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**The Ethics of Harm Reduction**

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**Abstract**

The paper attempts to set harm minimization within drug settings into a larger framework of harm minimization practices. It seeks to provide a plausible account of harm reduction and then explores four ethical challenges for harm reduction strategies.

**Keywords:** bottom line, code of ethics, delivery conditions, harm reduction, permissible strategies, reduction of harm, socially-contested, value-neutrality, voluntary v. mandatory.

*Introduction*

In 2000, while he was Governor of Texas, but in the process of campaigning for the American Presidency, George W. Bush had these remarks to make:

> *I do not favor needle exchange programs and other so-called "harm reduction" strategies to combat drug use. I support a comprehensive mix of prevention, education, treatment, law enforcement, and supply interdiction to curb drug use and promote a healthy, drug-free America, not misguided efforts to weaken drug laws. Drug use in America, especially among children, has increased dramatically under the Clinton-Gore Administration, and needle exchange programs signal nothing but abdication, that these dangers are here to stay. Children deserve a clear, unmixed message that there are right choices in life and wrong choices in life, that we are all responsible for our actions, and that using drugs will destroy your life. America needs a President who will aim not just for risk reduction, but for risk elimination that offers people hope and recovery, not a dead-end approach that offers despair and addiction.*[1]

Although Bush's remarks were focused specifically on needle and syringe programs, he saw his criticisms as applying more generally to "harm reduction" – sometimes called "harm minimization" – policies. Such policies remain anathema in the federal American context, though there have been a fair number of cautious local initiatives to introduce them. Nevertheless, at the federal level, there is so much antipathy to harm reduction in the drug field that – in an email I received late last year – a major US drug researcher informed me that if she wants funding from the National Institute on Drug Abuse (NIDA), her proposals can neither use the phrase nor employ the concept of harm reduction (except, perhaps, by way of critique).

[1] George W. Bush, *Response of Governor George W. Bush to the AIDS Foundation of Chicago* (2000): <http://www.aidschicago.org/pdf/GWB_response.pdf>. It is of course arguable that even Bush was in favour of harm reduction or harm minimization, even if he talks about harm elimination as though it is a higher road. But the term has come to have a narrower use and it is that to which my comments are here directed.

*The scope of harm reduction*

The most common context for speaking of harm reduction policies has been that in which the use of – or, often, "dependency" on – illicit drugs such as heroin or cocaine, or licit ones such as alcohol and tobacco, is involved. Harm reduction policies have therefore encompassed things such as needle and syringe programs, prescription heroin, random breath testing of drivers, bans on smoking in public buildings and the use of nicotine patches. But the phrase has also come to be used more broadly to encompass policies or strategies that are designed to reduce the risks or harms associated with other *socially contested practices* (such as gambling, adolescent or gay sex, or prostitution). Thus, responsible gambling programs, condom distribution to high school students or prisoners, compulsory medical checkups for sex workers, and specialized shelters for homeless LGBT youth are usually seen as harm reduction strategies.

The most recent – and at first blush, most surprising, and now doomed[2] – American example was an executive order signed early this year (2007) by Texas's Republican governor, Rick Perry, mandating that from September 2008, all girls entering sixth grade (11-12) be vaccinated with Gardasil, a patented compound that protects women from several strains of human papilloma virus (HPV) thought to be most closely associated with the incidence of cervical cancer. Since HPV is transmitted only sexually, the underlying assumption was that because a significant number of adolescents were likely to engage in sexual activity, they should at least be protected from one of its more serious possible outcomes. The outcry that followed Perry's executive action has made it unlikely that his order will survive, though in the subsequent debate it has been revealed that about 30 other states have been considering making Gardasil available to school children, and some have already begun them. Virginia is the only other state with a compulsory program, though it has incorporated a parental opt-out clause. New Hampshire has a very popular program that is voluntary and free. One of the reasons for controversy in the U.S. was the fact that Merck, its American manufacturer, lobbied intensively for the vaccine's availability and use.[3] Perry's case, though, illustrates how moral and ethical factors can figure in the success or otherwise of harm reduction initiatives. A measure that might have succeeded failed because prevailing moral views were marginalized for the sake of an end.

Perhaps the most interesting example of harm reduction is one that does not get paraded as such, for it is sponsored by those who are normally opposed to harm reduction policies.[4] Nevertheless, it satisfies all the central criteria for harm reduction. A few years ago, the Snowflakes Frozen Embryo Adoption

[2] On April 25, 2007, the Texas legislature voted 135-2 to bar the vaccinations until 2011. Perry's political mistake was to attempt – for motives that appeared suspect – an end run round the legislature and to make it compulsory.

[3] In Australia voluntary programs already exist. See Chee Chee Leung, "Vaccine Steps Up the Cancer Fight," *The Age* (Melbourne), April 17, 2007. Programs are also underway in some European Union countries and are likely to be initiated elsewhere.

[4] It shows, I think the extent to which the phrase has been politicized.

Program was initiated in the United States. Vigorously supported by President Bush, the program's participants – usually conservative Christians – engage in the implantation of "left over" embryos from in vitro fertilization (IVF) programs. Although the volunteers and their supporters are often opposed to IVF on moral/religious grounds, and particularly to the use of donors, they believe that it is better (i.e., more harm reductive) to "adopt" unused embryos than to dispose of them or use them in embryonic stem cell research.[5]

*What is harm reduction?*

So much for some of the background. What I want to do in this brief talk is first to look at the somewhat fuzzy notion of a harm reduction policy and then to isolate and review some of the ethical questions to which harm reduction gives rise. However, I don't want to focus especially (or exclusively) on the ethical questions as they are perceived by those who are ideologically opposed to harm reduction policies,[6] I am more interested here in some of the ethical questions that must be confronted by those who are generally supportive of them.

The concept of harm reduction or harm minimization is not a precise one. The phrase is so imprecise, in fact, that it has sometimes been exploited by those who oppose harm reduction policies, and used to characterize their own agendas and policies. The outlawing of contested practices and incarceration of those who engage in them is put forward as harm reducing. To avoid this conceptual cannibalism, some writers have therefore made a distinction between the "reduction of harm," understood to be "any measure which decreases the negative consequences of drug use" and "harm reduction," which is reserved for "those specific measures which prevent the baleful consequences of drug use without setting out to achieve this by interfering with drug consumption."[7] By contrast, opponents of harm reduction often see it as a public relations dummy for drug legalization. That, too, has been disavowed by many proponents of harm reduction, though altered drug-associated policies might not be incompatible with – and some would argue that they are supportive of – drug legalization (or at least decriminalization).[8]

Although the term "harm reduction" is only about 20 years old and was introduced as a convenient shorthand in drug user treatment circles, it was not initially provided with any scientific precision. Nor was it introduced to characterize something that came into being only in the 1980s. The concept had mid-twentieth-century precursors in responses to alcohol use ("making

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[5] See Pam Belluck, "From Stem Cell Opponents, an Embryo Crusade," *New York Times*, June 2, 2005. For the program's web site, see <http://www.nightlight.org/snowflakeadoption.htm>.

[6] For an attempt to address such arguments, see David Buchanan, Susan Shaw, Amy Ford, & Merrill Singer, "Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange," *Journal of Public Health Policy* 24, nos. 3-4 (2003): 427-44.

[7] Alex Wodak and Bill Saunders, Editorial, "Harm Reduction Means What I Choose It to Mean," Special Issue on Harm Reduction, *Drug and Alcohol Review* 14 (1995): 269.

[8] See, for example, Eric Single, "Defining Harm Reduction," *Drug and Alcohol Review*, 14 (1995): 289-90.

the world safe for drunks") and tobacco smoking (the promotion of chewing tobacco, snuff) before it came to be used to characterize efforts to counteract the communication of HCV and HIV/AIDS through shared drug paraphernalia and gay sex. Harm reduction has an even earlier exemplification in the nineteenth century publication of the Queensberry rules in boxing (1867). No doubt other examples could be provided. Nevertheless, the concept is contested, reflecting an ongoing debate, and is still developing.

So let me begin with some of its less controverted elements before moving onto those that are more contestable.

(1) Although it strictly need not be, harm reduction usually refers to *public policy or publicly supported practices*. This at least is the context in which it raises most controversy. For it usually involves the use or expenditure of public resources and, as should normally be the case, is therefore something for which those who expend the resources should be held accountable. Because it is practised in the public domain, it is appropriately subject to public scrutiny. Required resources may range from educational programs (such as "designated driver" campaigns) to legally mandated conduct (such as the promulgation and enforcement of seat belt laws.

(2) Harm reduction is *aimed at lessening (reducing, minimizing) the amount of harm risked and, ultimately, caused by certain practices*. The harms at issue will vary with the practice, though there is some agreement that they are or would be disproportionate to the practices. There is, however, some ambiguity about the identification and subject(s) of the relevant harms. One or all of three subjects of harm may be intended: (i) specified or general harm to the individual who is engaged in the purportedly risky or harmful activity; (ii) harm to others who may be affected (directly or indirectly, immanently or more distantly) by those who engage in that activity; and (iii) social cost – whether loss of productivity on the part of those harmed and/or social expenditures involved in treating those whose harms have been exacerbated by the activity. As I'll suggest later, harm reduction can become ethically problematic when the focus is disproportionately on one of these to the neglect of others. As well, people can differ significantly in what they count as relevant harms.

(3) Harm reduction is *generally centered on activities or practices that are socially contested/contestable*. What I mean by that is that the harmful or risky behaviour that generates harm reduction policies is usually the object of significant – though not universal – social controversy or disfavour. But there is a bit of slippage here. Some vehicle accidents will occur whether or not drivers speed or drive recklessly; nevertheless, since a large number of vehicle accidents are associated with speed, negligence, or recklessness, it is not unreasonable to think of the introduction of mandatory seat belt and safety helmet legislation in the 1960s as a harm reduction measure. Indeed, when introduced, they attracted one of the most common objections now made against needle and syringe programs, namely, that they would encourage greater risk-taking: a driver using a seat belt would feel less vulnerable and therefore take greater risks on the road. That anti-harm reduction conservatives do not usually cast their net so widely as to include seat belts

and safety helmets indicates the extent to which harm reduction has become politicized.

At this point, the concept, however, becomes much more problematic.

(4A) Some argue – and put it forward as part of the concept as well as a virtue of harm reduction – that it is *an ethically and even value-neutral approach to socially contested behaviours*. In a major contribution to the discussion, Erickson et al. assert that harm reduction takes a value-neutral approach to both drug use and drug users (though of course in the present context we might want to include other activities along with "drug use and drug users").[9] And even among those who reject this as too unqualified are those who argue "against the call for harm reduction to become more openly morally invested." Keeping moral and other values on the margins *as much as possible* is seen as a "powerful rhetorical intervention in the highly moralised landscape of drug debate."[10]

But what is meant by the ethical/value neutrality of harm reduction? Is it possible and, even if it is not, should we at least aspire to it?

The claim to neutrality may mean a number of things.

(a) One is that *harm reduction is a purely technocratic*[11] *strategy*; that is, harm reduction policies are focused exclusively on providing an effective means for securing a sought end. Just as hammers are effective for pounding in nails, distributing needles and syringes and mandating the use of seat belts effectively reduce the transmission of aids and the seriousness of vehicle accident injuries respectively. Such policies make no judgments about either the means or the ends beyond those concerning the effectiveness of the means in securing the ends.

But that can hardly be correct. For, at the most general level, whenever we act in a way that implicates the interests or well-being of others, our activity will have moral or ethical significance. Morality underpins our most ordinary interactions – that is why civility and politeness are so important. Moreover, and more specifically, advocates of harm reduction strategies argue not merely that they work, but that the fact that they work is a good thing. The implicit point is that harm (however identified) is something to be avoided or minimized and that – at least prima facie – a strategy that avoids or minimizes harm will be a good thing. It is not therefore the concern with strategic effectiveness that constitutes value neutrality, for the strategic effectiveness is embedded in ends that are implicitly valued.

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[9] Patricia G. Erickson, Diane M. Riley, Yuet W. Cheung, and Patrick A. O'Hare (eds), "Introduction: The Search for Harm Reduction," *Harm Reduction: A New Direction for Drug Policies and Programs* (Toronto: University of Toronto Press, 1997), 8.
[10] Helen Keane, "Critiques of Harm Reduction, Morality and the Promise of Human Rights," *International Journal of Drug Policy*, 14 (2003): 27.
[11] Sometimes the term used is "pragmatic" – though this is less obviously neutral.

What is more, there are quite stringent requirements associated with means-end reasoning, at least when people are involved. *Pace* John Strang et al., not anything will go, even if the end is the reduction of harm and the means are effective.[12] The side effects of a policy must be taken into account, and even if these might themselves be considered harms to be included in the equation, they are not always the harms that advocates of harm reduction have in mind. Thus, relevant harms might be thought to include the harms of greater participation in the risk-bearing activity or sending an inappropriate social message. Moreover, the harm reduction strategy may be intrinsically unacceptable (that is one of the problems with draconian penalties). At a secondary level, there are various risks and harms associated with the research necessary to determine whether the harm reduction equation is as it is purported to be.[13]

The value-laden implications go even deeper than this. They are not limited to the banality that the diminution of harm is a good thing. For what constitutes harm is itself deeply infused by evaluative and ethical considerations. A superficial review of harm reduction strategies might suggest that the relevant harms to be reduced or minimized can be easily identified: unwanted pregnancies, HIV/AIDS, cancer, and the social costs of dealing with them, might be seen as the obvious harms that are minimized. Merely reciting them is sufficient not only to make their minimization a good thing, but also to constitute their minimization a minimization or reduction of harm. But the identification and weighting of harms is infused with normative judgments and fraught with controversy, albeit often of the kind that avoids the careful exploration of assumptions. Defenders of the Snowflakes program consider that "embryo adoption" is patently less harmful than embryo destruction, and those who support the distribution of condoms to teenagers consider that the amount of harm caused by unwanted pregnancies or transmission of STDs is less than that involved in premarital sex, in the erosion of parental authority, or in the failure to send a clear moral message. More radically, some think that the harm to civil liberties involved in the criminalization of drug use or other contested practices is a greater harm than those eventuating from engaging in them. I don't want to argue that these are simply matters of opinion in some relativistic sense. But they point to the fact that the identification of certain behaviours as harmful either in themselves or because of their consequences, and the determination of how harmful they are is a matter of some controversy. Whatever else they are, harm reduction policies are not value neutral.

(b) Another possible interpretation is that harm reduction policies consider that the *underlying behaviour is value or ethically neutral*. That is, such policies do

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[12] "Harm reduction policies and practices (where anything goes, if it actually reduces harm) have fundamentally altered our approach to the drugs problem." John Strang and Rudi Fortson, "Commentary: Supervised Fixing Rooms, Supervised Injectable Maintenance Clinics – Understanding the Difference," *British Medical Journal*, 328 (10 January, 2004): 102.

[13] See Craig L. Fry, Carla Treloar & Lisa Maher, "Ethical Challenges and Responses in Harm Reduction Research: Promoting Communitarian Ethics," *Drug and Alcohol Review* 24 (September, 2005): 449-59; AIVL, *National Statement on Ethical Issues for Research Involving Injecting/Illicit Drug Users* <http://www.aivl.org.au/files/EthiicalIssuesforResearchInvolvingUsers.pdf>.

not take themselves to be merely technical tools for harm minimization, but regard the behaviour that has made them necessary as ethically neutral. This is not an impossible position, though I think it highly implausible. It might be argued that whether or not a particular form of behaviour has a determinate value is a function of the context in which it occurs and is not intrinsic to the activity itself. Thus drugs that are ingested in medical contexts are fine, as is sexual conduct that expresses the affection of those who engage in it.

But even if the central premise of this position is accepted, it is not likely to persuade those who are troubled by such strategies, for they will argue – and often with good reason – that the contexts in which the high risk behaviour occurs *are* especially those in which it is ethically questionable rather than value neutral. Moreover, even if they are wrong about that, those who claim that the behaviour is value neutral will bear some of the burden for arguing that behavioural contexts that call forth harm reduction policies are those in which the behaviour in question is value neutral. Wherever behaviour impacts on human interests, it is a candidate for evaluation, and it does not help the cause of harm-reduction advocates to ignore this or to prescind from the debate about whether the impacted interests are deleteriously affected or on balance advanced.

(c) What I think is probably intended most often when it is said that harm minimization policies are value or ethically neutral is that *such policies involve no ethical judgment on the underlying behaviour that causes or risks harm apart from the fact that it risks significant harm.* Such policies, it is claimed, make no judgment about adolescent sex or smoking or drug use or driving in certain ways. All that they do is affirm that the harms that are risked or caused by such practices, including any harms that might be involved in the practices themselves, will be reduced or minimized by such policies – whether they are condom distribution or needle and syringe exchange programs, seatbelt laws, or promotions of smokeless tobacco or nicotine patches.

But if that is what is meant, it is only contingently and contentiously the case that harm reduction policies are value neutral. Many defenders of harm reduction programs make a point of arguing that what they are advocating does not involve a condonation of the underlying behaviours and, moreover, that their policies are unlikely to result in any appreciable increase in the activities in question. Indeed, they generally concede that were particular harm reduction policies to result in a significant increase in the contested behaviours, then, even if they resulted in less overall harm, this would constitute a significant objection to or at least problem for those policies (though not necessarily all harm reduction policies). The point, I think, is not that harm reduction policies are value neutral but that they see the disvalue of the harms that are prevented or minimized by such policies as outweighing the harms – whatever they might be – of the underlying behaviours. In other words there is a judgment about the relative weight that different harms are to be accorded, and that the manifest harms prevented by harm reduction policies make them preferable to whatever the status quo without such policies may be.

Again, I am not arguing that these differences about what the relevant harms are and how they are to be weighted are simply matters of opinion; I am claiming only that presenting the issue as one of the value or ethical neutrality of harm reduction is misleading. There are rival contenders for the harms at stake and we do better to confront the rivalry than to argue that harm minimization avoids it. In the debate that followed Rick Perry's executive order, there was considerable discussion of the effects that it would have as well as whether it would minimize or reduce harm. Some pointed to the risks of vaccination, the need for booster shots, the epidemiology of cervical cancer, its treatability, the authority of parents over their children, the problems of adolescent sexuality, the validity of studies of Gardasil's effects, the social message it conveyed, the political manipulation, and the power of lobbying by drug firms. All of these questions need to be thought through by proponents of harm minimization, not just those pertaining to the validity of their central claims. Social policy in a liberal democratic society is not a one issue matter. In addition, what has become fairly clear in the Texas debate, and is also clear in a number of other cases – though I don't think all – is that significant questions were raised about the weighting and commensurability of harms. That is a deep and abiding philosophical issue. I would of course also agree that a fair bit of the debate has arisen from set positions, unlikely to be dislodged by argument. But I don't think that's a reason not to address them, even though it is a debate that is deeply infused by normative assumptions.

(d) But even if neutrality is not possible, should we be pushing for as much neutrality as possible – seeing harm reduction as a *pragmatic* strategy rather than as one that draws explicitly on moral perspectives. Helen Keane – following Kane Race – argues that "suspension of moral judgement combined with the objective of protecting health gives harm reduction unique critical leverage when faced with governmental strategies which allow moral qualification to obstruct the duty to provide care."[14]

I think I understand Keane's point, and I appreciate the political shrewdness it appears to show, but, as I will suggest very soon, I think it is inadequate. To the extent that it delivers something rather than nothing, it has much to be said for it, and may be what one has to settle for within a particular – though shifting – political environment. But it does not deliver nearly enough, and we should not try to avoid a moralised landscape just because it is not ours or the dominant one. Moral perspectives are not optional even though they have become politicised: they are integral to what we are about whenever we advocate policies or practices that impinge on others' interests. Although we may continue to use pragmatic arguments, they must be sustained by and supplemented with moral argument, even if only moral argument about pragmatic arguments. And that is simply because, as humans, moral argument constitutes the basic currency of our interpersonal relations, whether these operate directly or are mediated by institutional policies and

[14] Helen Keane, "Moral Frameworks, Ethical Engagement and Harm Reduction: Commentary on 'Ethical Challenges and Responses in Harm Reduction Research: Promoting Communitarian Ethics.' By C.L. Fry, C. Treloar & L. Maher," *Drug and Alcohol Review*, 24 (November 2005): 551, citing Kane Race, "Drug Spectacles: Purging the Nation," paper presented at the 1st International Conference of Asian Queer Studies, Bangkok, July 2005.

practices. If we do not like the morality that dominates our current social landscape, it is important that we understand it and the assumptions that inform it as a basis for its critique.

In fact I believe that Keane is probably incorrect about the wisdom of being as neutral as possible, though strategy of this kind may work better in a country such as Australia, which has somewhat more pragmatic and less moralistic traditions than in the United States. But in the latter, as Buchanan et al. have detailed, many efforts to introduce needle and syringe programs have failed precisely because "advocates of needle exchange tend to define the issue strictly as an empirical, scientific matter, whereas opponents define the question primarily as a normative, ethical one."[15] Harm reduction must be advocated on moral grounds and not simply as strategy to prevent certain undesirable outcomes. The complaint about such programs sending a mixed moral message must be addressed, for public policy is not simply a function of what works but of how a community chooses to live out its collective life.[16]

(4B) Rather than talking about the value or moral neutrality of harm reduction, I think it is better to say of harm reduction policies that *benefiting from their strategies is not made conditional on abstinence from the underlying behaviours*. Although some harm reduction strategies involve a modified engagement with the underlying behaviour or condition, forsaking the contested behaviour is not demanded as an eligibility condition for benefiting from the harm reducing measures. That itself involves an ethical judgment, a judgment about the priorities we should adopt in a particular social context, a judgment, moreover, that may be backed up by good or poor, relevant or irrelevant, reasons.

It is this condition that distinguishes harm reduction as an emerging strategy from approaches that seek to reduce harm by suppressing the risky behaviour that threatens such harm. This is quite apart from the skepticism we may have about their effectiveness as harm-reducing strategies.[17]

This alternative formulation leaves it open to those who are involved in the implementation of harm reduction strategies to associate those strategies with the possibility for and maybe even the encouragement of lifestyle or other decisions that will eventually result in abstinence or at least some measure of recovery. Syringe and needle programs may thus provide gateways into treatment programs for those who wish them. However, insofar as such options exist, they will not be offered in a way that alienates those for whom the harm reduction measures are intended from availing themselves of them.

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[15] Buchanan, Shaw, Ford, & Singer, "Empirical Science Meets Moral Panic," 430. Much is said about sending clear and unambiguous moral messages.

[16] I will not pursue such issues here. I have, however, endeavoured to address some of them in "Thinking Ethically about Needle and Syringe Programs," *Substance Use and Misuse*, 41 (6/7) (May 2006), 817-28.

[17] Those who are antagonistic to harm reduction in the sense that we are considering it here have often claimed to be doing more for harm reduction by suppressing the underlying behaviours. Although the almost draconian measures sometimes used in the United States have given the lie to this hope, what is almost always left out of account in such claims are the harms of suppression (the lives permanently disrupted by incarceration).

(This assumes of course that the harm reduction measure is a voluntary one and not mandated – an issue to which we will return.)

*Ethical challenges for harm reduction policies*

Let us suppose that, taking everything into account – the quantifiable harms to various parties as well as the less tangible harms that may be involved, such as the underplaying of a moral message, undercutting of parental authority, or even paternalism – we decide that it is better to have rather than not have a harm reduction policy. That is not the end of the ethical issues. Harm reduction confronts as many ethical issues in the matter of its delivery as in the determination of whether to support it. I mention four interlocking areas of contention. There are probably more.

(1) *Focusing on the "bottom line."* Harm reduction and harm minimization might seem to be unexceptionable social policies. Given that harm is an evil, and given again that we can agree about what constitute harms, it would seem clear that any policy directed to reducing or minimizing harm would be something about which we could wholeheartedly agree. But it is not as clear-cut as that. My suspicions about current harm minimization policies were triggered a couple of years ago when I was invited to speak at an Anex conference in Melbourne on the ethics of needle and syringe programs. One of the things that puzzled me as I prepared was why, given what I understood to be the present Australian government's general attitude to drugs, it should nevertheless have been willing to provide some support, albeit grudging, to needle and syringe programs. The situation was clarified considerably by a supportive 2002 Report titled *Return on Investment in Needle & Syringe Programs in Australia* that was produced for the Commonwealth Department of Health and Ageing.[18] The report's thrust was simple. Needle and syringe programs minimize harm in the sense of minimizing social cost, where this was construed as a balancing of the economic costs of needle distribution against the economic costs of caring for those who contract AIDS or hepatitis C. The balance, the report argued, strongly favoured of the cost-effectiveness of NSPs.

*Politically*, such an argument made good sense. It was cast in terms of reasons designed to "win over" those who might otherwise have been persuaded by moralistic considerations into opposing them. And it is an argument that those who administer needle and syringe programs might well have been willing to accept as a strategy for securing resources from an otherwise unsupportive provider. Nevertheless, I found the argument *ethically* disturbing in its symbolism as well as its effects.

The focus of the Report was not the plight of those whose dependency may itself have been burdensome and, moreover, placed them at great risk of contracting painful, debilitating, and potentially fatal diseases; nor was it on

[18] Health Outcomes International Pty Ltd, in Association with The National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University, *Return on Investment in Needle & Syringe Programs in Australia* (Canberra, ACT: Commonwealth Department of Health and Ageing, 2002).

their more immediate needs for medical and other care. Instead, the Report's focus was on the bottom line – understood as the economic cost of having to devote medical and social resources to HIV/AIDS or HCV should they be contracted or communicated to others in the absence of needle and syringe programs. The concern was with taxpayer dollars and how their expenditure might be minimized or optimized, not with the human plight of those whose situation, coupled with social policies concerning drug use, in many cases forced them to engage in high-risk behaviour. At a superficial level, of course, there was *some* regard for those who were drug dependant and in danger of contracting HIV/AIDS or HCV, for they would be beneficiaries of such programs. But the concern expressed was not for their plight or health or suffering as human beings, with lives to be lived, assisted, and restored, but with the cost of their care to the wider tax-paying community. The symbolism was inappropriate, for the focus was economic and utilitarian, not humanitarian.

But not only was the symbolism inappropriate, so also were the effects. Needle and exchange programs were financed only to the extent that they were focused on the bottom line – that is, minimization of the major economic costs of drug use. The concern was not so much with the various ancillary services that might be offered as part of a needle and syringe program – services that would address the broader human needs of those who were drug dependant – but only with what would serve to secure those who were dependant against the contraction or communication of certain diseases that are very expensive to treat. If, as I think most of us do, we think that there is often something humanly diminishing about drug dependence, particularly in an environment of prohibition, then responsive programs – even harm reduction programs – ought to be funded and administered in ways that enable and maybe even encourage them to address the underlying issues and problems of dependence and not simply the transmissible harms that place a heavy burden on taxpayers. True, were we lacking evidence that needle programs offer a safe and more effective bridge to treatment than would exist in their absence, that might be a reasonable position to take. But that evidence is available and though I would not argue that needle programs lack moral justification when they fail to be responsive to the deeper problems of those who need their services, I think that their justification is much less compelling than it might be.

The point of this criticism, then, is not to disparage harm reduction or harm minimization as such but to observe how the relevant harms may be contracted or selected in such a way that harm minimization becomes an ethically defective policy.

(2) *Voluntary vs. Compulsory?* A further major ethical question concerns the nature of participation in harm reduction programs. Should it be voluntary or compulsory? The shift (in New York) from requesting that diners not smoke while eating to requiring that restaurateurs create separate smoking and non-smoking areas in restaurants, and from that to banning smoking altogether from restaurants occurred with more than a little grumbling – though it eventually succeeded as the argument shifted from considerations of the

comfort of non-smoking diners to concern about the effects of secondary smoke, not only on the health of other diners, but also on service personnel who had less choice about their work conditions.[19]

Rick Perry ordered the compulsory vaccination of Texas schoolgirls; most other states (and Australia) have considered it only as a voluntary measure. We now require smokers to move outside whereas we once only requested their desistance. The wearing of seat belts has now been made mandatory, although in some places only for those in the front seats, leaving it optional for those in the back.

Whenever harm reduction strategies are enforced there will be ethical questions about the encroachment on people's liberties – whether with respect to decisions about their own well-being (the paternalism issue) or the well-being of others – and risk to whom may need to be weighed against the liberty of those wish to act in certain ways. There will also be important subsidiary questions about the nature and extent of compulsion, the consequences for violators, and appropriate exemptions. (When motor cycle helmets were first introduced into the United Kingdom, vigorous Sikh protests eventually gained them an exemption.)

Whether or not to impose a harm reduction measure or provide it on a voluntary basis (and under what conditions) will almost certainly take into account several factors. We are generally reluctant about imposing on others practices that are designed for their own good – or at least their own good *as we see it*. We are reluctant to act paternalistically toward adults, who can be expected to have their own (more intimately understood) views about what constitutes their good, and who can usually be expected to take responsibility for the risks that they want to bear in pursuit of their varied goals.

There is a more complicated issue here than the simple one of coercion – that is, whether or not to impose a harm minimization strategy. There is also the matter of identifying and making available an appropriate harm-minimization strategy. We can also pressure people by limiting the harm minimization options they have. In the context of heroin use, there is the issue of syringe and needle programs. But these programs can be conducted in several different ways, each of which has its pros and cons. In addition, there is the question whether other strategies that might be adopted as well or even instead – such as safe injecting rooms, prescription heroin – should be added to the schedule of available options. Although our answers to these questions will need to draw heavily on empirical data (and there are enough ethical questions concerning the ways in which we may properly gather such data[20]), they also have an important ethical dimension.

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[19] See U.S. Department of Health and Human Services, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General* (2006) <http://www.surgeongeneral.gov/library/secondhandsmoke/>. A more recent example of a similar phenomenon has been the banning of trans fats from some commercially prepared foods. See <http://www.nyc.gov/html/doh/html/pr2006/pr093-06.shtml>.

[20] See Fry, Treloar & Maher, "Ethical Challenges and Responses in Harm Reduction Research." This gets us into another set of ethical issues. What has come to be favored as

Where potentially or partially paternalistic measures are involved, we need to ask whether and to what extent those who will be recipients of harm reduction strategies should be part of this discussion.[21] If we take it – as we generally do in liberal democratic theory – that those who are affected by social decisions should have some say in them, then efforts should be made to accommodate or at least take account of the voices of those who will be affected by them. But should similar considerations apply to those whose engagement in risky behaviour is associated with a dependency? Does their dependency disqualify them or does it, perhaps, make it even more important that they be involved in decisions concerning the harm-reductive policies that are canvassed?

We will also want to be reasonably sure that compulsion with respect to a harm reduction measure is effective. In the case of illicit activities such as drug use (leaving aside the question whether and when it should be illicit), compulsion is likely to be counterproductive. What is already conducted largely underground is likely to go further underground if attempts are made to enforce the harm reduction measures.[22] In the case of seatbelt and safety helmet laws, however, compulsion has generally worked (even though, as noted, such laws have been amended to permit certain exemptions).

Yet another consideration, potentially quite important, has concerned the effects of the risky or harmful activity on others. To the extent that innocents or bystanders are likely to be caught up in the risk-bearing or harmful activity, we need to fulfil our social obligations to them, and in certain cases that may be sufficient reason to compel certain practices. As noted earlier, growing evidence of the effects of passive smoking have in some places led to bans on smoking in public buildings, aircraft, and restaurants.

The debate over voluntary vs. compulsory harm reduction schemes also presses us to consider more deeply the kind of community of which we wish

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evidence-based medicine is not without its own ethical challenges. See Milos Jenicek, "Evidence-Based Medicine: Fifteen Years Later. Golem the Good, the Bad, and the Ugly in Need of a Review?" *Medical Science Monitor* 12, no. 11 (2006): RA241-51 <http://www.medscimonit.com/pub/vol_12/no_11/9683.pdf>.

[21] Some critics of harm reduction strategies see them simply as additional expressions of the surveillance state. See Peter G. Miller, "A Critical Review of the Harm Minimization Philosophy in Australia," *Critical Public Health*, 11, no. 2 (2001): 67-78. That is probably taking it too far. See Keane, "Critiques of Harm Reduction, Morality and the Promise of Human Rights," 231.

[22] Even the voluntary availability of harm reduction measures is hampered by drug prohibition laws. There needs to be some understanding between law enforcement and harm-reduction programs so that those who wish to avail themselves of such measures can do so without fear of apprehension or arrest. For related discussion, see A. Fraser and M. George, "The Role of the Police in Harm Reduction," in P.A. O'Hare, R. Newcombe, A. Matthews, E.C. Buning, and E. Drucker (eds), *The Reduction of Drug-Related Harm* (London: Routledge, 1992), 162-71; Duncan Chappell, Tjibbe Reitsma, Derek O'Connell, and Heather Strang, "Law Enforcement as a Harm-Reduction Strategy in Rotterdam and Merseyside," in Nick Heather, Alex Wodak, Ethan A. Nadelmann, and Pat O'Hare (eds.) *Psychoactive Drugs and Harm Reduction: From Faith to Science* (London: Whurr Publishers, 1993), 118-26; Keith Hellawell, "The Role of Law Enforcement in Minimizing the Harm Resulting from Illicit Drugs," *Drug and Alcohol Review*, 14, no. 3 (1995): 317-22.

to be a part as well as the ways in which we may legitimately treat those on the margins of our communities  When we look at how harmful behaviour is caused – who it is caused by and who it is caused to – and consider strategies for dealing with it, an important ingredient in developing those strategies should be some conception of the social environment we wish to foster, whether and how different strategies will contribute to that, and what the consequences will be for those who deviate from such expectations. The issue of resources will be relevant to this, but it is not the only thing that is relevant. In my own view, the libertarian vision of independent individuals who make and bear the responsibility for their choices is ultimately an inadequate one. We do not – and indeed should not – be restricted to the Victorian idea that those who have made their beds must now lie in them. And one important reason why we do not is that the so-called "independent individuals" of libertarian theory are never merely that. We are all products of a long period of nurture (sometimes adequate, sometimes inadequate) and continue to be interdependent even as we become more independent, and what is available to us in our increasing independence is quite importantly a function of the social environment in which our perceptions, learning, judgments, and choices normally take place. Whether we compel, what we compel, and how we compel are critical to what and who we are and what and who we are not as well as what and who we may become. Harm reduction schemes recognize our interdependence and the obligations to which that interdependence gives rise. We can choose, as the United States currently has, to eschew harm reduction (at least at the federal level) and have the highest incarceration rate in the world[23] along with an appallingly bad public health care system,[24] or we can choose strategies that are more humanely and productively responsive to the very real problems that humans encounter. Processes as well as outcomes need to be considered.

(3) *Permissible Strategies.* It is one thing to argue that harm reduction constitutes an ethically legitimate social strategy. It is another to determine which harm reduction strategies are ethically legitimate. Obviously harm reduction strategies need to be *evidence-based* – that is, we need to have good reason to believe that they will be effective enough to make them worth implementing.[25] But beyond that ethical questions might be raised about individual measures. Consider, for example harm reduction policies with respect to illicit drugs, where there may be questions not only about the effectiveness of different types of needle and syringe programs, but also about the ethical acceptability of their component features – whether, for example, the program should require exchanges of paraphernalia rather than dispense them on an as-requested basis; whether wall dispensers depersonalize their delivery in an unacceptable way or discourage their users from getting access to services that will be responsive to their extended

[23] In 2005, the rate of incarceration was 737 per 100,000. See the work of the Sentencing Project <http://www.sentencingproject.org/Admin/Documents/publications/inc_newfigures.pdf>.

[24] OECD Health Data: 2005: How Does the United states Compare <http://www.oecd.org/dataoecd/15/23/34970246.pdf>.

[25] See, however, note 20, *supra*.

needs; whether eligible participants should be required to have an ID card, and so on. Although the different strategies are likely to focus primarily on questions of effectiveness and efficiency (this being itself of moral significance in the context of harm reduction), they might come to focus so single-mindedly on the issue of utility that the essential humanity of the drug users and the multifarious other needs that they have will be screened out. Should there be supervised injecting centres (and, if so, how should they be set up)? Should there be clinics that provide prescribed injectable heroin, methadone, or buprenorphine? These are not merely issues of effectiveness and efficiency. They draw on larger issues about how societies and governments see or fail to see, value or devalue, their members and citizens.

(4) *Delivery conditions*. The previous point, which dealt with the ethical acceptability of different harm-reduction strategies, overlaps with the issue of delivery conditions. The issue is not a merely technical one concerned with the mechanics of, say, a needle and syringe program, but also with the human dimensions of a harm-reduction program. As noted earlier, every transaction between human beings – from my demeanour when I buy my daily newspaper to a decision to go to war – is morally infused. Harm reduction is not merely about policies in a broad sense. It is also about:

- the day-to-day implementation of those policies – the training and manner of those who have face-to-face contact with those for whom the policies are intended (and who may therefore respond to them mechanically or caringly, knowledgeably or ignorantly);
- issues of confidentiality, referral, and transparency;
- the siting and amenities of the facilities within which the harm reductive services are delivered – in the case of needle and syringe programs, whether they are available only in poor and dangerous neighbourhoods (the NIMBY problem), and whether they are equipped to deal with a wide range of human needs;
- the social and legal risks faced by those who should avail themselves of the harm reduction measures (relations with local law enforcement); and
- the risk to workers who in some places may find themselves at legal risk.

A good start, though hardly the end of the matter, would be a code of conduct intended for those who deliver such services. I know of none. A code of ethics is no magic bullet, but engaging in the task of drawing one up manifests a certain seriousness about the conditions under which services are appropriately delivered.

*Conclusion*

What we see, then, is that even after we have made the broad decision to advocate a harm reduction approach we are faced with a range of ethical questions of varying generality and specificity that bear on the how of their implementation. It is easy to forget, when we adopt the politically strategic and

somewhat antiseptic language of harm reduction, that in many cases – at least in the case of licit and illicit drugs – we are dealing with human beings who suffer more than their share of indignities and burdens, and who need whatever compassionate assistance we can provide. For the rest we probably need much greater awareness of their lack of social preparation for making wise decisions, and offer what protections we can until they are better able to make wise decisions for themselves.