

# **Risk Environments and the Ethics of Reducing Drug-Related Harms**

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People who use drugs (PWUD) are at risk of developing serious health problems, including injecting-related injuries or infections. Traditionally, the locus of responsibility for mitigating the risk of injury and infection has been the individual—with public health interventions focusing on individual-level behavior change. However, the environment in which people use drugs may also confer risks that are often synergistic and, though their effects are manifest in the individual, exist beyond the individual's locus of control. This “risk environment” can be defined as “the space—whether social or physical—in which a variety of factors interact to increase the chances of drug-related harm” (Rhodes 2002, 88). In the context of injection drug use, the risk environment confers both social risks (including discrimination and other factors that create social disadvantage) and physical risks (including violence, as well as harms resulting from impurities or adulterants in the drug supply). These features of the risk environment are ethically significant considerations that must be taken into account when assessing the appropriateness of particular therapeutic and research interventions for PWUD.

The purpose of supervised injectable opioid assisted treatment (sIOAT) is to mitigate the harms of injection drug use among treatment-refractory heroin users by providing a regular, controlled dose of diacetylmorphine (or, as was the case with the SALOME trial, hydromorphone) in a supervised setting. Evidence establishes that sIOAT can be acutely lifesaving (e.g., preventing overdose from fentanyl-laced heroin acquired on the street) and/or chronically life-extending (e.g., providing substitution treatment for people who do not respond to conventional treatment). (Strang et al. 2015) Though the safety and efficacy of sIOAT have been well established, concerns about the ethical permissibility of sIOAT persist. Often these concerns focus on questions about the extent to which chronic treatment-resistant heroin users are able to provide informed consent. This concern has been raised by Charland (2002), Cohen (2002), Henden (2013), and others.

Like Steel and colleagues, we argue that it is incorrect to assume that PWUD lack the decisional capacity to provide informed consent; however, we disagree with the authors' approach to voluntariness, and with their use of an unnecessary distinction between the provision of sIOAT as treatment and as research (Steel, Marchand, and Oveido-Joekes 2017). Instead, we argue that voluntariness should be understood in the context of the risk environment and frame our discussion within the context of the North American fentanyl crisis. Through structuring the ethical analysis of the permissibility of using sIOAT around the contextual features of the risk environment, we propose and briefly outline the benefits of adopting a “situated ethics” within which we seek to balance the

relevant ethical considerations surrounding the provision of siOAT in the current context in which it is being offered. It is hoped that such a perspective provides a more holistic basis upon which to assess the ethics of reducing drug-related harms.

## **DECISIONAL CAPACITY, COMPETENCY, AND VOLUNTARINESS**

If PWUD are not competent to consent, then siOAT would be ethically problematic. Empirical evidence, however, suggests that PWUD are not incompetent to consent merely by virtue of their drug use. For example, Hart and colleagues demonstrated that when crack users were offered either crack cocaine or US\$5 (or a merchandise voucher of equivalent value) they often chose the money over crack cocaine (Hart et al. 2000). While individual decisions, preferences, and values can change with drug use, we cannot presume that drug dependency alone renders PWUD unable to make rational trade-offs between drugs and other values or preferences. Further, the fact that some PWUD chose not to participate in siOAT treatment or research—as well as the fact that a significant number of participants drop-out of research studies of siOAT—suggests that PWUD are able to demonstrate the capacity to make decisions not to obtain safe drugs at no cost when offered or when otherwise available. While PWUD can have variable decisional capacity—as can people who do not use drugs—the mere fact that siOAT provides PWUD access to drugs should not be thought to eliminate the possibility of making situated rational decisions—insofar as we recognize that what is rational is largely determined by context. Since PWUD are not always, or even usually, incapable of demonstrating situated decisional capacity, we should not fail to provide access to siOAT on the basis of ethical concerns over how drug addiction may affect competence or decisional capacity.

Despite minimizing ethical concerns about the decisional capacity of PWUD, there is still a need to consider whether the provision of siOAT raises any concerns about voluntariness. Charland and others have raised concerns about whether, in offering drug-based interventions, voluntariness might be compromised; it provides an option too difficult to resist (Charland 2002). In regard to participating in siOAT interventions, we believe that PWUD can also act voluntarily, as they have access to options to do otherwise and frequently demonstrate their ability to exercise those options. Their ability and choice to forgo the benefits of obtaining drugs in different circumstances also speak against the view that the provision of drugs has to be viewed as an undue inducement. The offer of siOAT also does not subject PWUD to coercion or take the form of forced participation. When attempting to evaluate whether concerns about voluntariness should raise ethical problems for siOAT, we suggest that voluntariness should not be understood in absolute terms. Instead, it should be understood as a fluid notion that is informed and defined in the context of the risk environment.

## FENTANYL AND THE RISK ENVIRONMENT

In recent years, fentanyl has come to define the context of injection drug use in North America. Between July 7, 2016, and August 3, 2016, for example, fentanyl was detected in 86% of street drugs provided by users of the Insite safe injection site in Vancouver, Canada (Vancouver Coastal Health 2016). In the United States, overdose deaths attributed to fentanyl have risen from a stable level of 1600 annually in 2010–2012 to 4200 in 2014 (Warner et al. 2016). New forms of heroin, including fentanyl-adulterated heroin, represent a significant change in the risk environment for PWUD (Ciccarone 2017). Only 0.002 g of fentanyl within 0.1 g heroin is potentially fatal; such tiny amounts make it almost impossible to effect a controlled dose. The existence of fentanyl-adulterated heroin, therefore, represents a clear and immediate danger to anyone procuring street drugs. This environment of heightened risk requires that we balance a concern for voluntariness with the ethical imperative to facilitate access to potentially lifesaving interventions (in either a treatment or a research context).

Making contextual features of the risk environment prominent within an ethical analysis of intervention acceptability is not new. In the context of an emergency, for instance, we regularly undertake investigative, preventive, and therapeutic interventions in individuals and groups—prioritizing the risk of harm to self and others over determinations of their voluntariness to consent (Viens and Selgelid 2012; Viens 2013).

Therefore, in a context in which fentanyl-laced heroin poses an immediate and potentially deadly threat, we should forgo making voluntariness such a prominent concern in the interests of providing a potentially lifesaving intervention. The rationale for taking this approach is strengthened by the fact that the individual can do little to change or otherwise influence the risk environment and, as such, cannot reasonably be expected to bear personally the responsibility for avoiding fentanyl-laced drugs, even if the individual believes that doing so is in his or her own self-interest.

A focus on the risk environment seeks to bring to light, and put more emphasis on, the morally relevant social and physical features that contribute to the probability and magnitude of drug-related harm. It does not seek to reject or diminish potential nonmaterial harms that could result from providing access to siOAT to PWUD (such as those nonmaterial harms we associate with subjecting persons to investigative or therapeutic interventions without adequate consent). Instead, it puts both material and nonmaterial harms on the same scale as morally relevant considerations that need to be balanced—and, in some contexts, traded off against each other. When we look to the specific context of providing siOAT in the midst of the widespread presence of fentanyl in the drug supply, taking the risk environment seriously should mean that our ethical analysis will need to

reflect this. Finally, it is appropriate to emphasize that framing the risk environment as a central ethical consideration gives us the opportunity to develop a complimentary concept of the enabling environment, one that speaks to the ethics of enabling affected individuals the right to choose. &

## REFERENCES

- Charland, L. C. 2002. Cynthia's dilemma: Consenting to heroin prescription. *American Journal of Bioethics* 2 (2):37–47. doi:10.1162/152651602317533686.
- Ciccarone, D. 2017. Fentanyl in the US heroin supply: A rapidly changing risk environment. *International Journal of Drug Policy* 46:107–11. doi:10.1016/j.drugpo.2017.06.010.
- Cohen, P. J. 2002. Untreated addiction imposes an ethical bar to recruiting addicts for non-therapeutic studies of addictive drugs. *Journal of Law, Medicine & Ethics* 30 (1):73–81. doi:10.1111/j.1748720X.2002.tb00722.x.
- Hart, C. L., M. Haney, R. W. Foltin, and M. W. Fischman. 2000. Alternative reinforcers differentially modify cocaine self-administration by humans. *Behavioural Pharmacology* 11 (1):87–91. doi:10.1097/00008877-200002000-00010.
- Henden, E. 2013. Heroin addiction and voluntary choice: The case of informed consent. *Bioethics* 27 (7):395–401. doi:10.1111/j.14678519.2012.01969.x.
- Rhodes, T. 2002. The 'risk environment': A framework for understanding and reducing drug-related harm. *International Journal of Drug Policy* 13:85–94. doi:10.1016/S0955-3959(02)00007-5.
- Steel, D., K. Marchand, and E. Oveido-Joekes. 2017. Our life depends on this drug: Competence, inequity, and voluntary consent in clinical trials on supervised injectable opioid assisted treatment. *American Journal of Bioethics* 17 (12):32–40.
- Strang, J., T. Groshkova, A. Uchtenhagen, et al. 2015. Heroin on trial: Systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction. *British Journal of Psychiatry* 207 (1):5–14. doi:10.1192/bjp.bp.114.149195.
- Vancouver Coastal Health. 2016. 86% Of drugs checked at Insite contain fentanyl. News releases. Available at: <http://www.vch.ca/about-us/news/news-releases/86-of-drugs-checked-at-insitecontain-fentanyl2017>.
- Viens, A. M., ed. 2013. *Emergency research ethics*. Farnham, UK: Ashgate.
- Viens, A. M., and M. J. Selgelid, eds. 2012. *Emergency ethics*. Farnham, UK: Ashgate.

Warner, M., J. P. Trinidad, B. A. Bastian, A. M. Minino, and H. Hedegaard. 2016. Drugs most frequently involved in drug overdose deaths: United States, 2010–2014. *National Vital Statistics Reports* 65 (10):1–15.