

Examining the Ethical Boundaries of Harm Reduction: From Addictions to General Psychiatry

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ABSTRACT

Harm reduction is a general term for pragmatic interventions aimed at reducing problematic behaviors. Emerging from addiction treatments, it is based on the understanding that people will continue to behave in ways that pose a risk to them and their communities, and that an important goal of any treatment program is to minimize the harm associated with these behaviors. Despite its evidence-based background, harm reduction is not readily applied in general psychiatry. This is mainly due to the complex ethical dilemmas arising within harm reduction practices, as well as a lack of scientific knowledge and theoretical frameworks essential for dealing with such ethical dilemmas. In this paper we introduce the fundamental theoretical and scientific base of harm reduction strategies, and present three clinical examples of the complex ethical dilemmas arising when working within a harm reduction practice. We finally present a theoretical framework for dealing with the ethical dilemmas and argue this may make harm reduction strategies more accessible in general psychiatry.

INTRODUCTION

Harm reduction is an umbrella term for interventions aiming to reduce the problematic effects of behavior. It is both a philosophy as well as a practice, and has been called “compassionate pragmatism” (1) because it begins with the pragmatic acceptance that people are and will continue to behave in ways that pose threats to themselves and their communities. Its compassionate and understanding approach promotes collaboration between patients and therapists and enables effective

interventions. Harm reduction has a human rights agenda in that it is committed to bringing effective treatment to marginalized groups that have traditionally been denied quality care. It is scientific in that it is committed to the discovery and implementation of evidence based interventions (2).

Stemming from the field of illicit drug use in the 1980s (3), harm reduction currently accommodates a vast array of interventions. Perhaps the most well known of these are needle exchange programs, whose goal is to prevent HIV transmission and other blood borne infectious diseases, as well as overdose prevention, including naloxone distribution and opiate substitution treatment (methadone, buprenorphine). Other examples include prioritizing less risky drinking habits for underage drinkers to reduce the risk of alcohol poisoning, encouraging safe sex, and replacing binge eating with healthier alternatives. More extreme interventions would be for example providing clean razors for those engaged in self injurious behavior, or educating intravenous femoral vein injectors how to inject drugs to safer sites. Some harm reduction techniques have already become a norm (e.g., opiate substitution treatment), while others remain highly controversial (e.g., educating injecting users on how to properly inject drugs in order to minimize health consequences).

In this paper we argue that harm reduction strategies are under-utilized in general psychiatry, mainly due to the complex ethical dilemmas these practices pose and a concern that such an approach may seem nihilistic. We describe the fundamentals of harm reduction and propose that pragmatic beneficence is at times more in-tune with medical ethical values than unattainable ideal beneficence. We shortly review the literature on the efficacy of harm reduction interventions introducing the reader to the scientific background. Finally, we present three clinical examples illustrating the challenging ethical dilemmas

when working within a harm reduction framework, and introduce a theoretical framework in which these can be effectively discussed. Ultimately, we wish to propose that though harm reduction has grown out of the field of addictions, a harm reduction standpoint should find its way to other branches of psychiatry in which current interventions are not effective enough.

PRINCIPLES OF HARM REDUCTION

Harm reduction attempts to “assess the actual harm associated with any [particular behavior] and then asks how these harmful effects may be minimized... within an amoral framework” (4). The key features of harm reduction include the understanding that the primary goal is reducing harm rather than problematic behavior per se; that problematic behaviors are a part of society and will never be eliminated; that priority is placed on immediate (and achievable) goals; and that harm reduction should provide a comprehensive public health framework (3, 5-7).

Tatarsky and Marlatt (2) have further suggested these following principles of harm reduction that provide a clinical lens through which to see the patient, create the treatment relationship and guide the selection of interventions. Though these are originally aimed at addiction treatment, they have been adapted here to meet the needs of the general psychiatrist (using the term “problematic behaviors” to indicate behaviors such as non-adherence to medication, self-injury, binge eating, etc.).

1. Problematic behaviors are best understood and addressed in the context of the whole person in their social environment.
2. Meet the patient as an individual.
3. The patient has strengths that can be supported.
4. Challenge stigmatization.
5. Problematic behaviors are used for adaptive reasons.
6. Problematic behaviors use falls on a continuum of harmful consequences.
7. Do not hold any other preconceived notions as a precondition of the therapy before really getting to know the individual.
8. Engagement in treatment is the primary goal.
9. Start where the patient is.
10. Look for and mobilize the patient’s strength in service of change.
11. Develop a collaborative, empowering relationship with the patient.
12. Goals and strategies emerge from the therapeutic process.

At its core, harm reduction supports any steps in the right direction. It is realistic in that it realizes that ultimate goals may not be attainable, particularly in the short term. Critics may contend that harm reduction somehow enables or excuses poor choices. Although abstinence may be the ultimate goal in addictions treatment, and is of course the only way to avoid all negative consequences associated with substance use, the harm reduction practitioner seeks to meet with the patient where he or she is in regards to motivation and the ability to change. Similarly, though full adherence with medication may be the ultimate goal in treatment of severe psychiatric disorders, in the face of non-adherence harm reduction strategies may openly focus on alternative ways of minimizing risks (reducing substance use, managing psychosocial stressors, etc.). Within a harm reduction framework, the practitioner’s goals are secondary to what the patient wants. This does not imply that the practitioner has no opinion; rather, the practitioner respects the patient’s decisions both for and against change.

As this is not merely a philosophical standpoint but rather one with practical clinical implications, we present below examples of treatment interventions in which these principles have been implemented effectively.

REVIEW OF THE EFFICACY OF HARM REDUCTION STRATEGIES

Harm reduction techniques range from prevention to intervention and maintenance (8). Here, we shortly present examples of the effectiveness of harm reduction in treating alcohol and substance abuse in a myriad of settings and with a multitude of patient populations. This will also demonstrate the spectrum of settings in which harm reduction is used, and the ethical dilemmas involved in some of these practices.

Prevention: Clearly, the most effective way to reduce harm associated with drug use is to prevent initiation and misuse in the first place. As some abstinence-based programs have produced either no effects or potentially harmful effects (9), other programs focus on social skills training, resistance skills and normative education. Two school-based programs with explicit harm reduction goals have resulted in significant reduction in harmful alcohol use – the Integrated School and Community-Based demonstration Intervention Addressing Drug Use among Adolescents (10) and School Health and Alcohol Harm Reduction Program (11). This last program included interactive interventions for 13-14 year

old students, focusing on discussions based on scenarios suggested by students, with an emphasis on identifying alcohol-related harm and strategies to reduce harm, as opposed to formal alcohol-education sessions stressing the need for abstinence.

Intervention: Substance abuse has been shown to be very prevalent among individuals with severe psychiatric disorders (12). Many practitioners and programs require that these individuals abstain from substances before receiving full treatment or before being accepted into residential programs. The example of the rehabilitation basket for psychiatric patients in Israel today is an unfortunate example of this, leaving thousands of patients suffering from concurrent psychiatric and substance use disorders without proper treatment programs. Harm reduction recognizes that although abstinence may reduce some of the harms executed by the individual, often these diagnoses are intertwined (13). Several harm reduction treatments have been shown effective for treating dual diagnosis patients. These include Seeking Safety (14, 15) which was effective in reducing substance use and symptoms of posttraumatic stress disorder and in improving family and social functioning, and Mindfulness-based relapse prevention (16) which has been successful in decreasing substance use and related problems in patients with dual diagnoses.

Though most treatment programs for homeless alcoholics require maintenance of abstinence and require eviction from residential homes in case of relapse (17), harm reduction protocols seek to offer housing and services without contingencies. The Housing First study found that individuals in housing (without any preliminary contingencies) reported not only less drinking and less intoxication, but also saved money in terms of medical and social service expenses (18).

Both nicotine substitution and opioid substitution are examples of harm reduction strategies that have been normalized. These therapies were identified to provide a less harmful substance (nicotine replacement or methadone/buprenorphine) and dozens of trials have shown their effectiveness across an array of outcomes, including reducing substance use and associated health risks (19, 20). These are, to date, perhaps the best examples of effective harm reduction treatments that have been incorporated into most health care systems in the world.

Maintenance: Needle exchange programs were developed to reduce the spread of blood-borne disease (HIV and hepatitis) among injection drug users. These programs have been shown to be effective, safe and

cost-effective in many countries worldwide (21) with no evidence of deleterious effects (22). There are currently several governments that provide safe injection sites as well as needle exchange (8). In these sites drug users can inject their own drugs using clean equipment in the presence of medically trained personnel. Studies have shown a significant reduction of needle sharing, overdoses, and increase enrollment in detoxification and other treatment programs (23, 24).

CLINICAL EXAMPLE - HARM REDUCTION IN GROIN INJECTING

In order to demonstrate the ethical dilemmas arising when working within a harm reduction framework, we will illustrate the case of groin injection among drug users. Groin (or femoral) injecting is an often dangerous practice reported by up to 50% of injecting drug users (25). Complications of groin injection include deep vein thrombosis, accidental arterial injection, venous ulceration and local infections, all which can have serious health consequences. There is little margin for error while injecting into the femoral vein, especially since this practice may be attempted while intoxicated. In the U.K., it has been proposed that groin injection has moved from being a “risk boundary” to being an “acceptable risk” (26). This conclusion is supported by research findings that novice and early career injectors sometimes use the groin as their primary injecting site (27).

One of the active provisions attempting to minimize harmful consequences of groin injection is assisting groin injectors to find other viable injecting sites within an appropriate environmental context. Practically, this means teaching drug-injectors how to inject into alternative veins within a medical setting. Though this practice can be seen as serving the principle values of autonomy (the patient’s autonomy is preserved because he is the one making the decision as to where he wishes to inject), beneficence and non-maleficence (the patient is being asked to engage in achievable behavior change within a safe context which minimizes immediate health risks), it clearly raises concerns regarding the physician’s active role in prescribing injection sites.

CLINICAL EXAMPLE - HARM REDUCTION IN HYPERSEXUAL BEHAVIOR

As previously proposed, harm reduction principles can and should be readily integrated into the work of the

general psychiatrist. Examples of situations in which harm reduction can be utilized include educating schizophrenia patients who announce they are planning to discontinue medications on how to taper off antipsychotic medications gradually or accepting drug-using psychiatric patients to residential programs without preliminary demands. We postulate that due to a lack of knowledge of the philosophy and practice of harm reduction, as well as concerns regarding professional and organizational norms, these practices are under-utilized. Regardless, ethical dilemmas will inevitably arise. We hereby present an example of supplying condoms to individuals with bipolar disorder and hypersexuality during a manic or hypomanic episode.

One of the significant behavioral manifestations of manic and hypomanic states is an excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained sexual behaviors) (28). This lack of planning in sexual behavior can have catastrophic implications, jeopardizing the physical as well as mental health of the patient. In the case of impulsive sexual behavior, this may result in sexually transmitted diseases, unwanted pregnancies, and more (29). Moreover, there are issues of teratogenicity in women taking mood stabilizers if they were to become pregnant while taking lithium, carbamazepine or valproate (30).

Though clearly the first line of clinical attention should be given to stabilizing the patient using conventional pharmacological measures and providing an adequate safe environment, many times patients in these situations have a lack of insight into their situation (31) and refuse pharmacological treatment or hospitalization. In these cases, particularly when patients in manic or hypomanic states do not fulfill criteria for being admitted against their consent, active provision of condoms may minimize some of the harmful consequences of the hypersexual state common in bipolar patients.

CLINICAL EXAMPLE - HARM REDUCTION IN SELF-CUTTING

One of the most controversial practices proposed in harm reduction today is the supply of sterile razors to patients engaged in self-cutting – a practice coined “safe self-harm.” Though self-mutilating behavior has been found to be relatively rare in the general population (affecting 4% of the general population in the past six months), it has been found to affect 21% of clinical populations, with

self-cutting (of arms and legs) being the most common form (32). Dangers of self-cutting with non-sterile objects (e.g., metal, glass, etc.) include wound site infection and consequent health risks. More than 25% of psychiatrically hospitalized adolescents reported sharing cutting implements with other adolescents (33). This raises the risk for transmission of HIV and hepatitis. These risks can be reduced by providing clean razors to patients unable to resist the urge for self-cutting. Despite similarities to needle exchange program for drug injecting patients (in which sharp metal objects intended for harmful behavior are readily handed out), providing clean razors to patients is a much less acceptable practice. Though we could not find current literature as to the prevalence of programs handing out clean razors, we hypothesize that this is a rare practice.

We do not pretend to propose a solution here to dealing with groin-injecting, hypersexual behavior or self-injurious behavior, but rather argue for considering harm reduction strategies with a structured ethical framework. We therefore approach these challenging dilemmas with the decision-making framework below.

ETHICAL FRAMEWORK FOR DECISION MAKING

Sadly, there is little dialogue on key ethical issues in clinical practice (34), and many therapists are left struggling with the ethical boundaries of harm reduction (35). Typically in applied ethics, practitioners are guided to use their moral intuitions to determine which of the principles of autonomy, beneficence, non-maleficence and justice are most important given the particular facts of the situation. In complex cases, depending on moral intuitions is highly difficult and problematic. It is therefore helpful to be familiar with the philosophical theories from which the above-mentioned principles have been abstracted, as well as to work within a framework in which decision making may be facilitated. The ethical dilemmas surrounding harm reduction may be traced back to the conflicts between deontological (duty-driven) and utilitarian (consequence-driven) philosophies.

Deontological ethics is derived from the philosophy of Immanuel Kant. According to Kant's deontology, the moral quality of an action depends on the Categorical Imperative test – whether the principle can be universalized without contradiction. In deontological ethics, the concept of fulfilling a role and obligation are fundamental and an emphasis is put on personal choice and autonomy. Consequences are irrelevant when considering the moral

quality of an action. As a physician, moral justification of an act must be based on adhering to the basic obligation of “do no harm.” Any kind of harm, according to a strictly deontological outlook, assisted by a physician, is not moral as it contradicts the physician’s basic obligations. Whether the harm caused is less than that which may have been caused without the physician’s intervention remains irrelevant according to this school of thought. The harm reduction approach cannot therefore be easily justified on a Kantian/deontological model, as its “raison d’être” is ultimately to avoid negative consequences.

The principles of beneficence and maleficence derive from utilitarianism and the philosophy of John Stuart Mill. According to utilitarian ethics, an action is moral if it tends to promote the greatest benefit for the greatest number of people. This is essentially a consequence-based approach: only after considering the current policy environment and the scientific evidence for each approach can we decide whether it is morally appropriate. As it has been shown above that harm reduction policies have been shown to be effective in various fields and help avoiding many negative consequences, this approach is clearly in line with utilitarian ethics.

As in many ethical dilemmas, situations in which harm reduction may be applicable include conflicts between different ethical principles, or moreover between ethical philosophies. This well-known tension between deontological and utilitarian ethical outlooks is at the base of many ethical dilemmas in medicine, including that of the justification of harm reduction. It has been proposed that an alternative to this narrow deontological-utilitarian dichotomy is the school of virtue ethics, most commonly associated with Aristotle (36). Virtue ethics do not focus on isolated acts but rather on the character of the agent (i.e., compassion, honesty, kindness, etc.). The highly regarded character traits are those well-balanced between the extremes. Moreover Aristotle views morality as depending on contextual factors; it is necessary to do the right thing, in the right way, to the right person. Virtue ethics thus takes into account context and consequences, without reducing ethics into a simple matter of promoting pleasure, reducing pain or doing one’s duty. In the case of harm reduction, it is proposed that the necessary character trait for policy makers and practitioners is that of compassion, which should be balanced between aiding a particular act as opposed to encouraging it (36). This form of virtue-based morality can provide an ethical foundation for some harm reduction policies without resorting to utilitarianism.

Regardless, dealing with the ethical and moral aspects of harm reduction is challenging and requires a structural framework. Though several frameworks have been proposed, in the following examples we will use the model proposed by White and Popovits (34). This model of ethical decision making comprised of a series of related questions, ensuring ethical issues are addressed adequately. Their model of ethical decisionmaking consists of three related questions:

1. Whose interests are involved and who can be harmed?
2. What universal or cultural specific values apply to this situation and what course of action would be suggested by these values? Which of these values are in conflict in the situation?
3. What standards of law, professional propriety, organizational policy or historical practice apply to this situation?

When addressing challenging ethical dilemmas like those described above, this framework facilitates a structured process which is critical if the complexity of the dilemmas are taken into account. The first principle highlights the fact that even in situations in which there is no apparent contradiction between values of autonomy, beneficence and non-maleficence for the patient, there are other individuals to be taken into account. In both cases described, although harm reduction practices (educating drug injectors about viable sites of injection and providing clean razors to self-cutters) support the patients’ autonomy to decide on their own behavior, have clear short-term benefits (reducing rates of infection) and adhere to principles of non-maleficence, other parties must be taken into account as well. The additional parties involved in these cases would include workers within the service providing the education (doctors, nurses, social workers), professional bodies (including associations, which have professional codes of conduct and standard), service commissioners (such as government health departments who focus on effectiveness and cost) and the local community. It is therefore important to note all of these, as ethical values can compete not only in the individual but among the different parties involved as well. As such, a beneficial act for one party may be experienced as maleficent for another. For example, supplying clean razors to self-cutters may benefit the patient (or, at least, this can be argued for), but at the same time compromise the professional integrity of the psychiatrist prescribing this practice, giving rise to competing ethical values between individuals – the patient and the doctor.

The second point emphasizes that alongside the well-known universal values of autonomy, beneficence, non-maleficence and justice, there are cultural values that must be considered as well. For example, this might suggest that though providing education regarding safe injection sites respects the patient's autonomy and has short-term beneficence, it conveys the idea that drug injection in general is acceptable in the society, which can be at odds with fundamental cultural values. It is therefore important to recognize not only the core biomedical values but the cultural norms and values as well.

The third point that White and Popovits emphasize is the very important and often overlooked influence that standards of law, professional propriety, etc., apply to the decision-making process and must be taken into account. In many cases, it may be these considerations, rather than competing values of autonomy, beneficence and non-maleficence, which determine the final course of action. It is therefore important to identify these considerations and openly recognize their importance. This means openly recognizing that one of the main factors taken into consideration when discussing the possible practice of educating drug injectors about safer sites of injection or handing out clean razors to self-cutters are those of professional propriety and potential malpractice. For example, can a psychiatrist be charged with malpractice if a self-cutting patient suffers severe injuries while using a razor prescribed by the psychiatrist? Adopting this question into ethical discussions allows raising the issue of what is achievable in the real world of clinical practice. Clinics operate on protocols that are "best fit" for the majority. This reinforces the need for simplicity and transparency in final guidelines, so that both staff and service users receive and acknowledge equitable treatment.

SUMMARY

Balancing competing ethical principles is a challenging task for clinicians. Harm reduction is an effective humanistic and pragmatic approach attempting to address this challenge. Though some harm reduction practices have become the norm, others are controversial, and challenge us regarding the ethical boundaries of the approach. Naturally, harm reduction focuses on health and social issues around which there is often community misunderstanding, stigma and fear. Successful treatments in these areas depend on novel methods and interventions which may often push the limits of knowledge and

accepted moral standards. Recognizing the theoretical and scientific background of harm reduction and using a structured ethical decision-making framework can assist the clinician when dealing with these complex ethical dilemmas. This may allow for using harm reduction strategies in general psychiatry in complex clinical situations where more efficient interventions are currently lacking.

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