Harm Reduction for Intravenous Substance Use

A Moral Analysis of Common Strategies

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Abstract. North America is facing an ongoing, persistent opioid epidemic, and Vancouver, British Columbia, continues to be one of its devastating epicenters, with record overdose deaths in 2020. Roman Catholic health care organizations in Vancouver are compelled to pioneer potential solutions to this public health crisis—in solidarity and employing necessary strategies to help the most vulnerable in the communities served. While controversial, harm reduction strategies for intravenous substance use keep people alive until they are able to receive the help that they need to recover. An evaluation of the degree of cooperation involved in some harm reduction strategies indicates that they can be considered morally permissible and compatible with core tenets of Catholic bioethics. *National Catholic Bioethics Quarterly* 21.1 (Spring 2021): 69–84.

Justin was a patient in his late thirties who was being treated in hospital for a serious septicemia that was probably a result of osteomyelitis related to illicit substance use.[1] Justin was an avid traveler, a teacher, and a chronic intravenous (IV)

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1. The patient's details have been changed to protect his confidentiality. Ethicists and health care professionals in Vancouver, British Columbia, try to avoid stigmatizing language

substance user. Part of Justin's hospital care involved the administration of 100 mg of hydromorphone IV three times a day—a dose 100–500 times higher than what an opioid-naïve adult would receive for pain control.[2] When not in hospital, Justin receives either diacetylmorphine (medical-grade heroin) IV or hydromorphone IV as prescribed from a medical clinic as part of a harm reduction strategy.[3] He then self-administers the substance at the clinic where he can be monitored for overdose or dangerous side effects. His treatment is overseen by health care professionals, including physicians who specialize in substance use disorder, nurses, social workers, and counselors. This clinic offers a number of other services, including assistance with recovery and rehabilitation, housing, employment counseling, and other primary health care services. According to Justin, this program allows him to manage his withdrawal symptoms without engaging in criminal activities to obtain illicit substances. During his medication administration and monitoring, Justin was visibly more at ease. We talked and laughed about our experiences traveling in India—Justin worked there for years as a teacher. Justin also shared his hope that he could continue to decrease his opioid doses and eventually stop his substance use.

Because of the serious harms (including death) of opioid use and the proven benefits of supervised injection facilities and injectable opioid agonist therapy,[4] certain harm reduction strategies are morally permissible—and perhaps even commendable—methods of keeping patients alive until they are able to receive help.

Harm Reduction and the Complexities of Opioid Dependence

Harm reduction is an important topic that has been thrust into the spotlight because of the opioid epidemic in North America. In Canada alone, about eleven people die from opioid overdose each day.[5] Of these, First Nations (indigenous) peoples make up a disproportionate number of the deaths—highlighting racial inequalities.[6] Substance overdose continues to increasingly claim lives in British Columbia. For example, in 2020 there were 901 deaths from COVID-19 compared to 1,716 deaths

such as *addiction*; rather, terms such as "substance use" or "substance use disorder" are used instead.

2. Lexicomp, "Hydromorphone: Drug Information," UpToDate, accessed October 2, 2020, https://www.uptodate.com/contents/hydromorphone-drug-information?search=hydromorphone&source=panel_search_result&selectedTitle=1~148&usage_type=panel&kp_tab=drug_general&display_rank=1#F180611.
3. Providence Health Care, "About SALOME," accessed April 26, 2020, http://www.providencehealthcare.org/salome/about-us.html.
4. Also called iOAT, this therapy provides prescribed injectable opioids to manage opioid dependence.
5. "Canada's Opioid Crisis (Fact Sheet)," Government of Canada, modified March 9, 2019, https://www.canada.ca/en/health-canada/services/publications/healthy-living/canada-opioid-crisis-fact-sheet.html.
6. Vancouver Coastal Health, *Response to the Opioid Overdose Crisis in Vancouver Coastal Health* (Vancouver: VCH, 2018), 18.

from substance overdose.[7] Overdoses cause more deaths in British Columbia than do traffic accidents, homicides, suicides, and COVID-19 combined, and there have been more than six thousand overdose deaths since 2016.[8] The United States is also facing an opioid epidemic with an average of 130 deaths per day.[9]

Not only can IV substance use lead to immediate death from overdose, but sharing needles and improper technique can lead to serious bacterial infections as well as communicable diseases such as hepatitis and human immunodeficiency virus. Of new HIV cases, one out of ten are associated with IV drug use.[10] These harms come at a high cost to the person using substances and also to society as a whole. In 2012 the costs in the United States for hospitalizations related to opioid abuse was almost $15 billion—$700 million of which was related to associated infections. Most of these costs were paid by Medicaid, and these numbers do not include costs for care after discharge from inpatient facilities. Many of these infections such as endocarditis and osteomyelitis can be directly attributed to injection substance use.[11] And this is entirely preventable.

Harm reduction recognizes substance use "as a reality and focuses on reducing its harmful consequences, including death, HIV, hepatitis C, criminal activity, and incarceration."[12] Harm reduction has also been proven to be effective in reducing frequency of overdoses.[13] The objective of harm reduction strategies is not to enable substance use but rather "to keep people who use drugs alive in the hope that they

7. Michelle Ghoussoub, "B.C. Announces 683 New Cases of COVID-19 and 8 New Deaths in Final Update of 2020," CBC News, December 31, 2020, https://www.cbc.ca/news/canada/british-columbia/b-c-covid-19-update-dec-30-1.5858754; and Melanie Nagy and Alexandra Mae Jones, "B.C.'s Overdose Crisis Killed 1716 People Last Year, More Than Ever Before: Coroner's Service," CTV News, February 11, 2021, https://www.ctvnews.ca/health/b-c-s-overdose-crisis-killed-1-716-people-last-year-more-than-ever-before-coroner-s-service-1.5306085.
8. Mike Hagar, "B.C.'s July Opioid Overdose Deaths near Province's Total COVID-19 Toll," *Globe and Mail*, August 25, 2020, https://www.theglobeandmail.com/canada/british-columbia/article-five-deaths-a-day-in-bc-from-opioid-overdoses-rate-eclipses-covid/.
9. Bernard Prusak, "Start with Safe: The Ethics of Harm Reduction and the Church of Safe Injection," *Commonweal* 146.16 (November 1, 2019): 46.
10. US Centers for Disease Control and Prevention, "HIV among People Who Inject Drugs," modified February 24, 2021, https://www.cdc.gov/hiv/group/hiv-idu.html.
11. Matthew V. Ronan and Shoshana J. Herzig, "Hospitalizations Related to Opioid Abuse/Dependence and Associated Serious Infections Increased Sharply, 2002–12," *Health Affairs* 35.5 (May 2016): 832–837, doi: 10.1377/hlthaff.2015.1424.
12. Kathryn F. Hawk et al., "Reducing Fatal Opioid Overdose: Prevention, Treatment and Harm Reduction Strategies," *Yale Journal of Biology and Medicine* 88.3 (September 2015): 239.
13. Chloé Potier et al., "Supervised Injection Services: What Has Been Demonstrated? A Systematic Literature Review," *Drug and Alcohol Dependence* 145 (December 2014): 48–68, doi: 10.1016/j.drugalcdep.2014.10.012; and Peter Meiszner, "Success of Insite Hailed on International Harm Reduction Day," Global News, May 7, 2014, https://globalnews.ca/news/1316390/success-of-insite-hailed-on-international-harm-reduction-day/.

will eventually seek treatment."[14] Without harm reduction strategies in place to mitigate the harms of substance use, people die.

This view considers substance use disorder to be a disease needing medical intervention, rather than focusing on it as a crime needing legal intervention or a sin needing a shift in morality. Bernard Prusak, director of the McGowan Center for Ethics and Social Responsibility at King's College, further argues that addiction involves compulsion, and therefore the person is unable to make completely voluntary choices. Additionally, substance use disorder/addiction is seen more in those who are already vulnerable from a history of mental illness, trauma, and abuse.[15] All of this may decrease a person's autonomy and agency. Indeed, the Canadian Conference of Catholic Bishops (CCCB) references Pope Francis's likening of drug addiction to "a new form of slavery." The clear implication is that the addiction is not a true expression of the person's will.[16] In *Amoris laetitia,* Francis explains that factors can diminish a person's moral culpability, and an objective wrong does not determine the person's culpability.[17]

Once one is dependent on a substance, one's will and ability to choose are decreased. Sin requires a free act of the will, and if an individual is embroiled in a substance use disorder, that person's acts to use illicit substances are not completely free. This does not eliminate all moral responsibility but can mitigate it. Consequently, the *New Charter for Health Care Workers* states that "without concealing any actual moral responsibilities on the part of the drug abuser," "emphasizing moral guilt [cannot] be the path to full recovery." The comparison of substance dependence to sin seems consistent with the *New Charter*, which identifies alcohol use disorder, which shares many characteristics with substance use, as a "social plague" that "warrants the engagement of integrally human recovery measures."[18] This is reflected in the comprehensive services provided at places like Crosstown Clinic. Moreover, this approach could be likened to field hospitals, where physical cure often cannot be achieved but where, nevertheless, in the words of Francis, the sick must be "looked after" as "objects of Christian concern."[19]

As noted above, harm reduction strategies have indeed been shown to decrease overdose deaths and infections in persons who use IV substances. For example, after

14. Prusak, "Start with Safe," 44.
15. Prusak, "Start with Safe," 46.
16. Douglas Crosby, "Statement on Canada's Opioid Crisis and Drug Addiction," Canadian Conference of Catholic Bishops, April 12, 2017, 1, https://hamiltondiocese.com/uploads/docs/letters/Statement%20on%20drugs%20-%20EN.pdf.
17. Francis, *Amoris laetitia* (March 19, 2016), n. 302.
18. Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, English ed. (Philadelphia: National Catholic Bioethics Center, 2016), nn. 123, 126. See also Daniel P. Sulmasy, "Catholic Participation in Needle- and Syringe-Exchange Programs for Injection-Drug Users: An Ethical Analysis," *Theological Studies* 73.2 (May 1, 2012): 433, doi: 10.1177/004056391207300207.
19. Francis, cited in Devin Watkins, "Pope at Audience: Church a 'Field Hospital' That Cares for Sick," Vatican News, August 28, 2019, https://www.vaticannews.va/en/pope/news/2019-08/pope-francis-general-audience-church-cares-for-sick.html.

Insite, North America's first supervised injection facility, was opened in Vancouver in 2003, the overdose deaths within five hundred meters of the site decreased by 35 percent.[20] According to a summary published by the College of Family Physicians of Canada, as of 2017, Insite prevented one overdose death per 1,137 users annually.[21] Also, there was no overall increase in IV substance use in the area around the facility.[22] Supervised injection facilities were also associated with less syringe sharing and more requests for education on safer injection practices. So, they show much promise for decreasing communicable disease and infections. Furthermore, persons who had injection-related skin lesions received primary care at the safe injection sites. Ultimately, usage of supervised injection facilities is associated with referral to addiction treatment centers, detoxification, and initiation of methadone treatment.[23]

A continuum of harm reduction strategies has been proposed as one way to address the epidemic of addiction and substance use disorder and to mitigate some of the harms resulting from it. Harm reduction strategies commonly include needle and syringe exchange programs, naloxone distribution, and opioid overdose education.[24] Other more specific approaches include safer consumption sites and overdose prevention sites, offering clean drug use supplies (e.g., sterile cookers, prefilled saline syringes, and dressings), prescribing and overseeing the use of medical-grade substances, testing substances for toxic mixtures and compounds such as fentanyl and benzodiazepines, allowing patients to inject one another, vein-finding, inserting IV lines, preparing illicit substances for use, and injecting these substances for individuals.

While some harm reduction programs have been adopted by Catholic health care organizations, others have been discouraged. Specifically, supervised injection facilities remain controversial within the Catholic Church, and some within the Catholic tradition reject the implementation of these sites as misguided and contrary to moral law.[25] For example, in 1999 the Sisters of Charity planned to support a supervised injection facility out of St. Vincent's Hospital in Sydney, Australia, but this was stopped when the Vatican's Congregation for the Doctrine of the Faith cautioned the Sisters that a supervised injection facility was "extremely proximate

20. Brandon D. L. Marshall et al., "Reduction in Overdose Mortality after the Opening of North America's First Medically Supervised Safer Injecting Facility: a Retrospective Population-Based Study," *Lancet* 377.9775 (April 23, 2011): 1433, doi: 10.1016/S0140-6736(10)62353-7.
21. Jennifer Ng et al., "Does Evidence Support Supervised Injection Sites?," *Canadian Family Physician* 63.11 (November 2017): 866.
22. Marshall et al., "Reduction in Overdose Mortality," 1434.
23. Potier et al., "Supervised Injection Services," 63–64.
24. Laura Vearrier, "The Value of Harm Reduction for Injection Drug Use: A Clinical and Public Health Ethics Analysis," *Disease-a-Month* 65.5 (May 2019): 120, doi: 10.1016/j.disamonth.2018.12.002.
25. Michelle La Rosa, "'Safe Injection Site Denounced as False Solution to Philadelphia Drug Problem," Catholic News Agency, November 3, 2019, https://www.catholicnewsagency.com/news/safe-injection-site-denounced-as-false-solution-to-philadelphia-drug-problem-59476.

material cooperation in the grave evil of drug abuse."[26] New information emerging in the last twenty-two years invites us to critically reexamine the type of cooperation involved in harm reduction strategies. The *Catechism of the Catholic Church* does indeed say that production and trafficking of drugs are serious moral offenses, as they constitute direct cooperation in evil, but the *Catechism* does not specifically address harm reduction and justifiable mediate material cooperation.[27]

It is important to note that harm reduction strategies are not unknown in Catholic health care. For example, a branch of Catholic Charities in the diocese of Albany, New York, has been operating a needle exchange program since 2010.[28] Providence Health Care (PHC), a Roman Catholic health care organization in Vancouver, also employs some harm reduction strategies as part of its philosophy of care. PHC's policy states that these strategies "provide optimal care for people who use substances throughout acute and residential health systems, based on a non-judgmental approach and maintains the dignity of patients" in "a safe, harm reducing environment for patients who are actively using substances," while providing a "safe environment for patients in recovery to avoid exposure to unnecessary triggers." PHC defines *harm reduction* as "an approach to care that seeks to reduce the adverse health, social and economic consequences of the use of legal and illicit substances. This approach respects individualized needs, supports individuals' active participation and informed decision making, takes a non-judgmental approach to all behaviors and views incremental changes as success."[29]

At PHC harm reduction philosophies also aim to treat withdrawal symptoms while the patient is in hospital and thus decrease harms associated with patient-initiated discharges before treatment is complete.[30] Patients may choose to leave the hospital if their withdrawal needs are unmet. Furthermore, employing a harm reduction strategy helps health care professionals to maintain knowledge of illicit substances the patient is using and thus maintains the patient on a healing trajectory. This approach at PHC is supported by specialists in addiction medicine as well as in legal services, social work, housing and income assistance, and community transition programs. Ideally, abstinence is the ultimate goal, but harm reduction strategies at PHC support patients to mitigate possible or known harms from substance use if they are unable to stop completely, while also protecting other patients and staff.

An outpatient facility that demonstrates PHC's harm reduction strategy is Crosstown Clinic, which Justin attends. Crosstown Clinic operates in downtown

26. Congregation for the Doctrine of the Faith, cited in Prusak, "Start with Safe," 48.
27. *Catechism of the Catholic Church*, 2nd ed. (Washington, DC: US Conference of Catholic Bishops/Libreria Editrice Vaticana, 2016 update), n. 2291. All subsequent references appear in the text.
28. Prusak, "Start with Safe," 45.
29. Providence Health Care (PHC), *CPF2100: Philosophy of Care for Patients and Residents Who Use Substances at PHC Providence Health Care*, revised July 2015, n. 1.2, http://leadersresource.providencehealthcare.org/sites/leadersresource.providencehealthcare.org/files/CPF2100_substance_care.pdf.
30. PHC tries to avoid the stigma associated with patients' leaving "against medical advice." Instead, the health system refers to these events as "patient-initiated discharges."

Vancouver where it offers injectable diacetylmorphine or injectable hydromorphone to persons who have been unable to tolerate traditional opioid agonist therapy such as methadone or suboxone.[31] Such substances are dispensed via prescription, and patients self-administer the substances under medical supervision. In a qualitative study examining patient experience at Crosstown Clinic, "participants emphasized that holistic care be delivered in a manner that encourages clients to '*have the responsibility to invest in* [our] *own lives*,'" an approach that can lead to human flourishing.[32]

Insights from Catholic Bioethics

The Moral Act

Catholic moral tradition has taken a firm, objective stance on illicit substance use. The *Catechism* states that the "the use of drugs inflicts very grave damage on human health and life. Their use, except on strictly therapeutic grounds, is a grave offense" (*Catechism*, n. 2291). Carol Bayley and colleagues similarly argue, "We assume that intravenous drug use is objectively intrinsically evil because it is non-therapeutic and causes serious harm to the user. It also encourages illegal drug trade and is linked to the spread of infectious disease."[33] In addition to physical and social harms, the magisterium adds that substance use "implies an irrational refusal to think, will, and act as a free person." A person "cannot and must not ever abdicate his personal dignity."[34] Thus, the Catholic Church's objective moral position on non-prescribed and illicit substance use is clear.

The Catholic tradition offers a methodology for the moral evaluation of human acts, which have three components or "sources" as described by *Catechism* n. 1750. The *object*, or act itself, is the "matter of the human act" or the "kind of action or behavior chosen." The *intention* is "dependent on the will of the one acting." And the *circumstances* of the act, or conditions in which the act occurs, describe "the manner in which the act is carried out."[35] One must also consider the end, or goal of the act, which is the good the agent desires to achieve and toward which the agent's action moves.

Overall, the objects of harm reduction may include a variety of acts, some morally illicit and others morally permissible. The goal to be achieved, or the end,

31. PHC, "Providence Crosstown Clinic," accessed April 26, 2020, http://www.providencehealthcare.org/hospitals-residences/providence-crosstown-clinic.
32. Kirsten Marchand et al., "Building Healthcare Provider Relationships for Patient-Centered Care: A Qualitative Study of the Experiences of People Receiving Injectable Opioid Agonist Treatment," *Substance Abuse Treatment, Prevention, and Policy* 15.7 (January 20, 2020): 5, doi: 10.1186/s13011-020-0253-y.
33. Carol Bayley et al., "Assessing the Ethical Issues in 'Safe Injection' Sites," *Health Care Ethics USA* 25.4 (Fall 2017): 23.
34. John Paul II, Address to the Participants in the Sixth International Conference on Drugs and Alcohol (November 23, 1991), nn. 2, 4, cited in Pontifical Council for Health Care, *New Charter*, nn. 123, 124.
35. Peter J. Cataldo, "The Moral Fonts of Action and Decision Making," in *Catholic Health Care Ethics: A Manual for Practitioners*, ed. Edward J. Furton (Philadelphia: National Catholic Bioethics Center, 2020), 2.3.

of harm reduction is to preserve people's lives until they are able to receive help in stopping the use of illicit substances. Circumstances are admittedly complicated and may include the ongoing opioid epidemic, substance use disorder itself, patients' histories of trauma and abuse, poverty, homelessness, and other social determinants of health.

We will now provide brief moral analyses of nine acts found in the spectrum of harm reduction strategies. Circumstances continue to vary and reflect numerous factors at play in individuals' lives.

1. *Injecting illicit substances for individuals*
   There exists a difference between injecting medical substances and injecting illicit/street supply for individuals. It is morally good or neutral for health care professionals to inject medications for their patients. However, in the case where the substances are illicit, the intention, or means, facilitates easier substance use. The act culminates in those who are not able to inject for themselves receiving illicit substances. The act is morally illicit.
2. *Preparing illicit substances for use*
   Again, it is different for a health care professional to prepare prescribed medications or substances for patients to ingest or inject; such an act is morally good or neutral. However, the intention in this case is to facilitate substance use by preparing illicit substances for individuals, which they may not be able to prepare for themselves. The end of the act is that those who are not able to prepare their own substances for injection retain access to prepared illicit substances. The act is morally illicit.
3. *Inserting lines to facilitate illicit substance use*
   Health care professionals insert peripheral IVs, PICC (peripherally inserted central catheter) lines, and other injectable devices for a variety of therapeutic medical treatments. However, when lines are inserted to facilitate illicit substance use, they become the means for the delivery of that substance. The goal of this act is to grant the person using illicit substances venous access when they might not have it otherwise.[36] The act is morally illicit.
4. *Vein-finding to facilitate illicit substance use*
   Health care professionals regularly vein-find when initiating IV access for patients. However, when individuals seeking to inject illicit substances are provided with venous access via vein-finding, the act of injection

36. There is a caveat to some harm reduction philosophies that line insertion and vein-finding are the lesser of two evils, as those persons seeking to inject substances without usable venous access points may inject in other, much riskier areas of the body such as the hand, neck, leg, and femoral vein. The use of injection sites other than the arm can be associated with an increased risk of vascular complications, infection, and trauma to organs in close proximity. See Mehrdad Karimi et al., "Drug Injection to Sites Other Than Arm: A Study of Iranian Heroin Injectors," *Frontiers in Psychiatry* 5 (April 7, 2014): 3, doi: 10.3389/fpsyt.2014.00023.

becomes easier. The goal of this act is to grant the person using illicit substances venous access when they might not have it otherwise. The act is morally illicit.

5. *Providing essential sterile supplies (needles, syringes, stericups/cookers, normal saline, and tourniquets)*
   These harm reduction supplies are not morally evil in themselves. However, they provide a means for illicit substance use. *Sterile* supplies reduce chances of life-threatening infection, and the end of the act is a safer source of supplies for those using substances. While providing them may be considered morally illicit by some, the proportionate benefits of providing such items may invite others to consider this act morally justifiable.
6. *Providing sterile nonessential supplies (bandages and alcohol swabs)*
   Similarly, such supplies are used throughout the health care setting. Even when providing nonessential supplies to those using substances, the act is not a means to the use of illicit substances. The end of providing nonessential supplies is to disinfect or to stop bleeding. The act is morally licit.
7. *Allowing a fellow patient to inject another with illicit substances if that person is unable to self-inject*
   Individuals use injectables such as insulin or other medications and may have difficulty injecting; they may request assistance from others. Those using illicit substances may likewise experience difficulty, and another individual may volunteer to perform the injection. The volunteer becomes the means for the injection, and this person's act is morally illicit. However, an organization tolerating this practice as a harm reduction strategy is not morally culpable for this act.
8. *Testing substances individuals wish to inject for toxic mixtures and compounds such as fentanyl and benzodiazepines*
   In the harm reduction spectrum, testing illicit/street supply is a common service offered to protect those persons using substances from toxic mixtures and compounds. The means or purpose is to alert the principal agent of unwanted substances, creating a safer supply. The end of the act is that the person is not unknowingly poisoned by the substance, resulting in life-threatening outcomes, including overdose and death. The act is morally licit.
9. *Prescribing and clinical oversight of medical-grade substances*
   Health care professionals routinely prescribe medications for patients that in their clinical judgment, have benefits that outweigh the risks. Medical oversight accompanies the prescription, as both the professional and patient work together to achieve a therapeutic goal. When medical grade substances such as diacetylmorphine are prescribed under the care of a physician specializing in addictions medicine, the therapeutic relationship and goals are the same. The substances prescribed are not considered illicit or street supply, because the physician deems the

prescription's benefits as outweighing the risks. We argue that this act is morally justifiable, but given possible perceptions that health care systems condone substance use, careful attention to theological scandal should occur.

Kieran Cronin points out that some terms in the *Catechism*'s entry are vague—*drugs* and *therapeutic grounds* are not strictly defined.[37] It could then be argued that providing someone with injectable hydromorphone or medical-grade heroin, such as at the Crosstown Clinic, would be considered therapeutic, as it treats painful withdrawal symptoms and occurs under the holistic support and supervision of a medical team. We can liken this to a person who is receiving anti-hypertensive medication for high blood pressure related to increased weight. The underlying cause is the excess weight; however, we treat the dangerous condition of high blood pressure with medication while encouraging the patient to make healthier lifestyle changes. We do not consider this to be enabling the patient's unhealthy behaviors. Thus, the therapeutic goals of both of these interventions are improving the health of the person and saving a life so that a person may eventually flourish.

The Principle of Cooperation

Referencing St. Thomas Aquinas, theologian James Bretzke says that "when you cannot reasonably expect a person to avoid the moral evil itself, you can counsel them at least to lessen or mitigate the potential damage of their action and can even help them in doing that."[38] Aquinas seems to be supporting cooperation to lessen harm that can result from someone's actions. *Cooperation* is described as "any free and knowing assistance by an individual or institution (the cooperator) in an immoral act performed by another individual or institution (the principal agent)."[39] Cooperation can be considered as "any real or physical help given to another person in the commission of a sinful act."[40] It can then be separated into formal cooperation, which is actively willed, and material cooperation, which is reluctant. It is important to note that "the term *evil* is not restricted to what society views as heinous acts, but encompasses any act that lacks the moral goodness it ought to have."[41]

Individuals or organizations can cooperate with others' doing evil by willingly and knowingly partaking in the performance of the evil act (formal cooperation). As explained in the *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*): "Cooperation is formal not only when the cooperator shares the intention of the wrongdoer, but also when the cooperator directly participates in the immoral act, even if the cooperator does not share the intention of the wrongdoer, but participates as a means to some other end. Formal cooperation may take various forms, such as authorizing wrongdoing, approving it, prescribing it, actively defending

37. Kieran Cronin, "Harm Reduction and Drug Abuse," *Furrow* 52.3 (March 2001): 159.
38. James Bretzke, cited in Prusak, "Start with Safe," 47.
39. NCBC Ethicists, "Cooperation," in Furton, *Catholic Health Care Ethics,* 3.48.
40. Cronin, "Harm Reduction," 156.
41. NCBC Ethicists, "Cooperation," 3.49. See section 3 of *Catholic Health Care Ethics* for additional information on the principle of cooperation.

it, or giving specific direction about carrying it out."[42] Formal cooperation, by an individual or institution, is always impermissible.[43]

In certain circumstances, one can perform a morally good act, but someone else uses the act to accomplish an evil result (material cooperation).[44] In material cooperation, the principal agent intends the immoral act itself, but the cooperating agent merely accepts or tolerates the principal act as an unintended result that is incidental to the cooperator's act, which in itself is good. Material cooperation is potentially morally permissible if done "in order either to gain some good or to prevent the loss of some good."[45]

Material cooperation may occur in two kinds: immediate and mediate. Immediate material cooperation occurs when the cooperator assists in or contributes to the *essential* circumstances of the immoral act. Immediate material cooperation in an intrinsic evil is itself an evil act. Mediate material cooperation entails cooperation in a *nonessential* action that in some manner makes possible an act or aids in its execution. At times mediate material cooperation may be justifiable, ethically and morally.[46] The *ERDs* also state that "the cooperation is *material* if the one cooperating neither shares the wrongdoer's intention in performing the immoral act nor cooperates by directly participating in the act as a means to some other end, but rather contributes to the immoral activity in a way that is *causally* related but not *essential* to the immoral act itself."[47]

Further delineation of mediate material cooperation includes *proximate* and *remote*, taking into account how far, or removed, the cooperator is from the evil act. The cooperation becomes more *remote* as the cooperator becomes further distanced from the immoral act and less closely related to the evil of the principal agent. According to the Catholic Health Association, proximate mediate material cooperation "is *close in causal terms* to the act of the principal agent," and remote mediate material cooperation is "*causally distant* from the principal agent's act."[48] Material cooperation may be permitted only for serious reasons, and one may act with reluctance with the goal of avoiding a greater evil.[49] Cronin quotes Henry Davis's *Moral and Pastoral Theology*: "In estimating the sufficiency of the excuse for material co-operation, we must consider the spiritual character and needs of another, our relations to him, what and how great is his offence against God, the

42. US Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Service*s, 6th ed. (Washington, DC: USCCB, 2018), part 6, intro.
43. NCBC Ethicists, "Cooperation," *Catholic Health Care Ethics*, 3.50.
44. Kevin D. O'Rourke and Philip J. Boyle, *Medical Ethics: Sources of Catholic Teachings* (Washington, DC: Georgetown University Press, 2011), 13.
45. Catholic Health Association of the United States (CHA), "The Principles Governing Cooperation and Catholic Health Care: An Overview," *Health Care Ethics USA* 21.1 (Winter 2013): 27.
46. NCBC Ethicists, "Cooperation," 3.49, 3.51.
47. USCCB, *Ethical and Religious Directives*, part 6, intro, emphasis added.
48. CHA, "Principles Governing Cooperation," 26, emphasis added.
49. Cronin, "Harm Reduction," 156.

harm that may accrue to a third person, the public harm likely to ensue, how close the co-operation, how indispensable it may be."[50]

The following list delineates some strategies in the harm reduction spectrum and proposes which are potentially justifiable mediate material cooperation and, conversely, which constitute illicit immediate material or formal cooperation.

1. *Injecting illicit substances for individuals*
   Explicit Formal Cooperation. The intention is to facilitate substance use by injecting substances for individuals. The cooperator is essential, the cooperator's act causes the principal agent's act, and such intervention may be perceived to authorize wrongdoing. It is thus morally impermissible.
2. *Preparing illicit substances for use*
   Explicit formal cooperation. The intention is to facilitate substance use by preparing substances for the principal agent. The cooperator is essential, the cooperator's act causes the principal agent's act, and such intervention may be perceived to authorize wrongdoing. It is thus morally impermissible.
3. *Inserting lines to facilitate illicit substance injection*
   Implicit Formal Cooperation. The cooperator is essential, and there exists a direct causation between the line insertion and act of substance use; the act cannot occur without the intervention and is morally impermissible.
4. *Vein-finding to facilitate illicit substance use*
   Immediate material cooperation. The intention of vein-finding is to assist the principal agent in the act of substance use. When vein-finding is required for the act of substance use to occur, it is of closer proximity to the act and is thus morally impermissible.[51]
5. *Providing essential sterile supplies (needles, syringes, stericups/cookers, tourniquets)*
   Proximate mediate material cooperation. *Sterile* supplies are not essential to the act of illicit substance use; those who wish to use substances will probably inject them regardless of the cleanliness of the items they utilize. However, these items are essential and causally necessary for the act of substance injection to occur. Sterile supplies decrease the chances of life-threatening infections such as HIV, Hepatitis C, endocarditis, osteomyelitis, sepsis, and other severe conditions. Cooperation may be morally justifiable in some cases.
6. *Providing sterile nonessential supplies (bandages, saline flushes, alcohol swabs)*
   Remote mediate material cooperation. The contribution of sterile nonessential supplies does not directly correlate with the act of substance

50. Henry Davis, *Moral and Pastoral Theology*, vol.1, *Human Acts, Law, Sin, Virtue* (London: Sheed and Ward, 1934), 342, cited in Cronin, "Harm Reduction," 157.
51. If individuals looking to use substances do not have a line or vein available for injection, they may inject in riskier areas, increasing the likelihood of infection and other health complications. See note 36.

injection itself. This is remote because the cooperator is nonessential to and causally distant from the act of illicit substance use, and distance from that act is maintained. Cooperation is morally permissible.

7. *Allowing a fellow patient to inject another with illicit substances if that person is unable to self-inject*
   Remote mediate material cooperation. There is no intention on behalf of the cooperator for the principal agent to use illicit substances; the other person is essential and incurs formal cooperation in the act of substance use. However, the cooperating organization is not essential nor linked to such an act. Cooperation is morally permissible.
8. *Testing substances individuals wish to inject for toxic mixtures or compounds such as fentanyl and benzodiazepines*
   Remote mediate material cooperation. There is no intention on behalf of the cooperator for the principal agent to use illicit substances, and the cooperating organization is neither essential nor linked to the act of substance use. The act of testing substances decreases the likelihood of a toxic substance combination, increasing the safety of illicit substances. Cooperation is morally permissible.
9. *Prescribing and clinical oversight of medical-grade substances*
   No cooperation. While part 6 of the *ERDs* describes formal cooperation as "prescribing" an act, the act of injecting a prescribed, medical-grade substance under the care of a clinical team carries a different moral liceity. We argue that the prescribed substances in these circumstances are morally permissible because they become medical treatment for those suffering from substance use disorder. Cooperation with evil does not occur in this specific situation, but care must be taken to avoid and address perceptions of theological scandal.[52]

Daniel Sulmasy, a prominent bioethicist at the Kennedy Institute of Ethics at Georgetown University, addresses the ethics of needle exchanges, but the same arguments may be applied to other areas of harm reduction. He argues that harm reduction in this case does not fall under formal cooperation, as one does not share in the intention of the user to abuse substances; however, it could fall under justifiable material cooperation. He compares needle exchanges to parents who do not want their child to ride a motorcycle, but as an adult, the child cannot be stopped. A parent may say something like, "I do not approve of your riding a motorcycle, but you are over 18 years old, and I cannot stop you, so, if you do, please promise me that you will wear a helmet. In fact, I have just bought you one. Please use it."[53] Riding a motorcycle itself is not considered immoral, but perhaps we can say that this child is riding the motorcycle recklessly, which would be immoral. This example could be extended to Crosstown Clinic or other supervised injection facilities: "I would prefer it if you were able to stop using substances completely, but if you are unable to stop right now, please use these clean supplies, and we will make sure

52. See USCCB, *Ethical and Religious Directives*, dir. 67. The ultimate determination of cooperation and scandal rests with each diocesan bishop.
53. Sulmasy, "Catholic Participation," 426.

that you do not overdose. Also, if you ever want more information on abstinence, we are more than happy to provide that to you and will be here for you to provide whatever will help keep you safe in the meantime."

Proportionality

The proximity of mediate material cooperation is an objective assessment of the causal association between the cooperator's and the principal agent's actions. It is not necessarily a moral evaluation, and the liceity of an act does not necessarily increase with its remoteness. Ultimately, liceity depends on whether there are proportionately grave reasons to cooperate. Evidence surrounding substance use strongly suggests that both the proximate and the remote mediate material cooperation described above are licit in these circumstances.

Indeed, a harm reduction approach was promoted by Canadian Catholic Bioethics Institute Executive Director Moira McQueen when she said that the moral good of saving lives, in a context of wrap-around, comprehensive services being offered, outweighs the negatives of operating supervised injection facilities where people bring their own supply of drugs.[54] As discussed above, mediate material cooperation can be justified depending on how serious the harms are, how proximate the mediate material cooperation is, and whether there are proportionate reasons for tolerating the cooperation. In this case, the goods of saving lives and promoting these individuals' chances for health are proportionate reasons for the acceptance of supervised injection facilities.

While this paper argues that some harm reduction techniques are morally permissible, some argue that harm reduction strategies may give rise to theological scandal—meaning an attitude or behavior which leads another to do evil, according to *Catechism* n. 2284. The argument is that by employing harm reduction strategies, Catholic health care organizations promote or enable the grave evil of substance abuse. This is simply not true. It would indeed be scandalous if places like Crosstown Clinic or supervised injection sites were to assist people in their initial experimentation with IV substance use or procure illicit substances for clients, but such actions absolutely do not occur there. Furthermore, supervised injection facilities do not increase overall substance use in the vicinity surrounding them, and as mentioned previously, engagement with supervised injection facilities is associated with referral to substance use/addiction treatment centers, detoxification, and initiation of recovery treatment.[55] While determination of scandal rests with the local ordinary, concerns about scandal can be mitigated through educational programs, marketing and communications, and overall explanations as to why a Catholic organization is participating in these activities. [56]

54. Michael Swan, "The Moral Debate around Safe Injection Drug Sites," *Catholic Register*, April 21, 2012, https://www.catholicregister.org/features/featureseries/item/14299-report-calls-for-safe-injection-sites-in-toronto-ottawa.
55. Potier et al., "Supervised Injection Services," 63–64.
56. USCCB, *Ethical and Religious Directives*, dirs. 67, 71.

Practical Recommendations

> Go forth and reach out to all people at the margins of society! Go there and be the Church, with the strength of the Holy Spirit.
>
> —Pope Francis

The *ERDs* emphasize that we ought to go to the margins to help those who are the most vulnerable—including those with chemical dependencies.[57] The CCCB stresses that substance use disorder treatment must address the physical, psychological, social, and spiritual dimensions of the sufferer. Furthermore, the Canadian bishops emphasize that harm reduction measures can reduce immediate danger to the person and decrease deaths; however, harm reduction does not address the root cause of addiction and should not be the main method of combating addiction. The CCCB does support medically supervised drug substitution.[58] This is probably referring to methadone and suboxone, as injectable opioid agonist treatment is a newer therapy.

We encourage the Catholic health care community to discern whether elements of the harm reduction spectrum correlate with their organizational mission and outreach toward the most vulnerable in society. Harm reduction strategies are intended not as a stand-alone approach to the devastating effects of IV substance use disorder and overdose, but as part of a holistic, wrap-around program designed to provide patient-centric care.

Harm reduction enables substance users to survive and pursue human flourishing even if some never achieve abstinence. Harm reduction and abstinence do not need to be seen as either/or options. Indeed, other programs besides PHC's combine the two.[59] Substance use disorder/addiction is a complicated condition, so it requires a complex solution that takes a holistic approach, offering a variety of therapies and allowing patients to take the lead in deciding on their plan of care. As the bishop of Greenburg, Edward Malesic, stated, the "current opioid crisis is one that involves the whole person," so we "need both a medical and pastoral response," advocating for replacement therapy with spiritual treatment.[60] Harm reduction approaches can be spiritual treatment by enhancing the dignity of the person struggling with substance use, as well as promoting solidarity by walking alongside them.

Additionally, more empirical research is needed on harm reduction and its correlation to eventual cessation of substance use. Organizations embracing harm reduction strategies are encouraged to capture data for research and quality improvement. Should it be clinically proven that harm reduction causes more harm

57. USCCB, *Ethical and Religious Directives*, dir. 3.
58. Crosby, "Statement on Canada's Opioid Crisis," 3, 5.
59. Heather Sophia Lee et al., "Harm Reduction and 12 Steps: Complementary, Oppositional, or Something In-Between?," *Substance Use and Misuse* 46.9 (2011): 1151–1161, doi: 10.3109/10826084.2010.548435.
60. John W. Miller, "The Opioid Crisis Demands a New Solution. Churches Are Hoping to Be Part of It," *America*, May 31, 2019, https://www.americamagazine.org/politics-society/2019/05/21/opioid-crisis-demands-new-solution-churches-are-hoping-be-part-it.

than benefit to already vulnerable patients and populations, such approaches should cease. As more clinical evidence on harm reduction emerges, we are encouraged to consider our views, perspectives, and moral and ethical analyses through a Catholic lens.

In conclusion, harm reduction strategies ultimately create networks of support in the local community by inspiring solidarity and promoting subsidiarity. Indeed, the *Compendium of the Social Doctrine of the Church* states that "the principle of *solidarity*, even in the fight against poverty, must always be appropriately accompanied by the principle of *subsidiarity*, thanks to which is it possible to foster the spirit of initiative."[61] This is a call to go to the margins of society and meet people like Justin exactly where they are, defending their dignity, promoting their freedom, and fostering hope.

61. Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (April 2005), n. 449.