” designed for harm reduction from drug use,  
47 including but not limited to drug contamination testing and injection drug preparation,  
48 use, and disposal supplies. (Policy D-95.987, “Prevention of Drug-Related Overdose”)  
49

50 It is reasonable to conclude, therefore, that this policy helps inform AMA support for SSPs, public

1 availability of sharps disposal units, and other areas. For example, AMA support for SSPs can be found  
2 here:

3  
4 . . . encourages the extensive application of needle and syringe exchange and distribution  
5 programs and the modification of restrictive laws and regulations concerning the sale and  
6 possession of needles and syringes to maximize the availability of sterile syringes and  
7 needles, while ensuring continued reimbursement for medically necessary needles and  
8 syringes. strongly supports the ability of physicians to prescribe syringes and needles to  
9 patients who inject drugs in conjunction with addiction counseling to help prevent the  
10 transmission of contagious diseases. (Policy H-95.954, “The Reduction of Medical and  
11 Public Health Consequences of Drug Use”)  
12

13 Finally, as discussed above, the evidence base for SSPs has been demonstrated. In contrast, the evidence  
14 base in support of safer smoking supplies has not. The Board, therefore, urges increased research as it  
15 relates to the latter.  
16

### 17 RECOMMENDATIONS

18  
19 The Board of Trustees recommends that the following new policy be adopted in lieu of Resolution 204,  
20 and that the remainder of the report be filed.  
21

- 22 1. That the American Medical Association (AMA) support efforts to decriminalize the possession  
23 of non-prescribed buprenorphine for personal use by individuals who lack access to a physician  
24 for the treatment of opioid use disorder; (New HOD Policy)
- 25 2. That the AMA oppose the concept, promotion, or practice of “safe smoking” with respect to  
26 inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy)
- 27 3. That the AMA encourage additional study whether “safer smoking supplies” may be a potential  
28 harm reduction measure to reduce harms from the nation’s overdose and death epidemic; and  
29 (New HOD Policy)
- 30 4. That the AMA reaffirm Policy D-95.987, “Prevention of Drug-Related Overdose.” (Reaffirm  
31 AMA Policy)

Fiscal Note: Less than \$500.

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