A Theological Justification for the Provision of Medically Supervised Injecting Facilities for People who Inject Illicit Drugs

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Abstract

The aim of this thesis is to make a case that medically supervised injecting facilities for people who inject illicit drugs are morally permissible and that Roman Catholic healthcare professionals should be involved in establishing and running such facilities if they feel called to do so.

Medically supervised injecting facilities (MSIF) are places where people can inject illicit drugs in a clean environment, using sterile equipment and under the supervision of healthcare professionals. MSIFs aim to reduce the harm caused by injecting illicit drugs and so are considered a form of harm reduction. The purpose of an MSIF is to reduce infections, overdoses, and deaths among people who inject drugs (PWIDs) and to reduce public nuisance and the risk of infection to the public. Globally, there is a small but expanding number of MSIFs.

There are questions around the effectiveness of MSIFs. In addition, there are social, legal and moral questions around the provision of MSIFs. The provision of MSIFs is a contentious issue and within the Roman Catholic Church, questions have been raised about the moral acceptability of such facilities.

This thesis aims to answer two questions. Are medically supervised injecting facilities for people who inject drugs morally acceptable? Is the provision of an MSIF an authentic way for Roman Catholic healthcare professionals to live out their commitment to Gospel values? The principles of cooperation in evil and gradualism are used to deal with these questions. The issues discussed in this thesis focus on the debates about the establishment of MSIF in Australia, North America, Ireland and Scotland.

Chapter 1 provides a historical background to illicit drug injecting and describes the origins, development and contentiousness of medically supervised injecting facilities.

Chapter 2 explains the role of practical theology within this thesis, the research methodology that is used and focusses on the reflexivity of practical theology and the vocation of the laity within the Roman Catholic Church.

Chapter 3 presents evidence that shows that MSIFs are both clinically and economically effective.

Chapter 4 applies the principle of cooperation in evil to justify the provision of MSIFs. The provision of a medically supervised injecting facility involves some degree of cooperation in illicit drug injecting. Injecting illicit drugs is understood as a moral evil. The principle of cooperation in evil is a traditional moral theology principle that is used to determine whether and to what degree one can cooperate in an evil act, in this case illicit drug injecting.

Chapter 5 applies the idea of gradualism to the provision of medically supervised injecting facilities. Gradualism is based on the understanding that moral development is a step-by-step process. Having found that the principle of cooperation in evil principle requires qualification to do justice to certain situations, the case is made that gradualism is an appropriate tool, in

addition to the principle of cooperation in evil, for exploring the morality of the provision of MSIFs. Gradualism involves a purpose of amendment. The use of an MSIF by a PWID to reduce the harm caused by injecting illicit drugs can indicate a purpose of amendment and a significant step in the right direction.

Chapter 6 discusses the situation that arose in Australia in 1999 when the Sisters of Charity planned to establish an MSIF in Sydney and the Congregation for the Doctrine of the Faith (CDF) blocked this proposal. The response from the CDF is analysed in detail and shown to be flawed.

Chapter 7 discusses the situation in North America comparing the very different views taken by the Canadian Conference of Catholic Bishops (CCCB) and the United States Conference of Catholic Bishops to the provision of harm reduction for PWID. The CCCB has given cautious approval of MSIFs. However, the USCCB has taken a much harder line to harm reduction in general to the extent of dismissing needle exchange as an appropriate means of harm reduction in 1990. Although the USCCB has not made any statement on the provision of MSIFs, several American theologians and at least one bishop have argued against MSIFs. Their arguments are analysed and criticised in this chapter.

Chapter 8 discusses the situation in Ireland, in particular the attempts by the Franciscan friars to set up an MSIF. Merchants Quay Ireland, a project run by the Franciscans was chosen by the Irish government to run a pilot MSIF in 2018. This proposed MSIF does not seem to have attracted any objection from within the Roman Catholic Church. However, the implementation of the MSIF has been delayed by legal problems and objections from the local community.

Chapter 9 discusses the attempts to set up a medically supervised injecting facility in Glasgow. A plan for an MSIF in Glasgow has run into legal difficulties. These difficulties and the response of the Roman Catholic Church in Scotland and the Church of Scotland to the proposal are discussed in this chapter. In addition, the decision by Peter Krykant to set up a mobile MSIF in Glasgow is discussed.

Conclusion.

The thesis finds that:

The provision of medically supervised injecting facilities for people who inject illicit drugs is morally permissible within certain conditions. Furthermore, the provision of medically supervised injecting facilities is not just morally permissible but is morally desirable because it is in harmony with the preferential option for the poor. Although opinion on the morality of the provision of MSIFs is divided in the Roman Catholic Church, this thesis argues that Roman Catholic healthcare professionals are morally justified in establishing and running medically supervised injecting facilities.

Table of contents

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This thesis is dedicated to the memory of my boy Brandon Rice, who at the age of 17, died from an ecstasy overdose while I was writing this thesis.

Ad marjorem Dei gloriam.

Author's Declaration

I confirm that this thesis is my own work and that I have:

Read and understood the University of Glasgow Statement on Plagiarism

Clearly referenced, in both the text and the list of references, all sources used in this work

Not made use of the work of any other student(s) past or present without acknowledgement. This includes any of my own work, that has been previously, or concurrently, submitted for assessment, either at this or any other educational institution.

Not sought or used the services of any professional agencies to produce this work

List of Abbreviations

AIDS Acquired Immune Deficiency Syndrome

BBV Blood Borne Virus

CDF Congregation for the Doctrine of the Faith

CHCP Community Health and Care Partnership

DVT Deep Vein Thrombosis

EMCDDA European Monitoring Centre for Drugs and Drug Addiction

HCV Hepatitis C Virus

HIV Human Immunodeficiency Virus

HSE Health Service Executive

NHS Nation Health Service

MSIF Medically Supervised Injecting Facility

NGO Non-Government Organisation

NX Needle Exchange

OFM Order of Friars Minor

PWID People Who Inject Drugs or Person Who Injects Drugs

Introduction

Aim

The aim of this thesis is to make a case that medically supervised injecting facilities (MSIF) for people who inject illicit drugs (PWID) are morally permissible and that Roman Catholic healthcare professionals should be involved in establishing and running such facilities if they feel called to do so. Specifically, Roman Catholic healthcare professionals in Scotland should be involved in establishing and running the proposed medically supervised injecting facility in Glasgow.

The Problem

The provision of medically supervised injecting facilities is a difficult and contentious issue that divides opinion in the Roman Catholic Church and in wider secular society principally because of the inherent moral ambiguity involved in such provision due to cooperation with the morally illicit practice of injecting drugs such as heroin. While some harm reduction services such as needle exchange have been provided by Catholic healthcare organisations, other services such as MSIFs continue to be controversial. Indeed, some Catholic theologians and bishops reject MSIFs as misguided and contrary to moral law (Fisher, 1999; Chaput, 2019; Bozza & Berger, 2020).

The Intractability of Injecting Illicit Drugs

Illicit drug use has been going on for thousands of years and is a problem that is set to continue for the foreseeable future. Unfortunately, there are now several million people throughout the world who are addicted to heroin and inject it on a regular basis. (United Nations Office on Drugs & Crime, 2015). This is detrimental to both their physical and mental health and has damaging effects on their families and the communities in which they live. Many people are desperate to stop using heroin but due to its addictive nature find it immensely difficult without expert help. Heroin is not just psychologically addictive, but it is also physically addictive.

Consequently, when a PWID suddenly stops using heroin, they suffer withdrawal symptoms that include nausea, vomiting, diarrhoea, muscle and bone pain, shaking and shivering, excessive sweating, palpitations, sleep disturbance, and unpleasant dreams. According to Stimson and Choopqanya (1998, 1) drug injecting takes place in countries of all religions, at all stages of economic development and in all political systems. It is a persistent problem with no easy solution.

MSIFs as Part of the Solution to Illicit Drug Injecting

Needle exchanges were first introduced in the 1980s to reduce the risks of harm associated with injection. A needle exchange is a service where people who inject drugs can initially collect a supply of sterile needles and syringes and also exchange used needles and syringes for sterile ones. Additionally, clients are usually supplied with a "sharps" container for the safe storage and return of used needles and syringes (Derricott *et al.,* 1998). Most needle exchanges in the UK provide other injecting paraphernalia and are anonymous (Riley & O'Hare, 2000). Over the last four decades needle exchanges have developed from being purely suppliers of clean injecting equipment into holistic harm reduction clinics. The concept of harm reduction will be discussed in Chapter 1.

Medically supervised injecting facilities are a more recent development in harm reduction services within a healthcare setting. This morally contentious development will be the major topic of this thesis. These are services in which people can inject illicit drugs in a safe clean environment with doctors and nurses on the premises to provide harm reduction advice and to intervene if someone takes an overdose. These services also provide opportunities and encouragement for PWIDs to overcome their addictions. The majority of MSIFs are provided as part of an integrated drug service that includes addiction treatment services and rehabilitation services. Staff in the harm reduction services encourage PWIDs to engage with treatment services while at the same time recognising that relapse is not unusual and encouraging them to continue their struggle rather than judge them. Most MSIFs are not standalone services. Almost all MSIFs have links to drug treatment services and encourage clients to engage with such services rather than continue to inject. An MSIF is not in itself a solution to an individual's drug problem. However, the provision of an MSIF can contribute to solving the problem and can keep a PWID alive until they are ready and able to take the next step in addressing their addiction.

The Reasons for Conducting This Research

People have been injecting illicit drugs in public places in Glasgow city centre for a considerable number of years. This criminal activity is both a public nuisance and a public safety issue. The risk of infection from discarded injecting paraphernalia is a serious threat to public health. In addition, this is an unhygienic environment where there is a high risk of the PWID of being caught in the act of injecting by the police. The unhygienic environment increases the risk of infection. Fear of arrest can lead to rushed injecting which increases the risk of injury to the PWID. In response to these issues, in 2017 NHS Greater Glasgow and Clyde recommended the establishment of a medically supervised injecting facility in the centre of Glasgow (NHS Greater Glasgow and Clyde 2016).

What is the proper moral response to this proposal? Are MSIFs morally permissible and morally desirable? Should Roman Catholic healthcare professionals be involved in establishing and running such facilities?

I have been a nurse for over twenty years and almost my entire career has been spent looking after the health of marginalised people. From a very young age, I have felt called to live out the Church's preferential option for the poor. Although, it was not until adulthood that I had the knowledge and vocabulary to express this calling. I believe that my career as a nurse and in particular looking after the health of the poorest in our society is my vocation; it is what God has called me to do in life.

It is vitally important for me and others who share a belief that we are called by God to serve the poorest and most marginalised in our society, that we develop a good theological understanding of what we do and why we do it. Gustavo Gutiérrez (1992) has described theology as the interpretation of the relationship between orthodoxy and orthopraxis; it is how we as Christians put faith into practice, how we live out the truth of the Gospel. It is right and proper that as Christians, we should know about our faith and are able to articulate how we try to put it into practice in caring for the poorest of our brothers and sisters. We need to be able to give an account of the hope that is in us and motivates our work. In working with PWIDs, we are not just performing a clinical role but are trying to live out the Gospel and the Church's preferential option for the poor. In order to do this effectively we need critically and theologically to examine what we are doing. Is providing and working in an MSIF morally good? Is the provision of an MSIF for PWID an authentic way to live out the Gospel?

Chapter 1

Historical Background:

The Origins, Development and Contentiousness of Medically Supervised Injecting Facilities

1.1 Introduction

The aim of this chapter is to set the scene and give a brief description of the contentiousness within both secular society and in the Roman Catholic Church of the issues around MSIFs. The aim of this chapter is to show that illicit drug abuse is a persistent problem that has been going on for many centuries and that the means of addressing the problem of drug abuse are contentious. It will briefly outline the origins of MSIFs and show that MSIFs are part of the wider harm reduction strategy that has its roots in the threat to drug injectors from human immunodeficiency virus (HIV); it will briefly explain what the aims of an MSIF are and it will explain that MSIFs are both supported and condemned by different groups and individuals within the Roman Catholic Church.

1.2 Origins of Recreational or Non-Therapeutic Drug Injecting

In this section, I will show that the recreational use of drugs has been going on for many centuries and that the injecting of illicit drugs has been going on since shortly after the hypodermic needle was invented. Injecting drug use is closely associated with serious infections. It is a longstanding problem that is likely to be ongoing for the foreseeable future. Although not a solution - though it might play a role in a solution - harm reduction services, including MSIFs can be used to alleviate the suffering caused by illicit drug injecting. In addition, MSIFs can be used to alleviate not only the suffering experienced by PWIDs but also the harm caused to the families of PWIDs and members of the local communities where PWIDs inject their drugs.

Extracts from the opium poppy have been used for thousands of years to dull physical and emotional pain (Whitehorne, 1977). By the end of the nineteenth century, hypodermic needles and syringes were widely available. This enabled the injection of opiates avoiding many of the unpleasant side effects associated with taking them orally (Rosenhek, 2009). However, the use

of hypodermic needles involved the unforeseen risk of infection and the first reported cases of infection associated with injection were recorded in 1874 (Derricott *et al.,* 1998, 12).

The risk of infection is greatly increased when any injecting paraphernalia, including syringes and needles, are shared by PWIDs. A particularly serious example of infection has been due to the human immunodeficiency virus (HIV). This virus was first isolated in May 1983 (Barre-Sinoussi *et al.,* 1983) and it was soon discovered that HIV can be transmitted by sharing injecting equipment (Huo *et al.,* 2005). Other infections associated with sharing injecting equipment include hepatitis and bacterial and fungal infections of the skin, heart valves, lungs and brain (Sulmasy, 2012). Injecting illicit drugs also greatly increases the risk of deep vein thrombosis (DVT) and associated complications such as leg ulcers and pulmonary embolism (Cornford *et al*., 2011).

1.3 The Concept of Harm Reduction

In this section, the concept of harm reduction for PWIDs will be defined. This definition deals purely with the harms to PWIDs and does not include the wider harms to society that are caused by illicit drug use. Ritter and Cameron (2006) suggest that there is not one agreed definition of "harm reduction" arguing that the term refers to both a philosophical approach to healthcare and a variety of interventions and programmes. Kleinig (2008) argues that the concept of harm reduction can be traced back at least as far as the Marques of Queensbury's Rules of boxing. The concept is much wider than reducing the harms associated with injecting illicit drugs and refers to reducing any kind of harm to health. The Canadian Nurses Association (2017, 15) describes harm reduction as a public health approach that seeks to reduce the consequences of actions that have an increased risk of negative health related outcomes. This understanding of harm reduction is significantly wider than reducing the harm associated with illicit drug injecting; it includes encouraging the use of seatbelts in a car, wearing a crash helmet when riding a motorbike and bans on advertising cigarettes and alcohol.

The aim of harm reduction services for PWIDs is to alleviate or reduce the harms caused by injecting illicit drugs. In addition to the harms to health listed in the previous section (1.2) the Canadian Nurses Association (2017, 10) shows that illicit drug injecting is associated with social harms including stigma, discrimination, homelessness, unemployment, violence, and economic costs. Ksobiech (2006) has a narrower focus stating that harm reduction seeks to

ameliorate a variety of harms to health associated with the use of psychoactive drugs without necessarily demanding a reduction or cessation in consumption. On the other hand, the Misuse of Drugs Act (1971) and the legislation in other jurisdictions that prohibit the use of certain psychoactive drugs, aim to reduce harm by reducing or eliminating the use of these drugs (Holland, 2020).

For the purposes of this thesis, harm reduction for people who inject drugs will be defined as a clinical service that seeks to reduce the damage to physical health caused by injecting illicit drugs without necessarily demanding that the PWID stops injecting illicit drugs.

Needle exchange was the original method of harm reduction for PWIDs. In the next section, I will describe how harm reduction services for PWIDs have developed over a period of more than forty years from basic needle exchanges to more comprehensive services.

1.4 The Development of Medically Supervised Injecting Facilities

In this section. I will give a brief outline of the development of MSIFs. I will begin with a description of the first needle exchanges, how they developed into wider harm reduction clinics and the ongoing development of medically supervised injecting facilities. I will point out the main difference between early needle exchanges and MSIFs. The purpose of this brief outline is to make it clear what exactly MSIFs are and what they aim to do.

The world's first needle exchanges (NX) were established in the cities of Groningen and Den Helder in the Netherlands in 1981 in response to an outbreak of hepatitis B (Derricott *et al.,* 1998, 22). However, the threat of HIV prompted the establishment of needle exchanges elsewhere in the early 1980s to provide PWIDs with sterile needles and syringes and a safe means of disposing of used injecting equipment (Riley & O'Hare, 2000). Since then, harm reduction services have developed from simple suppliers of sterile injecting equipment to holistic services that provide a wide range of injecting paraphernalia, foil for smoking heroin, condoms, general health advice, safe injecting advice, wound care, antibiotics for infected injecting sites, blood borne virus (BBV) counselling and testing, BBV vaccinations, sexual health services, referrals to specialist health clinics and referrals for substance abuse treatment (Des Jarlais *et al.,* 2009).

Medically supervised injecting facilities are a further development in harm reduction. They are known by a number of different terms including safe injecting facilities, safe injecting sites, medically supervised injecting centres, and drug consumptions rooms. The different terms used are indicative of different approaches and ways of working in different services. Throughout this thesis, the term "medically supervised injecting facility" (MSIF) will be used. This term emphasises that these are not just places where people can go to inject illicit drugs; they are not just "shooting galleries" but are medical facilities in which there are specialist healthcare professionals on site to deal with medical emergencies and to ensure that PWIDs are injecting in the least dangerous manner. These are facilities in which people can inject illicit drugs that they have acquired elsewhere, in a clean environment that is relatively safe. It is important to be aware that injecting any kind of drug, including prescribed medication, is a dangerous activity. Injecting illicit drugs is even more dangerous and can never be made completely safe. There is no quality control for illicit drugs and so the PWID cannot be sure of the dose that they are injecting. This greatly increases the risk of overdose. Furthermore, illicit drugs are not manufactured in aseptic conditions. This significantly increases the risk of infection for the PWID. Intravenous injecting of illicit drugs carries a high risk of overdose. Medical and nursing staff in an MSIF can initiate treatment if a PWID overdoses. It is unusual for PWIDs to have received formal training in the administration of intravenous injections. In more than 20 years of working in addiction services, I have never met a PWID with formal training in injecting technique. In an MSIF, doctors and nurses can advise PWIDs on the least dangerous ways in which to do an intravenous injection. This would include advice on which injecting sites on the body to avoid and very basic hygiene advice such as hand washing and cleaning the injecting site. According to the Scottish Government in 2021 there were more than one hundred MSIFs operating worldwide in at least sixty-six cities within ten countries (Scottish Government, 2021).

The main difference between an MSIF and a traditional harm reduction service is that in a traditional harm reduction service the clients are given sterile injecting paraphernalia to take away and use to inject illicit drugs elsewhere. Whereas in an MSIF the clients inject illicit drugs onsite within the MSIF under the supervision of specialist doctors and nurses, using sterile injecting paraphernalia provided in the MSIF. Both traditional harm reduction services and MSIFs provide additional health services for PWIDs, including wound care, treatment of bacterial infections, BBV testing and vaccinations for BBV.

According to Zajdow (2006), MSIFs tend to be used by PWID with the most challenges, many of whom have other problems such as being homeless, having recently been liberated from prison or be suffering from mental illness. More up to date information from the Scottish Government (2021) shows that homeless PWIDs are more likely to use MSIFs. This is unsurprising as one of the aims of MSIFs is to reduce injecting in public (Bayley, Bouchard and Yant, 2017; Strike, *et al.* 2014). Many homeless PWIDs inject in public because they have no other choice; they do not have a private place in which to inject.

Some MSIFs allow not only injecting but also other routes of drug consumption such as smoking. The traditional needle exchange type of harm reduction service provides PWIDs with a wide range of sterile injecting paraphernalia and other equipment and advice that will reduce the physical harm associated with injecting illicit drugs. However, in an MSIF, not only is sterile injecting paraphernalia supplied, but a clean safe space is provided for people to inject their drugs. Healthcare professionals are on hand both to advise on the safest, or least dangerous, ways to inject and to start emergency treatment if a client should overdose. Additionally, the healthcare professionals on hand can diagnose and treat other physical ailments associated with illicit drug injecting such as infected wounds and deep vein thrombosis (DVT). Furthermore, medically supervised injecting facilities aim to improve their clients' engagement with a wide variety of health services including addiction treatment services.

According to Bayley, Bouchard and Yant (2017) MSIFs have a number of aims. Their primary aim is to reduce the incidence and prevalence of disease and death among PWIDs. In addition, MSIFs are designed to improve the public health and reduce public order problems associated with injecting illegal drugs in public places (Strike, *at al.* 2014).

It is important to note that MSIFs do not supply illicit drugs and the PWIDs who use MSIFs need to obtain illicit drugs elsewhere. Furthermore, drug dealing is not normally tolerated within an MSIF. However, in order for an MSIF to be able to operate there needs to be some tolerance of the possession and consumption of illegal drugs in and around the MSIF. This issue will be discussed in more detail in Chapter 9. MSIFs aim to make the injecting of illicit drugs less dangerous but do not supply illicit drugs or licit medication.

However, there are a variety of pharmaceutical treatments for PWIDs available elsewhere. Methadone is the most commonly prescribed opiate replacement therapy in Scotland (Hill *et al.,* 2015). Buprenorphine, either on its own or in combination with naloxone is prescribed as

an alternative to methadone and is frequently used for rapid detoxification in highly motivated patients (Hill *et al.,* 2015). There are some specialist services in which pharmaceutical grade heroin – diamorphine - is prescribed as a from a maintenance therapy for PWIDs who do not respond to methadone or buprenorphine treatment (Department of Health, 2017).

Although it is legal to prescribe these drugs, methadone, buprenorphine and heroin are all physically addictive. Despite being addictive, the prescribing of these drugs has certain distinct advantages over illicit "street" heroin. If a PWID buys a wrap of heroin from a dealer, they will not know how much heroin is in the wrap. It is possible that the amount of heroin in the wrap can be determined by analysis in a laboratory, but this would involve specialist skills and equipment that are not normally available to a PWID. Therefore, the PWID does not know how much heroin they are injecting and so there is a much higher risk of overdose with the illicit heroin compared with a licit prescription. It is also unlikely that the PWID will know what the contaminants may be in the wrap of illicit heroin. However, the prescribed drugs are manufactured under strict conditions to reduce the risk of contamination. Therefore, the consumption of prescribed medication carries a much lower risk of infection and other harms associated with contamination.

Although prescribing physically addictive drugs to treat drug addiction is both morally and clinically problematic, it is not the focus of this thesis. This thesis will focus specifically on the morality of MSIFs and will leave aside the issues around the pharmaceutical treatment of addiction.

The history of MSIFs is complex and contested. In the 1980s and 90s there were illegal "shooting galleries" in New York City and Sydney. Organised crime groups ran these for profit and the safety and wellbeing of the clients were not a high priority for the operators (Dolan *et al*., 2000). In addition, research in the USA showed that there was a close correlation between use of "shooting galleries" and HIV infection among PWIDs (Wodak, 1999). According to Kimber and Dolan (2007), the operators charged $(AUS)10 fee for using the "shooting galleries" in Sydney, which were open 24 hours a day. Sterile injecting equipment was available for an extra fee. It was not unusual for prostitutes to use the same premises that were used as "shooting galleries". The combination of sex work and drug injecting was associated with widespread presence of faeces, vomit, sexual fluids, and blood, thus vastly increasing the risk of infection. Despite the risks, PWIDs were willing to pay the AUS$10 as using the "shooting gallery" alleviated the stress associated with public injecting. In addition, if a PWID

overdosed in a “shooting gallery”, there was a much greater chance of an ambulance being called than if they overdosed in a public space (Kimber & Dolan, 2007). Although I cannot find any evidence in the academic literature, I have personal experience of “shooting galleries” being set up in abandoned tenements in peripheral housing estates in Edinburgh in the late 90s and being used at the turn of the century. The tenement flats that were being used as “shooting galleries” had been cleared of their tenants and were awaiting demolition. They were a convenient place for PWIDs to inject indoors, in relative safety, protected from the weather and out of sight of the police. I have no evidence to suggest that the Edinburgh “shooting galleries” were being run for profit; it was merely a convenient coincidence that there were suitable empty buildings in areas that had a high prevalence of drug injecting.

Although the “shooting galleries” of New York, Sydney and Edinburgh gave some protection to PWIDs and reduced the risks to the public from the discarding of contaminated needles and syringes, they differ markedly from the legally sanctioned or legally tolerated MSIFs, in the care on offer in these facilities. PWIDs are provided with sterile injecting paraphernalia in the legally tolerated MSIFs and a clean environment. In addition, there are nurses and doctors in the MSIFs who can advise on the least dangerous ways to inject and can start medical treatment when a PWID overdoses.

Haemming & van Beek (2005, 161) state that the world’s first legally sanctioned drug consumption facility evolved in Berne, Switzerland in the late 1980s. A café had been set up for PWIDs who were unwelcome elsewhere. Customers of the café began to use it as a safe place to inject heroin and after discussion with law enforcement agencies, safe injecting in the café was legally sanctioned. Legally sanctioned medically supervised injecting facilities were opened up in other Swiss cities, in Germany and the Netherlands in the 1990s and from 2000 onwards in Spain, Luxembourg, Norway, Canada and Australia (Hedrich *et al.,* 2010, 307).

In a thesis that deals with the morality of harm reduction services, it is important to be clear that these services primarily aim to reduce the physical harms caused by injecting illicit drugs. In 1.3, I stated that harm reduction services for PWIDs aim to reduce the harms to PWIDs caused by injecting illicit drugs. MSIFs have a wider purpose in that they aim to reduce harm to the general public as well as PWIDs. The purpose of an MSIF is to reduce the risk of overdose and infection among the PWIDs who use the service and to reduce the risks to the public that are associated with public injecting. Injecting illicit drugs in a public place carries a high risk to the PWID of infection, vein damage and death from overdose. In addition, it

increases public nuisance and the drug litter associated with public injecting increases the risk of members of the public being infected by contaminated injecting paraphernalia. Harm reduction services aim to reduces these risks to both PWID and to the general public. The aim of these services is to reduce illness and death; they are not primarily concerned with the morality of injecting illegal drugs.

1.5 Medically Supervised Injecting Facilities and the Catholic Church

In this section, I shall consider the reaction of the Roman Catholic Church to attempts to establish MSIFs. I shall briefly describe four attempts to establish MSIFs delineating some of the theological arguments against the provision of medically supervised injecting facilities.

Two of these attempts to establish an MSIF were made by Roman Catholic organisations; St Vincent's in Sydney and Merchants Quay in Dublin would have been or will be operated by Catholic organisations.

The MSIF in Philadelphia is operated by an organisation called Safehouse, which is not a Catholic organisation. However, according to their own website, the leaders and organisers of Safehouse state that they are motivated by their Judeo-Christian beliefs (Safehouse, 2021). The proposal for Safehouse to establish an MSIF in Philadelphia precipitated a strongly worded condemnation of MSIFs by the then Archbishop of Philadelphia, Charles Chaput OFM Cap.

The fourth proposed MSIF to be described is in Glasgow. This does not have any specific links to the Catholic Church or to any religious organisation. However, it is included because it would be operated by NHS Greater Glasgow & Clyde. This is the health board that has employed me as a nurse for many years and so if I ever work in an MSIF, this is the facility in which I would be most likely to work. Many of my colleagues and I are motivated by our Christian faith to work with this particular group of people and so it is appropriate that some detail of this facility is included in my discussion. Furthermore, this thesis specifically attempts to answer the question should Roman Catholic healthcare professionals be involved in establishing and running the proposed medically supervised injecting facility in Glasgow? Is providing and working in an MSIF an authentic way for us to live out our Christian vocation?

1.5.1 St Vincent's Sydney

The earliest known instance of a Roman Catholic organisation attempting to set up an MSIF was in Sydney, Australia in 1999. Australia's first legally sanctioned MSIF would have been operated by the Sisters of Charity in St Vincent's Hospital. This was planned as an initial eighteen-month pilot project. However, the then Archbishop of Sydney, Edward Cardinal Clancy, referred the proposal to the Congregation for the Doctrine of the Faith (CDF). In a letter to Cardinal Clancy, the CDF refused permission for the sisters to operate the MSIF. The arguments put forward by the CDF in its determination were based, almost completely on the principle of cooperation in evil. However, the letter from the CDF also stated that there was not enough evidence of the effectiveness of MSIF and that there were some concerns about the sisters cooperating with the State of New South Wales. The reasons given in this letter for refusing permission will be discussed in more detail in Chapter 6 of this thesis (Fisher, 2012, 80).

1.5.2 Merchants Quay Ireland, Dublin

A further attempt by a Catholic organisation to set up an MSIF was in Dublin. In February 2018, the Irish Health Service Executive (HSE) announced that "Merchants Quay Ireland" was the preferred bidder to operate the first MSIF in Ireland. It was expected to open in 2021, initially as an 18-month pilot project. However, this proposed MSIF has come up against legal and logistical objections rather than theological objections. The manner in which these objections have been addressed shows a high degree of Christian moral thinking and are to a large extend based on key principles of Catholic social teaching.

1.5.3 Philadelphia

Initially the only legally sanctioned MSIFs operating in North America were in Canada. The Canadian Catholic bishops approved of the provision of MSIFs with some caveats. However, in October 2019 a US federal court gave legal clearance for an MSIF to be set up in Philadelphia (Bernstein, 2019). This news was greeted with sadness and condemnation by Archbishop Charles Chaput OFM Cap., the then Archbishop of Philadelphia who argued against the establishment of an MSIF on both moral and scientific grounds (Chaput, 2019). In addition to Archbishop Chaput, one priest of the archdiocese and two theologians closely connected to the Archdiocese of Philadelphia argued against the establishment of an MSIF. Their arguments were wide ranging and based on a variety of principles including cooperation in evil and

Catholic social teaching. The Philadelphia objections will be considered in some detail in Chapter 7.

1.5.4 Glasgow

In 2017, an MSIF was proposed for Glasgow City Centre, to be operated by Glasgow Community Health and Care Partnership (CHCP). Glasgow City Integrated Joint Board asked the Lord Advocate – at that time James Wolffe QC - for an exemption from the Misuse of Drugs Act (1971) so that those using the MSIF would not be arrested or prosecuted for possession of illicit drugs in the MSIF or its immediate vicinity. The Lord Advocate replied that he did not have the authority to grant such an exemption and the matter was referred to the Home Office. The Drugs Legislation Team at the Home Office stated that the UK Government had no intention to change the law to enable the establishment of an MSIF. The proposal remains in a legal deadlock and the Scottish bishops have not made any statement about it. However, several Church of Scotland ministers and at least one senior police officer have expressed their support for a MSIF in Glasgow. This proposal and the reactions to it will be discussed in detail in Chapter 9.

1.5.5 Catholic Arguments Against the Provision of Medically Supervised Injecting Facilities

Roman Catholic bishops and theologians have made number of arguments against MSIFs. These arguments include that MSIFs are not clinically effective, that they are an inefficient use of resources, and they involve an unjustified cooperation in evil. These arguments have all been put forward in response to the various proposed MSIFs that will be discussed in later chapters.

1.6 Summary

Medically supervised injecting facilities are part of the ongoing development of harm reduction services that were initially established principally in response to the threat of HIV. They aim to reduce deaths and disease among PWIDs and to protect the general public from the dangers of infection from discarded injecting paraphernalia. Furthermore, they aim to be a route for PWIDs to engage with health services in general and drug treatment services in particular.

There has been strong Church opposition to the operation of MSIFs in some places, such as Sydney and Philadelphia but apparently no Church opposition in other places. Although, the retired archbishop of Philadelphia has condemned MSIFs, the proposed facility in Philadelphia would be run by an organisation that professes Judeo-Christian values. In addition, opposition has come not only from Church groups, but also from secular organisations. In Dublin, objections to the MSIF have come from local businesses, while in Glasgow the major difficulty with the establishment of an MSIF has been legal. Despite this, the proposal for an MSIF in Glasgow has received wholehearted support from at least one Church of Scotland minister.

The moral arguments for and against the provision of an MSIF will be examined in later chapters in this thesis. However, before examining the moral arguments, it is essential to show that MSIFs are effective in what they set out to do. If MSIFs were ineffective, then their provision would be both pointless and unequivocally unethical. In Chapter 3, I will present evidence that will show that MISFs are both clinically and economically effective. In the next chapter, I will discuss the way in which this thesis fits into the discipline of practical theology and the research methodology that will be used in this thesis.

Chapter 2

Research Methodology

Practical Theology and the Role of the Lay Catholic Health Professional

2.1 Introduction

The purpose of a chapter on methodology is to inform the reader clearly and unambiguously how the research was carried out and why it was carried out in that particular way, so that the findings can be trusted (Biggam, 2010, 114). As this is a thesis for a doctorate in practical and moral theology, it is important to show what practical theology is and how this thesis is a piece of practical theology. This chapter begins with a discussion on the nature of practical theology before going on to describe the methodology used in this thesis.

2.2 Practical Theology

Before deciding exactly how to do research in practical theology it is important to know what practical theology is and what distinguishes it from other areas of theology. Practical theology is wide and varied and there is not one agreed definition but a multiplicity of definitions and descriptions.

Several hundred years before the birth of Christ, and therefore before there was such a discipline as Christian theology, Socrates is reputed to have claimed that the "unexamined life is not worth living" (Brickhouse & Smith, 1994, 201). Over a thousand years later Anselm of Canterbury was taking Socrates' advice and examining his life and in particular his faith in great detail and in doing so gave us the classic definition of theology as "faith seeking understanding" (Stanford Encyclopaedia of Philosophy, 2000).

There are a variety of different ways in which faith can seek understanding. Among these sub-disciplines of theology, practical theology is one of the most difficult to define succinctly. Bonnie Miller-McLemore argues that practical theology is a "multivalent" term that refers to at least four different and distinct things; an activity of faith among believers, a method for studying theology in practice, a curricular area within theological education and a scholarly discipline (Miller-McLemore, 2011, 5). Practical theology can be understood within this piece

of doctoral research as studying theology in practice. In this thesis, I will be examining how Catholic healthcare workers can live out their vocation in practice and how they can understand the theological underpinning of the clinical work that they do.

Stephen Pattison and James Woodward (2000, 1) make a distinction between pastoral and practical theology. They state that pastoral theology is the older term that is still used predominantly in the Roman Catholic tradition to describe the theological reflection that informs and guides practical pastoral activity. The term "practical theology" emerged in the German Protestant tradition in the late eighteenth century. Practical theology is seen as wider and includes pastoral theology as one of its many specialist areas of concern. Practical theology is concerned with how practical action that influences and interacts with the world around us can be theologically informed and influenced. Thus, it consists of theological reflection on practice. It involves reflection on actions, issues and events that are of human significance in contemporary society.

This thesis is not concerned with pastoral activity in the traditional sense; it is not concerned with the pastoral work that is normally carried out by clergy and lay pastoral workers such as Eucharistic ministers. However, it is concerned with theologically reflecting on the practical clinical work done by doctors, nurses and other healthcare professionals who look after the health and wellbeing of people who inject drugs. Many of these healthcare professionals will understand their work not just as a professional occupation but as a vocation, a calling from God. Providing healthcare is what God has called them to do with their lives, specifically providing healthcare to some of the poorest and most marginalised people in the societies in which they live.

John Swinton and Harriet Mowat (2006, 4) emphasise the importance of performance in practical theology. They argue that the Gospel is not just to be read but needs to be lived. They describe practical theology as a critical theological reflection on the practices of the Church and the ways in which they interact with the practices of the world with a view to living out and performing the Gospel more faithfully. This thesis will not focus specifically on practices within the institutional Church but will concentrate on how Catholic healthcare professionals, most of whom are lay people, live out their Christian vocation in their working lives.

According to Claire Wolfteich (2014, 2) practical theology involves thinking critically about what we do and how we live out our faith. It entails the examination of practices, contexts, cultures, and communities in the light of faith. Although practical theology has its roots in the

Protestant theological tradition, Wolfteich (2014, 3) argues that the Catholic contribution to practical theology is growing robustly. She goes on to argue that the Catholic theological tradition and imagination are especially well suited to the creative work of practical theology. Wolfteich (2014, 11) states that from Leo XIII's 1891 encyclical *Rerum Novarum* right up until the present day, Catholic Social Teaching has brought a critical faith perspective to contemporary economic, political, social and cultural issues and that the *Pastoral Constitution on the Church in the Modern World, Gaudium et Spes* can be seen as a preeminent work of practical theology (Wolfteich, 2014, 12).

In this thesis in practical theology, writings in Catholic social teaching and Catholic moral theology will be drawn upon to reflect on the moral desirability of the provision of MSIFs for PWIDs.

Catholic social teaching is concerned with human dignity, solidarity, the common good, the preferential option for the poor, and social justice. The formal expression of Catholic social teaching is often associated with the publication of Pope Leo XIII's encyclical *Rerum Novarum* in 1891 and the subsequent papal encyclicals that have addressed the application of Christian teaching to contemporary social problems. However, Catholic social teaching has a much longer history and is rooted in the social teachings of the Hebrew scriptures, the New Testament, the Church Fathers and was developed by St Augustine of Hippo and St Thomas Aquinas. In the words of Pope John XXIII, the development of Catholic social teaching involves reading the "signs of the times" (*Humanae Saluti,*1961; *Pacem in Terris,*1963).

This thesis will draw upon two main principles of moral theology: cooperation in evil, and gradualism. In doing so, medical ethics are placed within a theological context. This does not contradict any of the ethical principles published by the General Medical Council, the Nursing and Midwifery Council and the governing bodies of the other healthcare professions. However, it does place those principles within the context of a perfectly all-loving God who has created us with inviolable dignity and has a special love for the vulnerable, the oppressed, the marginalised and all those who are bowed down. This theological context strengthens the reasons for all patients to be treated with the utmost respect. The application of moral theology to healthcare does not take anything away from the ethical codes of the various healthcare professions but adds a certain authority and urgency.

2.3 The Vocation of the Laity within the Catholic Church

I am a lay member of the Roman Catholic Church. I strive to live out my lay vocation as a husband, a father and in my professional life as a nurse. I have been a registered nurse for twenty-five years and believe that God has called me to nursing.

From an early age, I have felt called to live out the preferential option for the poor (Vatican 2005, 182). At the age of three, my mother took me to see the film "Oliver". Not far into the film, Oliver asks for a second bowl of porridge and is refused. Shortly after that, there is a scene where the fat trustees of the orphanage are eating large platefuls of bacon and eggs. I was so upset by this that I could not stay to watch the rest of the film. Almost in tears, I persuaded my confused mother that we had to leave the cinema. Using the techniques described in the Spiritual Exercises of St. Ignatius (Corbishley, 1973), I now believe that this is where God began to call me to live out the Church's preferential option for the poor. I do not know if it is just coincidental that this was the same year that the letter in which the Jesuit General, Pedro Arrupe coined the term "option for the poor" was published (Arrupe 1968, 77). At the age of three, I had no idea of who Pedro Arrupe was and had probably never heard of the Jesuits. I certainly had not heard of the preferential option for the poor and would not become aware of the term until at least twenty years later. Nevertheless, the idea had a huge influence in my decision to become a nurse and my decisions to look after the health of homeless people and people suffering from addictions. I am utterly convinced that I was called by God to live out the preferential option for the poor and that among other things this has included my clinical work with people who inject drugs. This is a major part of my vocation as a lay person in the Church.

2.3.1 The Preferential Option for the Poor

Although the term "option for the poor" was coined by Arrupe in 1968, the ideas behind the term are not new. In "Rise up, O Judge", Enrique Nardi SJ has shown that the bible as a whole, in both the Hebrew Scriptures and in the New Testament, supports the idea of the preferential option for the poor (Nardi, 2004). This can be seen clearly in many of the books of the Hebrew Scriptures including, Exodus, Leviticus, Deuteronomy, the first and second books of Samuel, Tobit, Ester, Job, Proverbs, Ecclesiastes, Wisdom, Ecclesiasticus, the books of the prophets Isiah, Jeremiah, Ezekiel, Amos, and Zechariah. The psalms are particularly powerful in the expression of God's preferential option for the poor and in warnings to the rich; at least nineteen

psalms express God's preferential love of the poor and warn the rich against treating the poor unjustly.

This theme is continued in the gospels. Even before the birth of Jesus, Mary expresses God's preferential love for the poor in her hymn of praise and thanksgiving, the Magnificat (Luke 1:46-55). Here Mary rejoices because God has brought down the powerful, lifted up the lowly, has filled the hungry with good things and sent the rich away with nothing. In the beatitudes, recounted by both Matthew and Luke, the poor are blessed (Matthew 5:3). Furthermore, in Luke's version not only are the poor blessed but the rich are warned because they have had their consolation (Luke 6:20-24).

Possibly one of the most powerful gospel passages in regard to the poor is Matthew (19:16-22), where Jesus is asked by a rich young man what he has to do to have eternal life. Jesus concludes his answer by instructing the young man to sell all his possessions, give the money to the poor and follow him. This had a profound influence on St. Athony of Egypt, the father of Christian monasticism. On hearing this passage, at the age of 20, he gave away some of his family land to neighbours, sold the rest giving the money to the poor and went on to live the life of a hermit in the desert. He placed his younger sister in the care of a community of Christian virgins. No record survives of his sister's reaction to these arrangements.

In the gospel of Luke (14:12-14) Jesus advises the people to invite the poor, the crippled, the lame, and the blind when they give a lunch or dinner; showing again a preferential option for the poor and expanding who are included in this category. Further on in the gospel of Luke (16:19-31) there is the salutary tale of the rich man and Lazarus that ends with the rich man suffering in hell with no hope of escape and the poor man spending eternity in heaven.

In chapter 4 of the Acts of the Apostles there is a description of the communal life of the early Church (Acts 4: 32-36). The members of the community gave up private ownership and held everything in common so that no one among them would be in need.

According to Rhee (2011) the early patristic writers emphasise the distinction between this world and the world to come, while encouraging people to store up wealth in heaven by giving generously to the poor here on earth.

The mendicant orders of friars were founded in the late 12th and the early 13th centuries. These orders had a greater emphasis on poverty and service to the poor and marginalised. The most significant orders of friars founded in this period are the Dominicans, Augustinians, Carmelites,

and Franciscans; these four orders still exist, and their friars are still actively engaged in the preferential option for the poor. Of all the Church's religious orders, the Franciscans are the most associated with the poor.

The Second Vatican Council ended a few years before Arrupe coined the term "option for the poor". However, the idea of the option for the poor was discussed at the council and is clearly evident in one of the council's most important documents *The Pastoral Constitution on the Church in the Modern World, Gaudium et Spes* (Vatican, 1965a). *Gaudium et Spes* begins and ends with the poor. The document begins with the Church identifying with the poor and near the conclusion of the document, calls for the establishment of organism of the Church aimed at promoting justice and love for the poor (Vatican, 1965a, 90).

Initially, the preferential option for the poor was closely associated with liberation theology. However, support for the idea from Pope John Paul II, Pope Benedict XVI and Pope Francis in addition to its inclusion in the *Compendium of the Social Doctrine of the Church,* show that it is part of mainstream Catholic theology.

2.3.2 The Development of the Vocation of the Laity

In the early Church, there was no distinction between the clergy and the laity. Everyone in the Church was a member of the people of God and participated in decision-making. According to Lakeland (2006) this Church of the laity was replaced by a hierarchical structure that owed much to imperial Roman society and government. For the next 1500 years, until shortly before the Second Vatican Council, the laity were defined negatively as those who were not clergy and were not members of religious orders. Consequently, they were seen as having no specific function – unlike the clergy - and were not seen as being called to holiness – unlike monks and nuns. The laity had no power and were expected to be passive recipients of the teaching, the sanctification and the governance provided by the clergy.

Although Pope Paul III created several lay cardinals who took part in the Council of Trent, this council had almost nothing to say about the role of the laity in the Church. It did, however restrict communion for lay people to the host only and did not allow the laity to receive the precious blood from the chalice. This decision emphasised the passive role of the laity and the separation of the clergy from the laity.

More than three hundred years later, the passive role of the laity was reinforced in the draft schema for the First Vatican Council, *Supremi pastoris* quoted by Lakeland (2006, 198)

> the church is an unequal society in which God has ordained that some will command, and others obey. The latter are the laity, the former the clergy.

This sentiment was taken a step further a few years later in the encyclical of Pius X *Vehementer Nos* (Vatican, 1906, 8) which states

> the Church is essentially an unequal society, that is, a society comprising two categories of persons, the Pastors and the flock… the one duty of the multitude is to allow themselves to be led, and, like a docile flock, to follow the Pastors.

The Catholic Church's understanding of the role of the laity began to change in the twentieth century and this updated understanding was expressed to a large extent in three of the documents of the Second Vatican Council: the Dogmatic Constitution on the Church, *Lumen Gentium* (Vatican, 1964), the Pastoral Constitution on the Church in the Modern World, *Gaudium et Spes* (Vatican, 1965a) and the Decree on the Apostolate of the Laity, *Apostolicam Actuositatem* (Vatican, 1965b).

Chapter 1 of *Lumen Gentium* (Vatican, 1964, 5) is entitled "Mystery of the Church" and states that the Church has been commissioned by Christ to proclaim and spread the Kingdom of God among all the peoples of the earth. Chapter 2, "The People of God" establishes the communal nature of the Church; it is a community rather than just a collection of individuals (Vatican, 1964, 9). Membership of this community, of the Church, is conferred through baptism. By virtue of baptism, individuals are called to be part of a priestly and prophetic people and acquire the responsibilities of mission and witness (Vatican, 1964, 10). Chapter 3 discusses the hierarchical structure of the Church and Chapter 4 deals with the laity.

There is a story of a meeting between Leonardo Boff and the then Cardinal Ratzinger that was often repeated in communities of Franciscan friars in the 1990s. Boff, one of the most significant writers on liberation theology, had been called to Rome to be questioned by the Congregation for the Doctrine of the Faith (CDF) on some of the views he had expressed on the preferential option for the poor and the nature of the Church. Apparently, the conversation between Br Leonardo and Cardinal Ratzinger began with the cardinal asking Boff, "How are things on the margins of the Church, Leonardo?" to which Boff answered, "You tell me, Joseph."

Just as the admirals and generals are to be found at the edges of the battle rather than at its heart, so the laity rather than just the members of the hierarchy are to be found at the heart of

the Church's mission to grow the Kingdom of God in the world. This is made clear in Chapter 4 of *Lumen Gentium* (Vatican, 1964, 33) where it states that the laity have a particular "duty of working to extend the divine plan of salvation to all men in each epoch and in every land."

There is one particular word in the title of the Pastoral Constitution on the Church in the Modern World that is of disproportionate importance. The word "in" shows that this document is not about the Church *and* the modern world as two separate entities, completely separated from each other. The Church exists within the world and has a role to play that must involve cooperation rather than domination. The precise manner in which the Church and the world can cooperate can be determined by "scrutinising the signs of the times and interpreting them in the light of the Gospel" (Vatican, 1965a, 4). This was an idea that Pope John XXIII had been promoting since just before the Second Vatican Council. In both the constitution, *Humanae Salutus* (Vatican 1961) through which he convoked the Second Vatican Council, and two years later in the encyclical *Pacem in Terris* (Vatican, 1963), John XXIII use the term "signs of the times". *Gaudium et Spes* recognises the link between religious belief and temporal activity and that these two aspects of life should not be in opposition to each other. Furthermore, it emphasises the role of the laity in witnessing to Christ in all their activities in wider society (Vatican, 1965a, 43).

Although *Apostolicam Actuositatem* mentions lay involvement in some pastoral work such as teaching the faith and some liturgical functions (Vatican, 1965b, 24), there is a far greater emphasis on lay people building the Kingdom of God through improving wider society by their professional and social activity (Vatican, 1965b, 4). The laity have a particular calling to renew and constantly perfect the societies in which they live (Vatican, 1965b, 7). This is done to a large extent by seeking out and looking after the needs of those who are suffering, especially those suffering from illness. Whenever and wherever people lack the facilities needed to live a dignified human life, the Church, but in particular the laity have an obligation to provide appropriate relief. It is important that the freedom of those being assisted is respected and that they are given what they are due in justice and that such aid is not misrepresented as a charitable gift (Vatican, 1965b, 8).

Throughout my professional life, I have attempted to seek out and look after the needs of those suffering at the edges of the societies in which I have found myself. I have looked after the physical and mental health of homeless people and hope that I did it in a way that respected their dignity as people made in the image and likeness of God and loved by God. Although

there are a considerable number of healthcare professional who are members of religious orders, in my experience, the vast majority of Catholic healthcare professionals are lay people. This thesis will examine a particular role taken on by healthcare professionals and determine whether it is an appropriate expression of a lay Catholic vocation.

2.4 Methodology

I will be examining practical ways of working that aim to alleviate the suffering of a certain group of marginalised people, namely PWIDs. However, I will not be engaged in seeking out the root causes of oppression (Phan, 2000, 45) or aiming to transform the structures that oppress the poor (Phan, 2000, 44). Therefore, although this research is closely related to liberation theology, it will not be using the methods of liberation theology.

My research aims to link a particular section of the Christian tradition, certain aspects of moral theology, with a particular human experience, drug injecting and the prevention of the harms associated with it. I will endeavour to bring together both clinical research and theological research to produce new knowledge that influences praxis and public policy.

Practical theology is deeply reflective. It involves me personally reflecting on how I am struggling to live out my vocation in everyday life. It is more than an academic exercise. This particular manifestation of faith seeking understanding is about more than developing and refining orthodoxy; it involves me theologically reflecting on my practice of my faith and should lead me to improve my praxis; it should lead to a greater orthopraxis in addition to a greater orthodoxy. As such, it involves the use of subjective knowledge.

Therefore, in addition to clinical research and theological research, my own personal and professional experience will be used as evidence to contribute to the new knowledge produced in this doctorate. The questions that are asked in practical theology emerge from the context of human experience. The fact that these experiences are enlightened and influenced by belief in God means that the questions that emerge from these experiences are different to the questions asked by secular academics. Scientific knowledge and knowledge gained from personal experience can be fused together to produce a form of practical wisdom that can be used as a basis of good practical theology. Partly because theology is, to a large extent communicated through stories that are based on human experience, human experience is accepted as an importance source of evidence in practical theology. However, as Swinton and Mowat (2016,

6) point out, human experience is not itself a source of divine revelation. In addition to accepting experience as a source of evidence, practical theology aims to influence future human experience; the Gospel is not just to be read and believed but should be lived out. Practical theology aims to be a guide in how the Gospel is lived out by raising new questions, offering fresh challenges and hopefully providing some answers. Human experience is where the Gospel is lived out; it both influences and is influenced by practical theology.

However, in order to produce the type of high-quality new knowledge that is associated with practical theology, it is necessary to do more than just use human experience as evidence; it is essential to reflect upon that experience. According to Bolton (2014), reflective practice is a state of mind that can enable people to learn from their experience. By reflecting deeply on experience, professionals can learn about themselves, their work and the way in which they relate to wider society. One of the most important aspects of reflective practice is that it enables the reflective practitioner to ask questions about how his or her own actions match up with their beliefs. What motivates and informs their decision making when they are faced with a moral dilemma? Are actions and values in harmony? If not, why not? What prevents the practitioner acting in the way that they should? Is it lack of information or insight or some other reason?

As both a nurse and a student of theology, reflective practice is of vital importance to me. As I have already stated, reflecting on experience is an essential aspect of practical theology. Moreover, it is also an essential component of contemporary nursing practice in the UK. Reflective practice has been taught to nursing students in the UK for more than twenty years (Mallik, 1998). In addition, it became a compulsory component of revalidation for registered nurses in the UK in 2016. In April 2016, the Nursing and Midwifery Council (NMC) made reflection on practice a requirement for nurses to remain on the NMC register. In order to complete the revalidation process, registered nurses are required to write five reflective accounts and discuss these reflections with another registered nurse (NMC, 2019).

In this thesis, I will draw on my own experience as a nurse working with PWIDs and use this as reflective evidence.

In Chapter 3, I will present evidence that shows that MSIFs are effective in reducing disease, particularly infection among PWIDs. In addition, I will show that MSIFs are economically effective. In Chapters 4 and 5, I will apply specific principles of moral theology to the provision of MSIFs. In the subsequent chapters, I will examine four morally contentious examples of MSIFs and apply both clinical and theological knowledge to these situations.

Chapter 3

Effectiveness of Medically Supervised Injecting Facilities

3.1 Introduction

Many of those who oppose the provision of MSIFs argue that they are not effective, that they do not improve the health of people who inject drugs; they facilitate perpetual drug abuse (Wood, *et al.,* 2007); they do not protect the public and they are a drain on resources that could be more effectively used elsewhere to deal with addiction. Not only would it be pointless in a practical sense to provide an ineffective clinical service, but it would also be unethical. In this chapter, I will argue that MSIFs provide an effective service that improves the health of people who inject drugs and improves the safety and quality of life of the public in the vicinity of the MSIF. In addition, I will show that MSIFs are economically effective; rather than being a drain on resources, MSIFs free up resources. I will begin by outlining the aims of an MSIF, and then go on to examine the literature to show that MSIFs can do what they set out to do before finally showing that MSIFs are economically effective and free up scarce healthcare resources.

3.2 The Role and Purpose of Medically Supervised Injecting Facilities.

Clients can inject pre-obtained illicit drugs in legally tolerated medically supervised injecting facilities under the supervision of healthcare professionals. Illicit drugs are not supplied at MSIFs and drug dealing is not tolerated on the premises. However, the possession of illicit drugs is tolerated within and in the immediate vicinity of any MSIF (Kolla *et al.* 2017).

Bayley, Bouchard and Yant (2017) describe a wide range of aims of a proposed MSIF in San Francisco. Some of these aims are specific to this particular proposed MSIF. However, the principal aim of all MSIFs is to save the lives of the PWIDs who use the service. The aims that are common to most MSIFs are a reduction in drug related deaths, reduction of non-fatal overdoses, reduction in public injecting, reduction of improperly discarded used drug paraphernalia, decrease in infections among PWIDs, particularly BBV infection and an increase in the number of clients accessing substance use treatment. In the following section, I will present evidence that shows that MSIFs achieve these aims.

3.3 Achievement of Aims

3.3.1 Decrease in Drug Related Deaths

The most important aim of any MSIF is to save lives. Unfortunately, a large number of PWIDs have died from causes linked to drug injecting. Over the last twenty years, the number of drug related deaths has been persistently increasing. In the year 2015-2016 the number of fatal drug overdoses in the USA increased by 22 percent and is now the leading cause of death for people under the age of 50 in America (Bayley *et al,.* 2017). Between 1995 and 1998, the number of drug related deaths in Strathclyde, Scotland remained relatively constant at approximately 120 deaths per year for a population of approximately 2.25 million people (Seymour *et al.,* 2001). However, from the mid-1990s onward drug related deaths in the whole of Scotland, with a population of 5.4 million, have risen every year with 244 deaths in 1996 to 1187 deaths in 2018. In 2018, there was a 27 percent increase on the previous year and in 2019, there was a further increase of 6 percent to 1264 deaths, the highest figure on record. At 0.23 deaths per 100,000 of the population, this was by far the highest drug related death rate of any country in Europe (Scottish Government, 2020). One of the 1264 who died in 2019 was my own son, who died of an ecstasy overdose at the age of 17. In 2021, there were 1330 drugs related deaths in Scotland, 9 fewer than the previous year. This was the first year since 2013 that there has not been an increase in the number of drug related deaths in Scotland. However, it is still the second highest total recorded (Scottish Government, 2022a). The vast majority – 91 percent of the drug related deaths in Scotland in 2021 were due to accidental overdose (Scottish Government, 2022a). The most important aims of an MSIF is to reduce the number of drug related deaths, especially overdoses. For prescribed medication, an overdose is taking more than the prescribed dose. As illicit drugs are not prescribed, there is no prescribed dose. An overdose of an illicit drug, is taking a quantity of the drug that is greater than that needed to produce pleasurable effects and results in a risk to health and life. Opioids, including heroin, cause respiratory depression. When a PWID overdoses on an opioid, respiratory depression leads to respiratory arrest, which in turn can lead to cardiac arrest and death.

MSIFs have doctors and nurses on site who are able to intervene when a client overdoses and so reduce the number of deaths caused by overdose. The vast majority of MSIFs keep a supply of naloxone onsite. This is a medication that reverses the effects of opioids and is used in the treatment of opioid overdose (Handal, *et al.,* 1983). Boyd (2013) reports that in the first three years of its operation there were 300 overdoses at InSite, the MSIF in Vancouver, requiring

medical intervention but there were no overdose deaths. Butler *et al.* (2018) report a similar picture from the ten-year evaluation of the Sydney MSIF. As expected, there was a large number of overdoses in the facility. However, there was not one overdose death in the Sydney MSIF.

Jozaghi (2016) reports that in the first twelve years of its operation, more than fifty peer reviewed studies have been conducted into InSite, none of which showed an increase in drug use in the vicinity of the MSIF. However, a 35 percent decrease in overdose deaths in the vicinity of InSite has been reported (Jozaghi, 2016).

As of April 2018 there were ninety-three MSIFs operating worldwide, ninety of them in Europe, two in Canada and one in Australia (European Monitoring Centre for Drugs and Drug Addiction, 2018, 3). By 2021, the number of MSIFs operating worldwide had increased to more than a hundred in sixty-three cities within ten countries (Scottish Government, 2021). Most of these initiatives have been well researched and evaluated. In a review of systematic reviews of the effectiveness of MSIFs, May (2017) stated that no death by overdose had ever been reported in a researched MSIF and that the introduction of MSIFs in Australia, Canada, the Netherlands, Norway, Spain, and Switzerland has been linked with fewer overdoses occurring in their vicinities. Although no causal link can be proven, this strongly suggests that medically supervised injecting facilities do not cause an increase in drug related deaths, and it is highly likely that they contribute to their reduction.

3.3.2 Reduction of Non-Fatal Overdoses

In addition to saving the lives of PWIDs who have overdosed, MSIFs aim to reduce the number of drug overdoses that occur. According to Milloy *et al.* (2008) non-fatal overdose is not uncommon among PWIDs with up to fifty percent reporting a history of non-fatal overdose. The risk of non-fatal overdose is associated with involvement in the sex trade, public drug use, being a victim of abuse and needing help to inject. Despite the fact that many regular clients of MSIFs are members of high-risk groups, Jozaghi (2016) shows that MSIFs reduc the risk of non-fatal overdose particularly among the high-risk groups. It is thought that one of the reasons that MSIFs reduces this risk is it gives injectors the opportunity not to rush and to be more careful about their injecting, an opportunity that they would not have if they were injecting in a public place (Milloy *et al.* 2008).

3.3.3 Reduction in Public Injecting

Injecting illicit drugs in public is associated with an increased risk of the PWID experiencing violence, including sexual violence (Boyd*, et al*., 2018). Although primarily designed to reduce the harm caused directly by injecting illicit drugs, MSIFs also serve as a safe haven from violence especially the gender-based violence experienced by many marginalised women.

According to Butler *et al.* (2018) public injecting is associated with an increased risk of needle sharing, hepatitis C (HCV) infection and overdose. In addition, it creates a plethora of potential problems for the wider community; not the least of which is the nuisance caused by the sight both of people injecting and people who are intoxicated. In addition, people injecting in public frequently need to find a supply of clean water. I have personal experience of seeing a PWID using the holy water font at the entrance to a Catholic church as a source of clean water, thus putting everyone who attends the church at risk of infection.

Butler *et al.* (2018) state that the vast majority of PWIDs who inject in public places, do not want to but do so out of necessity; the majority state that they prefer to use an MSIF rather than a public place. However, withdrawal symptoms cause a sense of urgency to inject and without an MSIF, they have no suitable place to inject near the drug market.

Butler *et al*. (2018) state that studies from various different MSIFs in different countries show that MSIFs are associated with a decrease in public injecting in the vicinity of the MSIF. Jozaghi (2016) states that research and evaluation done over a twelve-year period showed that the operation of Insite in Vancouver was associated with a large-scale decrease in public injecting.

3.3.4 Reduction of Improperly Discarded Paraphernalia

The dangerous discarding of injecting paraphernalia is closely associated with public injecting. If people are injecting illicit drugs in public spaces without the means of safely disposing of their contaminated needles, syringes, filters, and spoons, then it is inevitable that these items will be discarded with other less dangerous street litter either in a bin or on the ground. Either way, such contaminated litter is a hazard to both the general public and to refuse collectors, posing a significant risk of bacterial and blood borne virus infection.

MSIFs provide a safe means of disposal of used injecting equipment. They provide small bins, known as “cinbins” for the safe disposal of contaminated needles, syringes, and any other

contaminated sharp objects. They also supply clinical waste bags for the safe disposal of any other contaminated waste. These are collected and safely destroyed using the local clinical waste procedures.

There is extensive evidence that MSIFs are effective in reducing improperly discarded drug paraphernalia and so improving the safety of refuse collectors and the general public (Wood *et al.* 2004; Butler *et al.* 2018; Hyshka *et al*. 2013).

3.3.5 Decrease in the Number of Infections Suffered by Clients, Particularly Blood Borne Virus Infections

The sharing of injecting equipment is a common cause of infection among PWIDs. Taylor *et al.* (2004, 38) show that the sharing of any injecting paraphernalia by PWIDs, not just needles and syringes, can cause the transmission of both bacterial infections and BBVs such as HCV and HIV.

MSIFs provide sterile needles, syringes, and other injecting equipment. In addition, they provide a clinically clean space for injecting. The preparation of drugs and their injection are supervised by clinical staff in the MSIF who ensure that PWIDs do not share drugs or any injecting equipment and that they wash their hands before and after injecting. This aims to reduce the risk of infection among PWIDs.

Ford (2010), Pinkerton (2010) and Jozaghi (2016) clearly show that MSIFs successfully reduce the transmission of infectious disease among PWIDs. Although these three studies have concentrated on the reduction of blood borne viruses, the proposal for an MSIF in Glasgow suggests that it would produce a reduction in both bacterial and viral infections in PWIDs (NHS Greater Glasgow and Clyde, 2016). Recently there has been a significant increase in infections among PWIDs in Glasgow including particularly marked increases in anthrax, botulism, and HIV. Trayner *et al.* (2020) predict that the provision of an MSIF would reduce the incidence of all infections among PWIDs in Glasgow including anthrax, botulism and blood borne viruses.

3.3.6 Increase in the Number of Clients Accessing Substance Abuse Treatment

One of the main criticisms of MSIFs is that they could potentially encourage perpetual drug use and lock people into addiction rather than enable them to overcome it (Chaput, 2019). Dr. Andrea Barthwell, of the White House Drug Policy Office, has argued that the provision of an

MSIF will prolong suffering and disease (Gandey, 2003). Her comments were in agreement with those of John Walters of the US National Drug Control Policy who described the Insite MSIF in Vancouver as "state sponsored personal suicide" (Gandey, 2003, 1063). However, MSIFs are not usually standalone services. Almost all MSIFs have links to drug treatment services and encourage clients to engage with such services rather than continue to inject. The MSIFs that have been planned in Sydney, Dublin and Glasgow are all intended to be part of an already operating drug service. Anyone attending these MSIFs would be encouraged in their journey of recovery and could be very easily referred onto treatment services located in the same premises and run by the same organisations.

Studies by Boyd (2013), Ford (2010), Hyshka et al. (2013), Jozaghi (2016), Pinkerton (2010) and Rhodes *et al.* (2006) all show that clients who use MSIFs on a regular basis are much more likely to engage in a detoxification programme than those who do not. Ford (2010) and Hyshka *et al.* (2013) point out that MSIFs attract the most marginalised PWIDs who are the highest risk of drug related harm. For many of these clients, the MSIF is the only route for them to become engaged in drug addiction treatment services. In some cases, the MSIF is the only way in which they will be able to engage with any kind of health service.

3.4 Economics of Medically Supervised Injecting Facilities

Archbishop Charles Chaput has criticised MSIFs for taking away funding and resources that are needed for what he describes as proven forms of addiction treatment (Chaput, 2019). In this section I will show that MSIFs save money and actually free up resources that can be used to provide treatment for PWIDs who are further along their journey of recovery.

An empirical study by Pinkerton (2010) has shown that MSIFs are not only good value for money but actually save more money that it costs to run them. It is estimated that the InSite MSIF in Vancouver, Canada prevents an average of 83.5 HIV infections per year. These prevented infections could have cost $(CAN) 17.6 million in life-time HIV related medical costs. This is considerably more than the $(CAN) 3million annual running costs of Insite. This study only investigated the savings associated with averted cases of HIV and did not take into account the savings that would be made from not having to treat other physical health problems such as bacterial infections, chronic wounds, HCV and DVT that are averted by the provision of an MSIF.

A more recent cost analysis study by Khair *et al* (2022) examined the costs of running the Safe Works Harm Reduction Program in Calgary and compared them to the benefits of costs averted from overdoses successfully managed within the MSIF. Khair *et al.* (2022) calculated that each overdose managed within the facility produces a saving of $(CAN) 1600. Over the period of 2 years and 3 months that was examined in this research, it was calculated that there was a total saving of $(CAN) 2.3 million.

MSIFs have been shown to be effective in freeing up scarce healthcare resources. Salmon *et al.* (2010) have shown that there was a significant reduction in the number of ambulance calls to drug overdoses in the vicinity of the Sydney MSIF after it started operating. It is not clear whether or not the service in Sydney reduced the number of non-fatal overdoses or if the reduction in ambulance call outs was purely attributable to the MSIF staff successfully treating overdoses on site. Whatever the exact reason, the operation of an MSIF in Sydney is associated with a reduced number of ambulances required to deal with overdoses; this valuable resource has been freed up and is available for other patients.

The provision of an MSIF undoubtedly frees up both funding and resources that can be spent on other forms of addiction treatment or on the wider healthcare.

3.5 Summary

MSIFs have a wide variety of aims the most important of which are to decrease drug related deaths, decrease non-fatal overdoses, decrease public injecting, decrease the amount of improperly discarded drug paraphernalia, decrease infection among people who inject drugs and increase the numbers accessing drug treatment services. There is evidence that suggests that MSIFs are achieving all of these aims.

In addition, this is being done in a cost-effective manner that is freeing up finance and healthcare resources to be used for other complimentary forms of addiction treatment and for healthcare more generally.

In this chapter, I have shown that MSIFs are clinically and economically effective. The evidence cited in the literature indicates that they do what they set out to do and in the long term, this saves rather than costs money. However, despite the proven clinical and economic effectiveness of MSIFs, there remain moral concerns about them. Debates about the morality

of MSIFs are continuing to take place within the Roman Catholic Church. In the next chapter, I will examine the morality of MSIFs using the principle of justified cooperation in evil.

Chapter 4

Applying the Principle of Cooperation in Evil to the Provision of Medically Supervised Injecting Facilities

4.1 Introduction

The provision of medically supervised injecting facilities is morally contentious and divides opinion within the Roman Catholic Church, within Christianity more generally and in wider society. In this chapter, I will begin by considering the nature of the evil of illicit drug injecting. The term "evil" will be used in a technical sense in this thesis. Evil is a traditional term in moral theology that is used to refer to harm or to wrongfulness. The provision of a needle exchange or an MSIF for people who inject illicit drugs will inevitably involve some cooperation in evil. This is because it involves providing equipment used for injecting illicit drugs and in the case of an MSIF, providing a place in which illicit drugs are injected. In this chapter, I will explore the arguments around whether or not such cooperation is justified. I will also consider the freedom of PWIDs to make moral choices.

4.2 The Nature of the Evil of Drug Abuse

4.2.1 Non-Moral and Moral Evil

When discussing the idea of evil, it is important to distinguish between non-moral or pre-moral evil on the one hand and moral evil on the other. According to William Cosgrave (1983) a non-moral evil is something that is harmful to humans but in itself has no reference to morality or free human action. Examples of non-moral evil include disease, injury, suffering, poverty, and hunger. On the other hand, moral evil is simply immorality, an action that is morally wrong. A moral evil takes place when a non-moral evil is caused in an unjustified manner. A moral evil always involves free human action.

A man falling overboard from a ship could be used as an example to distinguish between moral and non-moral evil. If the man falls overboard and is injured, then his injury is a non-moral evil. If he is deliberately pushed overboard without any justification, then the man's injury still remains a non-moral evil but the act of pushing him overboard is a moral evil.

4.2.2 Object, End and Circumstance

Traditional manualist moral theology has made use of this three determinants approach in assessing the morality of an action. This approach has sometimes been applied in an uncritical manner to complex situations; this has in some occasion, resulted in strange conclusions. According to this approach, every human action is made up of three elements, the object, the end, and the circumstances (Cosgrave and O'Callaghan, 1977). The object of an act is what happens; it is what we would observe if we were to witness the act. In discussing the morality of drug abuse, the object of the act is injecting or consuming a drug. The act of injecting or consuming a drug can, in itself, be considered morally neutral.

The end is the goal or intention of the person committing the act, what the person had in mind when they carried out the act. It is not unusual for a nurse to inject medication into a patient's vein. When this happens, the intention of the nurse is normally to treat the patient's illness and to relieve their suffering. This is a morally good end that aims to reduce the non-moral evils of disease and suffering. However, when PWIDs injects themselves with illicit drugs, the end is not so obvious. When a PWID injects an illicit drug into their own body, they could be doing it to relieve the pain and suffering caused by withdrawal; or they could be doing it to relieve emotional pain and suffering which has many possible causes. On the other hand, the PWID may be injecting a drug purely to become intoxicated. It is difficult if not impossible to assess the moral end of a PWID injecting themselves with an illicit drug.

The circumstances are the context in which the act is done. The questions who, what, where, by whom and to whom help us to understand the circumstances of the act. The circumstances around drug abuse are complex and include the social and moral environment in which the person abusing drugs has been brought up and their life experience including any trauma or abuse that they may have experienced.

4.2.3 Intrinsic Evil

The concept of intrinsic evil contrasts sharply with the three determinants approach of object, end, and circumstance. According to Selling (2016, 20), intrinsic evil is defined as an action that in itself is evil and neither good intentions nor any circumstances can justify the performance of these acts. As the act of injecting a drug can be done for therapeutic reasons, it cannot be consider intrinsically evil. Injecting illicit drugs can only be considered morally evil because of the intention of the person injecting and the circumstances in which they inject. The

evil of injecting illicit drugs is closely associated with the non-moral evil consequences of this action rather than being an evil action in itself.

4.2.4 The Catholic Church on the Morality of Drug Abuse

The Catholic Church's view on the morality of drug abuse is succinctly described in the *Catechism of the Catholic Church* (Vatican, 1994, 2291) which states that:

> The use of drugs inflicts very grave damage on human health and life. Their use, except on strictly therapeutic grounds, is a grave offense. Clandestine production of and trafficking in drugs are scandalous practices. They constitute direct co-operation in evil, since they encourage people to practices gravely contrary to the moral law.

This statement begins by making a link between the use of drugs and damage to human health and life. This suggests that the non-therapeutic use of drugs is considered morally evil because of the harm caused to human health and so not intrinsically evil. Drugs such as heroin and cocaine can be injected for legitimate therapeutic purposes. Opioids, such as heroin can be extremely useful in treating intractable pain and persistent cough; and cocaine and its derivatives are widely used as local anaesthetics (Sulmasy, 2012; Brian & Coward, 1989). Therefore, the injecting of these drugs is not always evil, as they can be injected for a good end and there are some circumstances in which their use is beneficial rather than harmful. It is important to note that it is the non-therapeutic use of drugs that is a grave moral evil because of the damage done, rather than drug use in general.

There is a degree of vagueness in this statement in the *Catechism* with no definition of the terms "drugs" or "strictly therapeutic". Kieran Cronin (2001, 159) points out that cigarettes and alcohol are drugs, but their use is not condemned by the Roman Catholic Church. The Royal College of Psychiatrists (1986) describes alcohol as "our favourite drug" in a publication that explores the damage to physical and mental health caused by alcohol. Rather than condemn the strictly non-therapeutic use of alcohol, the Church encourages the sacramental use of wine, and the Vatican is reported to have the highest per capita consumption of wine in the world (Withnall, 2014). The lack of a definition of "strictly therapeutic" means that it is possible that the administration of methadone to patients suffering from opioid addiction in order to relieve withdrawal symptoms, could be considered strictly therapeutic or it could be considered unjustified cooperation in the evil of drug abuse. The idea of justified and unjustified cooperation in evil will be discussed below in section 4.3. Like heroin, methadone is physically

addictive, and it is only licit to administer it to people who are already addicted to heroin or to similar opioid drugs. Methadone has the benefits of relieving heroin withdrawal symptoms without the risk of infection and has a significantly lower risk of overdose compared to injecting illicit heroin. Since it has some benefits within the context of the treatment of addiction, it may be considered therapeutic. However, even in therapeutic doses it is possible for patients to become intoxicated by methadone; in such circumstances the use of methadone may be considered not to be "strictly therapeutic".

Despite this vagueness, it is clear from the use of the terms "grave offense" and "evil" that the non-therapeutic use of drugs is viewed by the Church in terms of personal sin. The Church condemns the non-therapeutic use of drugs as a morally evil act. However, like any other morally evil act, it must be judged within the context of the end of the act, what the purpose of the act is, and the circumstances in which the act takes place.

4.3 Cooperation in Evil

Having established that the non-therapeutic use of certain drugs, such as heroin and cocaine, is considered by the Catholic Church to be a moral evil, in this section I will argue that the provision of an MSIF involves cooperation in evil but that this cooperation is morally justified.

John McDermott (2014) states that by the end of the 17th century teachers of theology were writing manuals of dogmatic, moral, and pastoral theology that aimed to produce pedagogical clarity. This was the beginning of the manual tradition that was dominant in moral theology up until the Second Vatican Council in the 1960s (McDermott, 2014). Bernard Häring (1962, 494) begins his discussion on co-operation by stating that we are all called to work for the establishment of God's Kingdom of love. Yet efforts to establish the Kingdom, efforts to love neighbours and to make God's love for humanity more widely known, can inadvertently lighten the task of those who's intentions are evil. Häring (1962, 492) advises against withdrawing from the world altogether, arguing that this would prevent Christians from witnessing to God's love and prevent them reaching out to all humanity. Instead of withdrawing from the world, Häring (1962, 495) offers the principle of co-operation in evil as a guide for engaging with the world. Although formulaic and rule based, Häring (1962) shows that any application of the principle of co-operation in evil, must have the establishment of God's Kingdom of love as its ultimate aim. The correct application of the principle of co-operation in evil should enable

Christians to love both God and neighbour more fully in a world tainted by sin. Christians are not called to withdraw from the world altogether to remain unblemished by corruption but are to bear witness to the love of Christ by reaching out to all of humanity. Gerard McGill (2012) puts forward the case that the principle of cooperation in evil can be used as a tool to distinguish immoral complicity from an honest commitment to diminish evil in a world of compromised values and sinful actions. Julie Rubio (2017) points out that the principle of cooperation in evil was widely used by the manualists in the early part of the 20th century and is an integral part of the manual tradition. Rubio (2017) argues that the framework of cooperation in evil is a crucial aspect of social ethics. She goes on to state that anyone who is concerned about the possibility of contributing to the wrong-doing of others by somehow lending their support to actions that they consider morally wrong, wrestles with cooperation with evil but that many people in this situation lack the knowledge of how to apply the concept coherently.

According to Thomas Aquinas (Summa Theologica, First Part of the Second Part, question 94, Article 2) the first principle of natural law is to do good and avoid evil. In applying the principle of cooperation in evil to MSIFs, my aim is not just to show how clinicians can avoid evil but also to show that in a justified degree of cooperation in evil, in the case of MSIFs, they can do good by saving the lives and improving the health of both individual PWIDs and the general public.

Cooperation in evil can be defined as a contribution to the morally evil action of another person (Ferrer, 2000, 185). In discussing the principle of cooperation in evil in relation to the operation of an MSIF, the main agent is the person who injects drugs and the co-operator is the person operating or working in the MSIF. It has been claimed that the provision of an MSIF involves unjustified cooperation in a morally evil act (Bozza, Berger, 2020). The provision of an MSIF undoubtedly involves cooperating in the morally evil act of illicit drug injecting (Bayley, Bouchard & Yant, 2017). However, cooperation in evil can be justified and is not always illicit.

In order for cooperation in evil to be justified certain conditions must be established: (i) that the main agent cannot be deterred from their evil act, (ii) that the cooperation must not be formal, (iii) that it is contingent rather than necessary, (iv) that it is remote rather than proximate, (v) that there must be a proportionally grave reason for cooperation and (vi) that it should not cause scandal. The way in which these conditions apply to the provision and operation of MSIFs will be discussed in turn in the following sections.

4.3.1 Inability to Deter the Main Agent from their Morally Evil Action

Cooperation in evil can only ever be justified when the main agent cannot be persuaded from continuing in their evil action by reasonable means. The main agent could be coerced into desisting from their evil action. However, this is not the same as persuading the main agent. It would not be acceptable to cooperate in an evil action when the main agent can reasonably be persuaded to desist (Ferrer, 2000, 186).

However, MSIFs are aimed at people with severe drug addiction problems. Although the terminology has changed over the years, drug addiction is now described as involving compulsive, uncontrolled, drug-seeking behaviour (O'Brien, 2011). Healthcare professionals agree that PWIDs cannot easily stop as they are addicted to the drugs that they inject. Littrell (2010) describes the changes in the brain that occur as a person becomes addicted to a particular substance and shows that addiction is a physiological condition rather than a matter of choice. Once someone is addicted to a drug, the ability to exert self-control in relation to that drug is extremely difficult which is manifested in physical terms by the large increase in the consumption of glucose. Littrell's (2010) description of the changes in brain physiology explains the process of addiction and reinforces the fact that it is not a matter of choice. In addition, poverty, oppression, loneliness, and alienation all add to the difficulty in changing behaviour than many people addicted to illicit drugs experience. People who inject drugs cannot just give up this habit and so the first condition needed to justify cooperation in evil is satisfied in this situation.

4.3.2 Formal or Material Cooperation

When using the principle of cooperation in evil, it has to be determined whether any cooperation is formal or material. As Jose Ferrer explains (2000, 186), formal cooperation involves participation in the evil intention of the main agent. Formal cooperation implies an approval of the main agent's evil actions. In formal cooperation, the main agent and the co-operator have the same moral intention at least to some extent. This could happen through an interior approval of the evil action or through a contribution that, by its very nature represents such approval. An example of formal cooperation is a getaway driver in an armed robbery of a bank. Although the driver does not enter the bank or threaten anyone with a weapon, he fully co-operates with the rest of the gang who do enter the bank and do threaten bank customers. His co-operation is implied not only by driving the rest of the gang from the scene of the crime but, by the driver taking his cut of the money robbed from the bank. Thus, the driver formally

co-operates with the rest of the robbers. Implicit formal co-operation is recognised in both criminal and civil law as evil, by the doctrine of common purpose or joint enterprise (Baker *et al*, 2012, 475). Implicit cooperation happens even when the co-operator does not explicitly express their approval of the evil action of the main agent (Keenan & Kopfensteiner, 1995). Formal cooperation is wrong because both the main agent and the co-operator are willing a morally wrong action. Formal cooperation is always wrong and there is no situation in which it could be morally justified because the main agent and the co-operator have the same bad moral intention.

On the other hand, material cooperation in which the co-operator need not share in the evil intention of the main agent, can be morally acceptable under certain circumstances. As I have shown in Chapter 3, (3.2) MSIFs have a variety of aims, the most important of which is to save the lives of PWIDs. Even though it is impossible to know for certain the moral intention of every member of staff of every MSIF, I can rely on my own experience of working in harm reduction services for PWIDs. I know that my own intention was to reduce the harm caused by injecting illicit drugs. As far as I could tell, all of my colleagues working in harm reduction clinics shared the same intention. There is no doubt that by supplying PWIDs with injecting paraphernalia, we were co-operating in the evil of illicit drug use. However, we did considerably more than just supply sterile injecting paraphernalia. Among other things, we provided wound care, antibiotics for infected wounds, vaccinations against hepatitis and, possibly most importantly, advice on how to prevent injecting-related harm. I believe that this is more than adequate evidence that we did not share the same intentions as the PWIDs we were working to help and so our co-operation was material rather than formal. However, Bozza and Berger (2020) take a very different view, asserting that anyone who provides or supports the establishment of a harm reduction service that supplies sterile injecting equipment, is taking part in formal co-operation no matter what their intention is. Bozza and Berger (2020) are writing specifically about the provision of an MSIF. Nevertheless, their point about the distinction between formal and material co-operation not relying on the intention of the co-operator would apply equally to a traditional needle exchange type of harm reduction clinic as it would to an MSIF. Bozza and Berger (2020) assert that clinicians involved in harm reduction services are involved in implicit formal co-operation. Nonetheless, I submit that the wider aspects of harm reduction, the advice, the wound care, the provision of antibiotics and vaccines, show that the clinicians that provides these services do not share the same intentions as the

clients of the services and therefore the provision of these services cannot be considered implicit formal cooperation.

According to Wright & Tomkins (2004), the aim of those providing an MSIF is *not* to enable illicit drug injecting, but to make it less dangerous. It is important to note that the purpose of an MSIF is to improve the safety not just of the PWIDs who use the service, but also the safety of the general public who live and work in the vicinity of the MSIF (Wood *et al.* 2004; Butler *et al.* 2018; Hyshka *et al.* 2013). The stated intention of the operators of MSIFs is to seek to reduce the risks to both PWIDs and to the general public, not to facilitate illicit drug injecting. MSIFs are usually sited in places where drug injecting is already taking place and are a response to a serious public health problem. Their purpose is not to enable more drug taking. Those operating them state that they do not encourage or approve of the evil of drug injecting but provide a service that aims to reduce the harm done by injecting illicit drugs. MSIFs are usually and ideally part of a range of services that encourage and enable people into recovery and become free from drug addiction (Boyd, 2013; Ford, 2010; Hyshka, *et al.* 2013; Jozaghi, 2016; Pinkerton, 2010; Rhodes, *et al.* 2006).

It is impossible to know the moral intention of every client of an MSIF. However, my experience of working in harm reduction suggests that the clients who use these services intend to get intoxicated by injecting an illicit drug either as a form of recreation or to relieve withdrawal symptoms. The reason that they inject illicit drugs and the reason that they use a harm reduction service are not the same. The clients use a harm reduction service to reduce the risks associated with drug injecting, but they inject illicit drugs for pleasure or to reduce the pain of withdrawal. The express intention of those operating an MSIF is not to share in the moral intention of the clients to get intoxicated but, instead to reduce harm. Harm reduction, including the provision of an MSIF, could therefore not reasonably be considered to constitute formal co-operation in the evil of recreational drug injecting. Therefore, the operation of an MSIF involves at the most material rather than formal cooperation.

Despite this, Bozza & Berger (2020) argue that anyone who supports or helps to establish an MSIF is a formal co-operator in a gravely evil act whatever good they intend, as they are helping to facilitate the continued use of illicit drugs. They state that

> Persons in the public or private sector who support and help establish SIS, whatever good is intended, are helping to facilitate continued use of illicit intravenous drugs, a

> gravely evil act. They are formal co-operators and, as such, are equally culpable for the evil act committed. (Bozza and Berger, 2020, 91)

Bozza & Berger (2020) use the term Safe Injecting Site and the abbreviation SIS; this is merely a different term for an MSIF. They argue that the operators of an MSIF are involved in implicit formal cooperation. They argue that the operation of an MSIF is an illicit means to a good end. However, the operators of MSIFs make it explicit that they do not encourage illicit drug injecting in any manner but work primarily to reduce the harm caused by drug injecting, both to the individual PWID and to the general public. As they have made it explicit that they do not encourage illicit drug injecting, the operators of MSIFs cannot be involved in implicit formal co-operation. According to Kelly (1958) material rather than formal co-operation involves disapproval of the evil act in which one is co-operating. This disapproval is an internal act that can be expressed externally. Such an external expression of disapproval would show that the operators of an MSIF are not taking part in implicit formal co-operation. The explicit expression that they do not encourage illicit drug injecting is such an expression of disapproval and shows that no implicit formal co-operation is taking place.

A secondary purpose of an MSIF is to enable and encourage PWIDs to engage with treatment services and ultimately to break free of addiction. Bozza & Berger (2020) claim that even though the evil act – injecting illicit drugs – is not desired by the operators of the MSIF, it is still intended as a means of attaining other beneficial ends. Bozza & Berger (2020) state,

> Although their purpose in doing so is to curb drug overdoses and reduce public nuisance, this is an illicit means to a good end. This purpose is known as implicit formal cooperation since 'the evil act is neither desired nor openly acknowledged but is an intended means for attaining other beneficial ends'.

In the last sentence of this quote, Bozza & Berger (2020) quote from John Di Camillo's 2013 article "Understanding Cooperation in Evil".

I submit that Bozza & Berger (2020) are mistaken, as in the ordinary operation of an MSIF, the operators do not intend an evil act. It does not make any sense to say that they intend this evil as means to a beneficial end. The operators of an MSIF do not use the injection of dangerous illicit drugs as a means to any kind of end. Injecting "street quality" heroin is extremely dangerous. The purpose of an MSIF is to reduce these dangers rather than facilitate an extremely dangerous act. This is done by providing sterile injecting paraphernalia and a safe

place in which to inject. Those operating an MISF do not intend to facilitate heroin injecting but provide a safe space and sterile equipment to make injecting less dangerous. The injecting of illicit drugs, such as heroin would have happened whether or not the MSIF was available.

As I have argued in Chapter 3, the provision of MSIFs reduces drug related deaths, non-fatal overdoses, public injecting, the amount of improperly discarded injecting paraphernalia, the number of infections suffered by PWIDs – particularly BBV infections – and increases the number of PWIDs accessing substance abuse treatment services (Boyd, 2013; Butler *et al.* 2018; Jozaghi, 2016; Milloy *et al.* 2008; Wood *et al*. 2004; Hyshka *et al.* 2013; Pinkerton, 2010; Rhodes *et al.* 2006; Ford, 2010). The availability of an MSIF makes injecting illicit drugs less dangerous but does not facilitate it.

Despite Bozza & Berger's (2020) suggestion that the operation of an MSIF involves implicit formal cooperation in a gravely evil act, the fact that the operators of MSIFs do not intentionally facilitate but actively discourage the evil action of illicit drug injecting shows that the provision of MSIFs involves material rather than formal cooperation in evil.

4.3.3 Necessary or Contingent Cooperation

The fact that the cooperation is material rather than formal is not enough in itself for it to be morally acceptable. It must also be contingent rather than necessary (as well as remote rather than proximate – see next section) (Ferrer, 2000, 189).

Necessary cooperation is defined as cooperation with the main agent when such cooperation is necessary for the commission of the act. If the cooperation is necessary, then the evil action cannot take place without the aid of the co-operator. Necessary material cooperation is morally wrong and cannot be justified as the condition entails that were it not for the cooperation given, the morally wrong action would not take place. Di Camillo (2013) uses the terms immediate and mediate, stating that immediate cooperation is direct or essential to the evil act and that mediate cooperation is indirect or non-essential.

The injecting of illicit drugs has however, been taking place for many years before MSIFs were ever set up. MSIFs are not essential for people to inject illicit drugs. MSIFs were established in response to problems caused by drug injecting in specific localities. Drugs were being injected in these areas well before the MSIFs were established and it is likely that they will continue to be injected whether or not the MSIFs continue to operate.

The operation of an MSIF involves providing sterile needles and syringes to PWIDs and a safe space in which to inject. This provision does not add anything essential to the act as the PWIDs who are injecting in these locations already have needles and are already injecting illicit drugs in an unsafe environment. The people operating the MSIF are merely substituting one dangerous instrument with a less dangerous one and substituting a dangerous environment with a safe space, rather than providing something essential that was not already present.

Therefore, the provision of an MSIF is contingent rather than necessary cooperation in illicit drug injecting. Furthermore, it is contingent material cooperation as the co-operator does not share the intention of the main agent and the morally evil action of drug injecting can and does take place without such cooperation.

4.3.4 Proximity or Remoteness.

Keenan and Kopfensteiner (1995) argue that co-operators are required to distance themselves as far as possible from the evil action of the main agent. Ferrer (2000, 188) states that proximity and remoteness are a matter of degree. In discussing proximity and remoteness, Ferrer (2000, 188) asked whether the provision of a needle exchange service can be considered remote co-operation. Ferrer (2000, 188) leaves this question unanswered but argues that even if the provision of a needle exchange service is considered proximate, this would not necessarily mean that it involves unjustified cooperation but that in this case a strong reason would be needed to justify it.

Sulmasy (2012) argues that supplying needles and syringes in a needle exchange service constitutes remote co-operation rather than proximate co-operation because it is distant in time and space from the actual drug injecting. This suggests that the operation of an MSIF may be considered closer to proximate cooperation than a needle exchange because there is less separation in time and space between the supply of sterile needles and syringes and the actual drug injecting in an MSIF.

When a PWID uses a needle exchange, they take sterile injecting equipment to another place that may not be clean and probably does not have healthcare professionals and equipment on hand to deal with an overdose. Yet, applying the proximate and remote distinction, it could be argued this is more morally justifiable than providing an MSIF, with a clean space and healthcare professionals on hand to deal with emergency situations because the MSIF is not separated in time or space from the actual drug injecting. This strikes me as highly counter-

intuitive and even perverse: it would be to give moral preference to conditions for drug-taking that are *more* dangerous to PWIDs rather than *less* dangerous. This would be to violate the axiom that one should seek to avoid harm.

The principle of cooperation in evil, along with the principles of double effect and tolerance, has been developed through a process of casuistry in which the analysis of previous moral problems revealed a congruency that could be expressed in a shorthand that became a structured and abbreviated expression of moral reasoning (Keenan 1993). The way these moral principles have been developed is similar to the manner in which case law is used to set legal precedents that are then expressed as legal rules in common law jurisdictions. However, judges have applied these rules in an appropriately flexible manner so that justice is served, rather than rules slavishly followed.

In some cases, these moral principles have been applied in a manner that has conferred them with an unwarranted moral authority (Keenan 1993). Thus, the uncritical application of the principle of cooperation in evil to MSIFs can lead to the conclusion that it is morally acceptable for clinicians to supply sterile injecting equipment to PWIDs but morally unacceptable for clinicians to be present to deal with emergency medical situations that may occur as a result of the PWID injecting illicit drugs.

Therefore, if the remote/ proximate distinction is to have its standard moral significance in the case of MSIFs in comparison with needle exchanges, then it ought to be understood in a different fashion.

Indeed, Cavanaugh (2017) argues that proximity and remoteness, although suggesting spatial and temporal aspects of cooperation, should instead be understood as the extent to which the co-operator's action is orientated to the main agent's act. This suggests one alternative way that the proximate/remote distinction may be understood. The co-operator's action is orientated towards reducing harm while the action of the main agent is orientated to injecting illicit drugs. I submit, therefore that the extent to which the operation of an MSIF is orientated to the main agent's action is remote. Without access to an MSIF, the main agent would inject illicit drugs in an unsafe environment without immediate access to emergency medical care. The intention of the co-operator is to provide a safe or less dangerous environment and to provide access to emergency care rather than enable illicit drug injecting.

4.3.5 Proportionately Grave Reason for Cooperation

Nevertheless, I submit that the provision and operation of an MSIF might still be considered to be morally justified cooperation in evil even if it does involve proximate cooperation because there is an overriding reason to justify it. Kelly (1958, 334) argues that wider implications need to be taken into account when considering proportionate reasons for clinicians to cooperate in evil and suggests that conscientious clinicians can do a great deal of spiritual good in secular healthcare settings. This is particularly true in harm reduction settings such as MSIFs and needle exchanges. MSIFs provide an opportunity for clinicians to establish therapeutic relationships with people who are distrustful of professionals and with whom it is difficult to establish any kind of relationship.

In discussing the Roman Catholic Church's preferential option for the poor, Gutiérrez (1992) speaks of the early and unjust deaths of poor people. MSIFs make a significant contribution to reducing the number of early and unjust deaths suffered by PWIDs most, if not all, of whom are poor. As I have shown in Chapter 2 (2.3), MSIFs contribute to reducing the morbidity and mortality associated with injecting illicit drugs. MSIFs decrease drug related deaths, non-fatal overdoses, public injecting, infection among people who inject drugs and increase the number of PWIDs accessing drug treatment services. In short, MSIFs save the lives of PWIDs, their sexual partners, and their children and in addition they avoid the social and financial costs to the whole of society that such morbidity and mortality entail. Kelly (1958, 333) argues that the risk of losing one's job without the reasonable chance of alternative employment would be a sufficiently proportional reason for material co-operation. I submit that saving the lives of PWIDs is a much more grave reason for cooperation in evil, even if that cooperation is considered proximate due to the cooperation and the evil action taking place in the same location and at the same time. I submit that saving lives, especially the lives of the poorest, most despised, and most marginalised members of our society is a proportionately grave reason for engaging in cooperation in evil and that to do otherwise would cause scandal.

4.3.6 Scandal

For cooperation in evil to be morally justified, the co-operator must do all that they can to avoid causing scandal. The concept of theological scandal is found in the New Testament, was developed by Thomas Aquinas and is defined in the *Catechism of the Catholic Church* (Vatican, 1994, 2284) as "an attitude or behaviour that leads another to do evil". There is a serious concern that the provision of MSIFs by Catholic organisations or the involvement of

Catholics in the operation of MSIFs may be a source of scandal. There is a wide variety of people who represent the Roman Catholic Church, including clergy, members of religious orders, the lay faithful and people employed in prominent roles by the Church. Everyone representing the Roman Catholic Church in any way needs to be aware of the signals that their actions send to the rest of the world, even if those actions are morally justified.

According to Sulmasy (2012), scandal is caused when someone observing the behaviour of members of the Catholic Church, is led to the conclusion that the Church does not believe what it claims to believe, and this leads the observer to commit sin related to this observed behaviour. Examples given by Sulmasy (2012) include priests not living their commitment to chastity and so causing people to believe that the leadership of the Church does not take its own sexual ethics seriously and this belief leading the observer to indulge in sexual promiscuity. Another example given by Sulmasy (2012) is the possibility of banks associated with the Church laundering money. This would be a source of scandal if it caused an observer to conclude that they could be involved in financial crime, such as tax evasion, because the Church was involved in illegal financial practices.

Bayley *et al.* (2017) warn that the Church's involvement in the provision of MSIFs causes a significant risk of scandal because the principle of cooperation in evil is complicated and may be difficult to explain to the public. Therefore, the involvement of the Church could give the appearance of morally illicit cooperation in evil. However, this would not be, as I am arguing in this chapter, a true case of morally illicit cooperation since MSIFs are, I believe, morally justifiable. Instead, the issue would be how the Church succeeds, or fails to succeed, in explaining its motivations and the nature of what it is doing. In other words, such ill-founded scandal could be avoided through adequate explanation.

Thus, in speaking specifically about needle exchanges, Sulmasy (2012) argues that for the Church to give scandal by participating in harm reduction services it would be necessary for people to be led to think that such involvement shows that the Church really believes that drug abuse is not a serious moral wrong. Furthermore, it would be necessary for this to lead people in a direction favourable to taking illicit drugs. Sulmasy (2012) suggests that this seems very unlikely. He goes on to state that in his medical practice he has treated hundreds of patients who were addicted to injecting illicit drugs and that he does not recall any for whom the opinions or actions of the Roman Catholic Church had any impact whatsoever on their drug use.

This corresponds closely with my own clinical experience. In a career of more than twenty years, I have never known injecting habits of a PWID to be influenced by the official proclamations of the Roman Catholic Church. A considerable number of my patients were Catholics and would tell me where they had recently been to Mass and which priest has said what in their sermons. This did not seem to have any influence whatsoever on their drug use, which is to be expected given the nature of their addiction.

However, what did seem to have some influence on their behaviour was the way in which they were treated by members of staff, not just clinical staff but all members of staff. Everyone, including people who inject drugs, has been created in the image and likeness of God and so everyone has an inherent and immeasurable worth and dignity (Vatican 2005, 144). This dignity cannot be taken away. Both my clinical experience and my experience in Catholic parishes throughout the west of Scotland, suggests that failing to treat people who inject drugs with the respect that they deserve as sons and daughters of God is much more likely to be a source of scandal than providing an MSIF.

The Roman Catholic Church teaches that the dignity of everyone before God is the ultimate foundation of the radical equality of all people (Vatican, 2005, 144). Any words or actions by any members of the Roman Catholic Church, laity or clergy, which can be interpreted by PWIDs as treating them as inferior, may lead the PWIDs to the conclusion that the Church does not believe what it claims to believe about the dignity and equality of all people. This lack of respect may diminish the self-respect of the PWIDs and increase the risk of further drug taking and thus would be a source of scandal.

The involvement of members of the Roman Catholic Church in the provision of an MSIF is not a source of scandal, as it does not in any way show that the Church does not seriously believe what it claims to believe about the moral evil of illicit drug injecting. On the other hand, disapproving of or refusing to become involved in the provision of an MSIF may be another source of scandal as this would demonstrate an inconsistency between what the Roman Catholic Church claims to believe about the dignity of all people and the need expressed by the Catholic Church to alleviate suffering and harm, especially among the most vulnerable in society.

4.3.6.1 Scandal and the Principle of Double Effect

However, even if the provision of an MSIF by members of the Roman Catholic Church was shown to be a source of scandal this could still be justified by the principle of double effect. The principle applies in a situation where an action has two effects, one of which is evil and the other is good and so it can be applied to the provision of an MSIF if it is believed that the MSIF is a cause of scandal. The good effect is the reduction in death and disease while the evil effect is scandal.

According to James Keenan (1993) for an action with both a good and an evil effect to be justified, there are four conditions that must be met. Firstly, the object of the action must be good or indifferent: it cannot be intrinsically wrong. Secondly, the wrong effect, even though foreseen, cannot be intended. Thirdly, the wrong effect cannot be the means to the good effect. Fourthly, there must be a proportionate reason for allowing the bad effect to occur.

In the case of provision of an MSIF, the object of the action is the provision of sterile injecting equipment - and thus the avoidance of contaminated injecting equipment - and a space in which to inject; this in itself is not evil. Sterile injecting equipment and a place to inject can be provided for evil or for good reasons. These were provided in the shooting galleries of New York and Edinburgh to encourage drug injecting in order for dealers to make a profit. This was an evil end. On the other hand, sterile injecting equipment is provided in an MSIF with the intention of reducing illness and death; this is a morally good end. However, the provision of sterile injecting equipment and a space in which to inject is not, in the terminology of Keenan, intrinsically evil but is morally neutral.

An important wrong effect in relation to society is that it could potentially lead to theological scandal. The *Catechism of the Catholic Church* (1994, 2284) defines theological scandal as "an attitude or behaviour which leads another to do evil."

It is not the stated intention of those providing an MSIF to cause theological scandal. The provision of an MSIF is intended to reduce the spread of infection and keep PWIDs alive until they are able to engage in the treatment they need to recover from addiction (Connaughton & Boerstler, 2021). Therefore, the wrong effect, even though it may be foreseen, is not intended.

The wrong effect, scandal cannot be the means to the right effect. In the provision of an MSIF, scandal is not the means by which the right effect, keeping PWIDs alive, is accomplished. Therefore, the third condition is met.

The fourth condition is that there must be a proportionate reason for allowing scandal. I have argued in paragraph 3.3.5, that preventing the early and unjust deaths of poor marginalised people is a sufficiently grave reason for co-operation in evil. I submit that it is also a proportionate reason for allowing scandal. I further submit that any attempt to avoid scandal that risks the lives of the poor, for whom the Roman Catholic Church claims to have a special love (Vatican 2005, 182), would itself be a source of scandal.

The Roman Catholic Church has a long and unfortunate history of attempts to avoid scandal that have actually caused greater scandal. Most prominent among these are the Church's attempts to avoid the scandal associated with sexual abuse of children by clergy. These have involved cover-ups and the unjustified silencing of victims, which in itself may be considered a greater evil than the original sexual abuse and undoubtedly led to a greater theological scandal.

Saving the lives of poor marginalised people is a more than proportionate reason for risking this particular scandal and so the fourth condition is met.

All four conditions of the principle of double effect have been met. Consequently, if it were shown that the provision of an MSIF by a Roman Catholic organisation or by individual members of the Roman Catholic Church was a source of scandal, then that scandal would be justified. Furthermore, any attempt to avoid scandal that involved putting the lives of PWIDs at risk, would itself be a greater source of scandal.

4.3.7 Justified Cooperation

The provision and operation of medically supervised injecting facilities for people who inject drugs is a morally justified cooperation in evil. The injecting of illicit drugs is an evil action. Most PWIDs are addicted to the drugs that they inject and so would have immense difficulty in changing their behaviour. The provision of an MSIF in which people can inject illicit drugs involves cooperation in evil. This cooperation is material rather than formal because the operators of the MSIF do not share in the moral intention of the drug injectors. It is contingent rather than necessary as the morally evil action of drug injecting can and does take place without the provision of an MSIF. The operation of an MSIF may be considered proximate rather than remote cooperation because there is no separation in time and space between the supply of sterile needles and syringes and the actual drug injecting in an MSIF. On the other hand, the idea of proximity and remoteness may be regarded as the extent to which the co-

operator's action is orientated to the main agent's act. However, proximate cooperation can be justified by a proportionately grave reason. MSIFs save the lives of PWIDs and protect the public from injury and infection. Therefore, refusing to provide an MSIF would be negligent and wrong in both a practical and moral sense and would be a cause of scandal. Consequently, there is a proportionately grave reason for proximate cooperation. The provision of an MSIF by members of the Catholic Church is not a source of scandal. However, refusing to support the provision of an MSIF may cause scandal.

The provision of a medically supervised injecting facility by members of the Catholic Church therefore fulfils the criteria for justified cooperation in evil. However, the principle of cooperation in evil presumes that the main agent has a sufficient degree of moral freedom and is able to choose whether or not to take part in the evil action. There is an assumption that PWIDs can choose whether or not to inject illicit drugs. In the next section, I will investigate whether or not this assumption is valid.

4.4 Moral Agency

Steven Bozza and Daniel Sulmasy hold entirely opposing views about the ethics of harm reduction for PWID. Bozza (2019) argues that MSIFs violate the principles of beneficence and non-maleficence. He asserts that the provision of an MSIF makes it easier for PWIDs to engage in life-threatening behaviour and so it does harm rather than good and is therefore in breach of the principles of beneficence and non-maleficence. On the other hand, in an article that deals with the ethics of needle exchange, Sulamsy (2012) argues that harm reduction services for PWIDs are a morally justified cooperation in evil. Despite their differences, both Bozza (2019) and Sulmasy (2012) agree that PWIDs are addicted to the drugs that they inject and this addiction compromises their autonomy. Similarly, Pope Francis states that compulsive drug addicts cannot choose to forgo a fix and that no other decision is possible for them other than to use illicit drugs (*Amoris Laetitia*, 2016, 273). Once someone is addicted to a particular drug their ability to make decisions about the use of that drug is severely impaired and so they cannot be held morally responsible for using it.

However, Sulmasy (2012, 436) has gone on to argue that the first time someone uses a drug, they are not addicted and therefore they can be held morally accountable for its use. Is this really the case? Are there social circumstances that encourage and facilitate the use and abuse

of illicit drugs to the extent that the drug user cannot be held morally responsible for their initial drug use? There is some evidence, which will be discussed in the next section, that traumatic early life experiences and peer pressure remove or at least limit the drug user's freedom to choose and thus consequently remove or limit their moral responsibility even in the case of initial illicit drug use when addiction has not yet become established.

4.4.1 Influences on Initiating Illicit Drug Use

Before I examine the issue of moral agency among drug-users, I will address the issue of the influences on initiating illegal drug use. My reason for doing this is because it is at this initial point that the moral agency, and thus the moral culpability, of the future drug-user seems to be at its strongest (all other things being equal). That said, even in cases in which the drug user is fully culpable for their initial drug-taking, this is not to deny that their agency can decline sharply once addiction kicks in. Yet, initial culpability – or otherwise – is worth examining in order to have an adequate picture of the main morally relevant factors.

For many years, in fact for several decades, health authorities in many countries throughout world have run campaigns to deter people from using illicit drugs. These have included a wide variety of advertising campaigns and health education programmes within schools to deter young people from initiating drug use. Most of these emphasise the risks to health involved in taking illicit drugs. In addition to these campaigns, those who use illicit drugs run the risk of a criminal conviction and subsequent punishment, which may include imprisonment. Despite these campaigns and risks, the number of people using illicit drugs has continued to rise (United Nations Office on Drugs and Crime 2018, 11).

The risk of becoming infected with HIV through injecting illicit drugs has been well known since the 1980s (Huo *et al.,* 2005, 64). Not only has it been well known in the scientific and clinical communities, but the risks of becoming infected with a BBV have been very widely publicised through a serious of public health campaigns. Additionally, other risks to physical health associated with drug injecting, such as deep vein thrombosis and a wide range of infections, are well known to the scientific and clinical communities and are well publicised in drug treatment facilities.

There is no shortage of academic literature that deals with the ill effects of illicit drug use; how to prevent initiation of drug use, how to reduce the associated harms and how to treat addiction.

However, there is a dearth of literature that addresses the issue of why people take drugs in first place.

Many people start using tobacco and alcohol before they move on to illicit drugs use. The use of legal recreational drugs is common in many parts of the world. The use of tobacco is so widespread that the World Health Organisation has described it as an epidemic (World Health Organisation 2017, 25).

Having previously used alcohol and tobacco, cannabis is frequently the first illicit drug used by many young people. Much has been written about cannabis as a "gateway" drug and the idea of cannabis use leading on the use of harder drugs is examined in some detail by Baggio *et al.* (2015) where they assert that the use of cannabis increases the probability of using other illicit drugs. However, although Baggio *et al.* (2015) have recognised a correlation between the use of cannabis and the use of other illicit drugs, there is no temporal relationship established and so it is not shown that cannabis causes or even leads onto the use of other illicit drugs. On the other hand, Baggio *et al.* (2015) did establish a correlation between subjective experience of first cannabis use and the types of other illicit drugs used. A positive first experience of cannabis was associated with increased likelihood of using softer less dangerous drugs such as hallucinogens, stimulants, and poppers. Conversely, the use of harder more dangerous drugs such as heroin, ketamine and crystal meth were associated with people who experienced negative feelings on their first use of cannabis. Despite the establishment of these correlations, no definite causal link has been proven between cannabis use and the use of other illicit drugs.

In an attempt to explain why people begin to use illicit drugs, Daley and Chamberlain (2009) make a distinction between "recreational drug use" and "problematic substance abuse" among young Australians. They argue that many young people experiment with alcohol and illicit drugs but that most of them do not progress from recreational use to problematic abuse. They describe problematic substance abuse as a situation in which drug use dominates a person's life at the expense of other activities and has adverse consequences for both physical and mental health. In an attempt to explain why some young people progressed from recreational to problematic substance misuse, Daley and Chamberlain (2009) identified four structural factors: state care and protection system; growing up in an environment where substance use was either accepted or encouraged; leaving school early; and homelessness.

Likewise, Boyd, Fast and Small (2016) show that childhood abuse, neglect, foster care, institutional care, incarceration, a family history of substance abuse, homelessness and unemployment are all associated with drug addiction.

The vast majority of the young people in the Daley and Chamberlain (2009) study were brought up in families where drug use was normal, and many had parents with substance abuse problems. Consequently, the young people took up recreational drug use without incurring any parental disapproval. Thus, they may have been under the impression that there was nothing morally wrong with using illegal drugs.

Geoffrey Hunt and Kristin Evans (2008, 331) explored the most obvious, but possibly the most ignored reason for taking illicit drugs: pleasure, when they describe the pleasures and benefits of drug taking, in this case ecstasy. Hunt & Evans (2008, 331) show that although illicit drugs have been consumed for pleasure throughout history, this central and fundamental feature of drug use, the pleasure that users experience, has largely been ignored by those doing research in the drug field. Hunt and Evans (2008) describe the pleasure associated with the consumption of illicit drugs as a significant and integral feature of drug use that research has almost completely failed to explore. People use drugs, legal and illegal, because they give enjoyment. A multitude of social, historical, and political reasons could be suggested as to why pleasure has been ignored by researchers. There has been a focus on drugs as dangerous substances that need to be controlled to reduce or eliminate the harm that they cause and the problems that they produce for both individuals and society. The reason that the pursuit of pleasure is downplayed or completely ignored may be because acknowledgement of the pleasure associated with drug use might be seen as inadvertently encouraging it.

Almost all of the studies that have been cited in this section downplay the importance of pleasure. In doing so, these studies decontextualize the “drug user” to the extent that drug use becomes their over-arching and defining characteristic. Hunt and Evans (2008) mentioned the unmentionable and explored the subjective experiences of people who use illicit drugs for fun.

Having explored some of the limited academic literature on the reasons that people start to take illicit drugs, I have come to the conclusion that the best explanations for why those who start taking drugs principally in search of pleasure is not to be found in academic studies, but in the authentic fiction of Irvine Welsh and the personal experience of growing up in poverty described by Darren McGarvey.

McGarvey (2017, 48) describes a sense of hopelessness and powerlessness in poor communities stating that there is a feeling that things will never change and that those in power are self-serving and not to be trusted. In describing the effects of living in poor quality housing in an area of high unemployment, McGarvey (2017, 42) says that drug dealers supplied temporary relief from the bleak realities of life in a deindustrialised city.

Welsh describes heroin users who are convinced that they are

> …the lowest of the fuckin low, the scum of the earth. The most wretched, servile, miserable, pathetic trash that was ever shat intae creation. (Welsh, 2001, 78)

This corresponds closely with my experience of looking after the health of PWIDs. Many of them, as Daley and Chamberlain (2009) show, have experienced homelessness and residential care and as Boyd, Fast and Small (2016) show, have experienced childhood abuse, neglect, incarceration, homelessness and unemployment. In my experience, many people who have had these kinds of experiences have the extreme low self-esteem described by Welsh.

He describes the effects of intravenous heroin

> take yir best orgasm, multiply it by twenty, and you're still fuckin miles off the pace (Welsh, 2001, 11)

This feeling can be bought for £10, and all the misery of abuse, neglect, homelessness, unemployment and poverty can be forgotten about for a few hours. Given these descriptions and Welsh's own personal experience of the Edinburgh drug culture, it is not difficult to understand why some very unhappy people start to use heroin to relieve their emotional pain and experience intense pleasure, even if it is only for a short time.

4.4.2 Reasons for Injecting Illicit Drugs

Of all the routes of administration of illicit drugs, intramuscular and intravenous injection are the most dangerous with the highest risks of infection, overdose, and other physical harms. Despite these risks, people continue to inject illicit drugs, especially heroin. This may be for several reasons. Firstly, almost none of the drug is wasted. Secondly, it takes effect more quickly. Thirdly, it is easier to hide.

Just as drug use in general is tempting to marginalised young people, so drug injecting is tempting to the poorest and most desperate drug users who cannot afford to waste any of their

drug. Homeless people who are living outside or in a shared hostel space usually have no choice but to take their drugs outdoors. In this case, they need to be able to take their drugs quickly before they are seen by members of the public and reported to the police. As drug use is illegal, most drug users try to hide their use. Prisoners have particularly good reason to hide their drug use. Smoking heroin produces a distinctive smell. This can be avoided by injecting instead of smoking.

Illicit drugs, especially heroin, are injected rather than taken by any other route, by the poorest, most desperate, and most vulnerable members of our society.

4.4.3 Lack of Sufficient Moral Agency

Even allowing that in some cases initial drug-taking is due to seeking out pleasure and thus may involve a high degree culpability, many people who are addicted to illicit drugs started to take them when they were young and vulnerable to peer pressure (Daley & Chamberlain, 2009). Many of them came from socio-economically deprived backgrounds and had suffered some sort of emotional trauma; many had suffered sexual abuse (Boyd, *et al.*, 2016). A considerable number were from families where illicit drug abuse was accepted as normal and may even have been encouraged. In addition, many people who inject illicit drugs, do so out of desperation rather than choice. When these factors are taken into account, it seems that Sulmasy's (2012) statement that drug users can be held morally accountable for their actions the first time they use, may not be fully justified.

Yet, what remains a good deal less in question is that those who are addicted, by virtue of their addiction typically have greatly reduced agency (Daley & Chamberlain, 2009; Boyd et al., 2016). This means that those operating an MSIF must take great care that they never facilitate initial drug-taking, which is when agents are most likely to be able to exercise moral agency and thus not give in to the temptation to take drugs. Although this would not be exactly to violate the condition I have already accepted above – for morally licit cooperation with evil one must be unable to deter the main agent from their morally evil action - since the main agent even when sufficiently free might insist on taking drugs, it does come close to violating it since there is also the opportunity to appeal to their freedom and rationality not to proceed on the highly self-destructive path of drug addiction.

For MSIFs to fail in this responsibility would be for them to fail in the fundamental moral principle to seek to avoid evil. The moral case I make in defence of MSIFs assumes that the MSIF do not fail in this fundamental moral responsibility.

4.5 Summary

The non-therapeutic use of drugs is condemned by the Roman Catholic Church as morally evil. The operation of an MSIF involves cooperating in this moral evil. However, this cooperation is justified because the main agent cannot be persuaded to desist from using illicit drugs; because the cooperation is material rather than formal; because the cooperation is contingent rather than necessary; because the proximity of the cooperation is justified by the grave reason that it saves lives; and because the cooperation is not a cause of scandal.

The underlying assumption in the analysis in this chapter is that injecting illicit drugs is morally wrong and that people who inject drugs have sufficient moral agency to be able to choose whether or not to take part in this activity. However, the clients of MSIFs are addicted to the drugs that they inject, and addiction significantly diminishes their moral agency. In addition, many people who become addicted to illicit drugs have experienced severe social disadvantage and emotional trauma that precipitates their first use of illicit drugs. Such social disadvantage and trauma also diminishes their moral agency and reduces their culpability for their first use of illicit drugs.

The fact that the underlying assumption of sufficient moral agency is in doubt suggests that the principle of cooperation in evil may not be the most appropriate tool for the moral analysis of medically supervised injecting facilities. In the next chapter, I will consider the application of gradualism to the provision of medically supervised injecting facilities.

Chapter 5

The Application of Gradualism to the Provision of Medically Supervised Injecting Facilities

5.1 Introduction

In Chapter 4, I used the principle of cooperation in evil in an attempt to ascertain whether the cooperation involved in the provision of an MSIF is morally justified. A strong case was made that the cooperation needed to operate an MSIF is justified.

However, the traditional formulation of the principle of cooperation in evil includes the condition that for co-operation to be justified, it should be remote rather than proximate. In an MSIF, the provision of sterile injecting equipment and the actual act of injecting illicit drugs are not separated in time and space and so the co-operation can be seen as proximate rather than remote. A strict application of the remote – proximate distinction would give a moral preference to conditions of drug taking that are more dangerous for PWIDs rather than less dangerous; it would increase the risk of non-moral evil such as infection and overdose among PWIDs. This, therefore, suggests that another tool in addition to the principle of cooperation in evil may be needed for the moral analysis of MSIFs.

In Nicholas Austin's commentary on *Amoris Laetitia*, he suggests that marriage and family life cannot be discussed in any depth merely by reference to canon law and law-based moral theology but must also involve some reference to love (Austin, 2016). I submit that this applies to more than just marriage and family life. The manualist principles of cooperation in evil and double effect that were discussed in Chapter 4 are rule based. There is a temptation to apply the rules linked to these principles in the manner of an algorithm, as a mathematician or computer programmer would do to solve a technical problem. If these principles are applied in this manner, this risks severing the link between the principles and the moral values from which these principles have been derived. Laws and rules on their own, used uncritically and without an overall prudential judgment, are insufficient for dealing with the complexities of life in general and insufficient for exploring the appropriateness of particular aspects of clinical and pastoral care of people suffering from drug addiction.

I will make a case that gradualism is an appropriate tool, in addition to the principle of cooperation in evil, for exploring the provision of MSIFs. In this chapter, I will explore the use

of gradualism in regard to the provision of MSIFs and the treatment of addiction. I will begin this chapter by discussing what gradualism is before applying it to the clinical and pastoral care of people who inject drugs.

5.2 The Nature of Gradualism.

Austin (2016) states that gradualism is based on the understanding that moral development is a step-by-step process and in many cases does not happen all at once. Virtues, such as courage and honesty are not all or nothing concepts; people develop such virtues at different rates. Gradualism implies that even when an individual's current situation falls short of perfection, it still has moral value and that it is better to encourage the positive aspects of a person's life rather than rebuke their flaws.

Both in a pastoral and in a clinical context, it involves pastors and clinicians accepting human weakness and guiding people to a better way of living. Gradualism puts a positive construal on imperfect behaviour when this behaviour is understood as unavoidable in some way – such as drug addiction. Gradualism is part of a process of moving towards overcoming the need for or tendencies towards that imperfect behaviour.

Pastoral and clinical practice informed by gradualism, meets a person where they are and accompanies them encouraging them to take the next small step. As Austin (2016) points out, gradualism maintains the moral law while at the same time recognising the individual's situation, which in many cases may prevent immediate and complete change. It recognises that people gradually grow in virtue over time rather than jump immediately to perfection.

In the context of drug injecting, gradualism involves guiding people towards a way of living that is both physically and spiritually healthier. It also involves accepting that many people may not reach their ultimate goal, but that every step on the way towards that goal is to be celebrated and is pleasing to God. Gradualism is not a new concept. It was referred to by St. John Paul II in *Familiaris Consortio* (1980, 9) and by Pope Benedict XVI in his interview with Peter Seewald (2010, 117-119) and is a major theme in *Amoris Laetitia* (Pope Francis, 2016). Gradualism involves meeting a person where they are now rather than where they should be, or where the Roman Catholic Church thinks they should be.

Gradualism has both moderate and stronger forms. The moderate form emphasises a continuous and permanent conversion that is brought about by steps that lead us forward and

is described by St John Paul II in *Familiaris Consortio* (1981, 9). On the other hand, gradualism in its stronger form is being open to the moral legitimacy of someone continuing in a behaviour that in itself is wrong, but which can be morally countenanced with certain conditions. The person must be incapable or not ready to give up completely the wrong behaviour in question all at once. They must also be seeking gradually, over time, to overcome the need to engage in the problematic behaviour, or at least seek to weaken the need for the behaviour.

In *Familiaris Consortio* (1981, 34) St. John Paul II distinguishes between the "law of gradualness" and "gradualness of the law". Here he encourages a gradual step by step advance in order to overcome difficulties but warns against a relativism that proposes different degrees in God's law for different individuals and different situations.

In *Evangellii Gaudium*, Pope Francis (2013, 44) recognises and applauds the gradual small steps forward that people struggle to make saying

> A small step, in the midst of great human limitations, can be more pleasing to God than a life which appears outwardly in order but moves through the day without confronting great difficulties.

There are many "great human limitations" associated with injecting illicit drugs. Addiction itself places a severe limitation on a person's freedom to choose whether or not to inject drugs. The socio-economic conditions in which a person lives can also place limitations on their ability to choose how to act. Among the particular socio-economic conditions that can limit someone's freedom are peer pressure and living in conditions where drug use is perceived as a solution rather than a problem (McLaughlin, 2018).

Furthermore, in *Amoris Laetitia* (2016, 300), Pope Francis accepts that gradualism can help people conform to the will of God, not in some abstract manner but in the messy situations in which most of humanity find themselves. Some interpretations of *Amoris Laetitia* understand it as Pope Francis permitting those in irregular marital unions but still engaged in conjugal relations to receive Holy Communion and therefore Pope Francis, unlike Pope John Paul II, is allowing for a stronger form of gradualism in certain circumstance. I submit that one example of the messy situations in which a stronger form of gradualism is appropriate is addiction, in particular addiction to illicit drugs.

5.3 Gradualism and the Treatment of Drug Dependency

As I have shown in Chapter 3, (3.4.1 and 3.4.2), the injecting of illicit drugs is often closely associated with childhood abuse, neglect, low educational attainment, incarceration, homelessness, unemployment and subsequent low self-esteem. Consequently, many people who inject drugs live extremely chaotic lives. My clinical experience suggests that the lives of most PWID are considerably more chaotic than the messy situations alluded to by Pope Francis (2016) in *Amoris Laetitia.*

Just as religious and moral conversion seldom happens as a sudden once and for all experience, so too recovery from drug addiction does not usually happen suddenly and completely. Addiction has frequently been described as a chronic, relapsing disease (National Institute on Drug Abuse, 2020). It is extremely unusual for people who are addicted to illicit drugs to go suddenly from injecting several times a day, to abstinence without any relapse and without any gradual change.

Therefore, from a clinical point of view, it is extremely important to encourage any step in the right direction however small. The movement forward in such small steps will inevitably involve some degree of acceptance of PWIDs continuing to inject illicit drugs, a behaviour that is in itself objectively wrong. The continued injecting of illicit drugs in such circumstances can be morally acceptable because almost no PWID can completely give up drug injecting all at once because of their addiction. However, for this gradualist approach to be countenanced, the PWID must be making some effort to overcome the need to engage in drug injecting, or at least seeking to weaken the need to inject or to reduce the harm caused by injecting.

One of the first steps that a PWID can take on the road to recovery is the use of a harm reduction service such as a needle exchange or an MSIF in order to keep themselves alive and as healthy as possible until they are able to take the next steps. The PWID's use of a harm reduction service may show some assumption of responsibility. It could indicate that the PWID realises that continuing to inject illicit drugs is harmful to his or her self and can cause harm to other people.

This has some similarities to the situation described by Pope Benedict XVI in his interview with Peter Seewald (2010, 119) in which he said that a male prostitute using a condom to reduce the risk of the spread of HIV infection could be "a first step in the direction of moralisation, a first assumption of responsibility, on the way toward recovering an awareness that not everything is allowed and that one cannot do whatever one wants." The prostitute is still

involved in behaviour that is morally wrong but in using a condom, he takes a step that makes his behaviour less morally wrong; in this situation, commercial sex with a condom is a lesser evil than commercial sex without a condom. When the prostitute has sex with a client without using a condom, he is putting himself at risk of becoming infected with HIV. He is not only risking his own health but is risking the health of his clients, their families and possibly his own family. By using a condom, the prostitute is reducing these risks and so his behaviour is less evil.

It is worth noting that although the Roman Catholic Church disapproves of the use of artificial contraceptives, it does not specifically disapprove of the use of condoms (Pope Paul VI, 1968, 14 -15). If we assume that the male prostitute is taking part in commercial sex with other men in the example given by Pope Benedict XVI, then by no stretch of the imagination, could this use of condoms be regarded as a form of contraception in this case and so this particular use of condoms is not disapproved of by the Catholic Church. However, a clarification provided by a Vatican spokesman later confirmed that Pope Benedict XVI said the same would apply if the prostitute was female. Pope Benedict XVI did not disapprove of the use of a condom as a contra-infective, rather than contraceptive. In using a condom as a contra-infective, the behaviour of the prostitute is a lesser evil.

The use of an MSIF by someone addicted to heroin can arguably be seen as morally similar to Pope Benedict's male prostitute using a condom. If a PWID is using an MSIF for its intended purpose, then they are taking the first step in assuming some responsibility for their own health and the health of those who may be physically harmed by their drug use. Injecting illicit drugs with sterile equipment in the relatively safe environment of an MSIF, is a lesser evil than injecting illicit drugs with previously used equipment in a back alley. Injecting illicit drugs is an objectively evil act wherever it is done, in a back alley or in an MSIF. However, injecting illicit drugs in an MSIF, using sterile injecting equipment, reduces the risk of evil consequences such as death and disease. Therefore, injecting illicit drugs in the relative safety of an MSIF is a lesser evil than injecting illicit drugs elsewhere.

It is possible that a PWID may be using the MSIF merely as an easy supply of sterile injecting equipment and a safe and comfortable place to inject, rather than a means of taking responsibility for the consequences of their actions.

However, even if a PWID is using an MSIF for his or her own convenience, rather than as a means of taking responsibility for their actions, the MSIF can still be of benefit to both the

individual PWID and to the wider public. It can still reduce the amount of non-moral evil. As I showed in Chapter 3 the provision of harm reduction services, including MSIFs has specific benefits for public health. The provision of an MSIF reduces public injecting (3.3.2); it reduces the amount of improperly discarded contaminated drug paraphernalia (3.3.4); it reduces the number of infections, both bacterial and viral and so reduces the amount of infection circulating in the population (3.3.5) and it saves more money that it costs to run such a service thus freeing up resources that can be used elsewhere in the health service (3.4). Therefore, the MSIF can be a source of benefit for the public even if individual clients have no intention of stopping or reducing their drug injecting. In such a situation, the provision of an MSIF can reduce the amount of non-moral evil, including death and disease, even if it does not reduce the amount of moral evil.

5.3.1 Risk of Inadvertently Encouraging Drug Abuse

While clinicians and society in general can rejoice that a PWID who is using an MSIF for its intended purpose, has taken the first step in the right direction, there can be a danger that clinicians may inadvertently encourage illicit drug injecting.

Therefore, the manner in which an MSIF is run is very important. Staff must have the appropriate clinical training in overdose treatment, wound care and treatment of infections among other skills in order to be able to provide a safe and beneficial service. Staff working in an MSIF must treat the people who use the service with the respect that they deserve as sons and daughters of God.

All who use such a service must be treated in a manner that respects their inviolable dignity (Vatican, 2005, 107). Ethna Regan (2019, 201) states that belief in inherent human dignity is the foundation of Catholic social teaching and is based on the doctrine that we are all created in the image and likeness of God (Genesis 1:27). The dignity that comes from being made in the image and likeness of God is the basis of our dignity before each other and the basis of the radical equality of humanity (Vatican 2005, 144). Thus, it would be totally unacceptable for any member of staff working at an MSIF to give the impression that they might consider themselves in any way superior to the people that they are employed to serve. Staff working in an MSIF must show the utmost respect to the people who use the service; in this way they can establish therapeutic relationships with their clients.

Furthermore, people who use MSIFs deserve to be treated with the utmost respect not only because of their dignity as sons and daughters of God but because of their poverty. As I

described in Chapter 3, (3.4.1 and 3.4.2), the injecting of illicit drugs is closely associated with childhood abuse, neglect, low educational attainment, incarceration, homelessness, and unemployment. Moreover, people suffering from addiction, especially drug addiction, are highly stigmatised (Seear, 2020). PWIDs are a marginalised group of people and are counted among those who the Church views as poor and to whom the Church has a special obligation as part of its preferential option for the poor. The Church's preferential option for the poor should motivate and inform the work of any Roman Catholic clinicians working with some of the most marginalised people in our society.

Gustavo Gutiérrez (1988) describes this kind of poverty as scandalous, inimical to human dignity and contrary to the will of God. Therefore, we are obliged to do something to challenge this scandal. The Church invites its members to preach good news to the poor (Vatican, 2005, 29) and to recognise the poor and suffering as our brothers and sister (Vatican, 2005, 105). The provision of MSIFs for PWIDs, challenges the scandal of poverty and marginalisation that PWIDs suffer. Those who provide MSIFs also bring the good news to the people who use this service. Even when they cannot give up injecting illicit drugs, even when they feel that they are "…the lowest of the fuckin low, the scum of the earth" (Welsh, 2001, 78) the good news that is brought to the poor people who use MSIFs is that they are not totally abandoned, that they are loved, that their lives matter and their inviolable dignity is respected.

In establishing a therapeutic relationship with their clients, members of staff will be able to steer the clients in a gradualist direction, encouraging them along the road towards abstinence while accepting that change takes time, effort, and a huge amount of encouragement and that in many cases the ultimate goal of abstinence may not be achieved.

In attempting to treat PWDs with the respect that their dignity deserves, in striving to bring good news to the poor people suffering from drug dependency, there is a danger that clinicians running an MSIF may inadvertently encourage drug injecting. MSIFs should provide a physically and emotionally safe environment in which PWIDs are respected and not judged. It is important that in attempting to create such an environment, clinicians continue to maintain a gradualist attitude that accepts the realities of addiction but does not inadvertently encourage more drug abuse.

It is difficult to maintain a balance between providing a safe place to inject and at the same time not inadvertently encouraging injecting. Any misplaced sympathy for PWIDs that

inadvertently encourages drug injecting, does not actually respect their dignity and is in fact contrary to the Church's preferential option for the poor.

Clinicians need to maintain a non-judgemental attitude that treats clients with respect and in a professional manner. If a clinician in an MSIF were constantly to remind a client that this is all part of a pathway to abstinence, then it could undermine the relationship between client and clinician and may be highly counter-productive. This may actually cause rather than reduce harm.

There is strong evidence to suggest that a hard-line abstinence enforcement policy can increase harm to both PWIDs and the communities in which they live. An overly enthusiastic enforcement of drugs laws by Lothian and Borders Police was shown to have significantly contributed to the high incidence of HIV in Edinburgh in the early 1980s (Pearson, 1991). This hard-line taken by the police did nothing to reduce the amount of drug injecting that was going on but did increase the sharing of injecting equipment. This in turn led to a huge increase in the prevalence of HIV in Edinburgh, not only among PWIDs but in the wider community. Consequently, Edinburgh became known as the AIDS capital of Europe (McCarthy and Welsby, 2003).

Bozza and Berger (2020) have interpreted the non-judgemental attitude maintained by clinicians, as implicit support for illicit drug injecting. In this particular sense, "non-judgemental" does not mean being moral neutral about illicit drug taking. Clinicians have moral and ethical values but conduct themselves professionally in a fashion that does not judge the individual patient. Bozza and Berger (2020) argue that the very nature of an MSIF encourages illicit drug use and does nothing to dissuade clients from harmful and objectively immoral behaviour. Chaput (2019) argues that in enabling the use of illegal drugs, those who operate an MSIF violate divine law. However, the purpose of an MSIF is not to enable the injecting of illicit drugs but to make this activity less dangerous by reducing the harm both to the individual PWID and to the public (NHS Greater Glasgow & Clyde, 2016).

I have no personal experience of working in an MSIF, but I have significant experience of working in harm reduction clinics that provide needle exchange in addition to a wide range of other clinical services that aim to reduce the physical damage to health caused by illicit drug injecting. My clinical experience has taught me the importance of establishing and maintaining good therapeutic relationships with the PWIDs who used these clinics. I have no doubt that continually reminding the PWIDs who use these clinics that they should be striving for

abstinence would undermine the therapeutic relationship. Instead, conversations in clinic with PWIDs are about the most effective ways of avoiding harm to themselves and their families if they continue to inject illicit drugs. It is not just about using sterile needles and syringes but includes reminders about things as simple as washing their hands. In addition to such practical issues, the clinicians in a harm reduction service need to get to know the clients and build up trust.

I am reminded of one particular episode. One young woman was a regular client at a harm reduction clinic. Over a number of years, I got to know her and built up a trusting relationship. However, as this was an anonymous service, I did not know the client's name. This particular client never attended the clinic intoxicated and was always extremely polite. On this occasion, she appeared drowsy, unable to keep her eyes open and her speech was becoming increasingly slurred. If I had not spent the time getting to know this woman, I would have assumed that she was intoxicated. However, because I had built up a professional relationship and knew her, I realised that something was wrong. I examined her and quickly realised that she was showing symptoms of botulism. I sent her to hospital where a diagnosis of botulism was confirmed, and she spent a week in intensive care. In this particular instance, a non-judgemental attitude and a good therapeutic relationship undoubtedly contributed to saving the life of this young woman. If I had continually spoken to her about abstinence, I seriously doubt that she would have survived her episode of botulism.

However, in order for an MSIF to be effective, it is necessary for clinicians to encourage some kind of purpose of amendment among the PWIDs who use the service. As most harm reduction services are operated and staffed by clinicians with little or no theological expertise, it is highly unlikely that they would use the term "purpose of amendment".

Nevertheless, it is important that a purpose of amendment, a motivation to change, be encouraged by those running a harm reduction service for PWIDs including those running an MSIF. In discussions on the sacrament of reconciliation, a purpose of amendment is often described as an honest intention not to sin again. Within treatment services for PWIDs, a purpose of amendment could be described as an honest intention not to inject illicit drugs again. However, as previously discussed, it would be unrealistic for someone who is addicted to injecting drugs to suddenly and completely stop injecting. It would be much more reasonable to understand a purpose of amendment in such circumstances, as an honest intention to gradually reduce drug use with the ultimate goal of abstinence.

5.3.2.1 Imperfect Purpose of Amendment

However, my experience of working in harm reduction services suggests that there are a considerable number of PWIDs who use these services but do not intend to give up injecting illicit drugs. It could be argued that, this absence of a willingness to change shows that these harm reduction clients do not have a purpose of amendment. Nevertheless, rather than no purpose of amendment, the fact that they are using a service to reduce the harm caused to themselves and others, may show an imperfect purpose of amendment.

In paragraph 5.2, I said that, as part of a gradualist approach, some objectively wrong behaviours could be countenanced under certain conditions. Firstly, the person must not be capable of totally giving up the wrong behaviour in question all at once. Secondly, they must also be seeking gradually, to overcome the need to engage in the problematic behaviour.

This second condition, seeking to overcome the need to engage in the problematic behaviour, shows that the person has a purpose of amendment. However, even if the person is not seeking to overcome the need to engage in problematic behaviour, an imperfect purpose of amendment may be demonstrated under certain conditions. If a PWID is using a needle exchange or an MSIF in order to reduce the risk of harm to their own health, to the health of their family and to the health of the public, this shows an imperfect purpose of amendment.

A narrow or strict interpretation of gradualism would not countenance continued injecting of illicit drugs without any effort or intention to overcome this behaviour. Such an interpretation of gradualism suggests that providing a harm reduction service to PWIDs who have no intention of stopping is not acceptable. However, I disagree with this for two reasons. Firstly, it would be unethical for a doctor or nurse to make a clinical decision based on a moral assessment of the patient. Secondly, even when the PWID's purpose of amendment is imperfect, their use of a harm reduction service reduces the evils of disease and suffering and protects the health of the public.

I do not have the right to make a clinical decision on the basis that the behaviour of a patient is objectively morally wrong. In fact, I have both a religious and an ethical obligation not to be judgemental about my patients. The obligation not to be judgemental is stated clearly in the Gospel of Matthew (7:1) "Do not judge and you will not be judged." and reiterated in the Gospel of Luke (6:37).

In addition, the professional ethical codes of both nursing and medicine in the UK warn doctors and nurses against making moral judgments about their patients. The General Medical Council (GMC) (2013, 1) states that doctors "must treat patients fairly and with respect whatever their life choices and beliefs" and that they "must not refuse or delay treatment because you believe that the patients' actions or lifestyle have contributed to their condition" (GMC, 2013, 1). The Nursing and Midwifery Council (NMC) Code (2018, 20.2) states that nurses and midwives must "act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment." Furthermore, the NMC Standards for Competence for Registered Nurses (NMC, 2014, 6) states unequivocally that nurses must practise in a non-judgemental manner.

Both the tradition of Christian ethics and the professional ethical codes make it clear that it would be unacceptable to refuse treatment to any patient because of their beliefs or their lifestyle. Healthcare professionals, including Christian healthcare professionals, cannot make clinical decisions based on moralistic judgements of their patients. Therefore, it would be unethical to refuse a patient access to any harm reduction service, including an MSIF, because the patient does not intend to stop injecting illicit drugs or because they do not have a full purpose of amendment.

However, this does not mean that any behaviour is acceptable or that it is up to the individual to decide for themselves. The non-therapeutic use of drugs is morally wrong. Nevertheless, the fact that a patient is engaged in an objectively evil act, does not in itself, give the doctor or nurse the right to refuse treatment especially when this treatment is beneficial not just to the patient but to wider society.

The fact that the patient is engaging with a harm reduction service can be seen as evidence that the patient is taking some responsibility for their actions and is making some attempt to reduce danger to themselves and others from their illicit drug injecting. Although not evidence of a full purpose of amendment, this is evidence of an imperfect purpose of amendment and a small step in the right direction. In a gradualist approach, every step in the right direction is encouraged. As Pope Francis states in *Evangelii Gaudium* (2013, 44), small steps forward in the midst of great human limitation are pleasing to God.

In using a harm reduction service, the patient is reducing the spread of the evils of disease, pain and suffering caused by injecting illicit drugs, especially the disease, pain and suffering experienced by innocent members of their families and innocent members of the public. Even

if the patient has no purpose of amendment at all and is using an MSIF purely as a source of injecting equipment and a comfortable and convenient place to inject, the disease, pain and suffering associated with injecting illicit drugs is still being reduced. This is in itself a good thing. Reducing the risks to the general public and to the families of PWIDs is a benefit that would be unjustifiably lost if an MSIF were not to be operated because some or even all of the patients did not have a full purpose of amendment.

5.3.2 Gradualism and Patience in the Treatment of Drug Dependency.

Austin (2016) states that pastoral practice informed by gradualism requires patient realism. This same patience is required by everyone working with people who are suffering from any kind of addiction. This applies to both pastoral workers and to clinicians working in addictions. Patience is needed, by both the addicted persons and by those helping them in order for change to have any chance of being successful.

In chapter 12 of Mark's gospel, an episode is described in which a scribe asks Jesus what is the first of the commandments. Jesus replies "This is the first: Listen, Israel, the Lord our God is the one Lord, and you must love the Lord your God with all your heart, with all your soul, with all your mind and with all your strength. The second is this: you must love you neighbour as yourself. There is no commandment greater than these." (Mt.12:28-31)

The commandments to love God and our neighbour prompt us to ask the question what is love. This is answered by St. Paul in his First Letter to the Corinthians where he gives an eloquent description of love beginning with the statement that love is always patient and kind. (1 Corinthians 13:4-7) St. Paul spends a considerable portion of this passage describing love negatively, saying what love is not rather than what love is. Among other things, he states that love is never jealous, never boastful and never conceited. It seems significant that the first word he uses to describe love and one of the few that he uses in a positive sense is "patient". It seems to suggest that in order to love our neighbours, we must first be patient with them.

The significance of patience is reiterated by St Francis of Assisi in the episode in the Fioretti where he describes perfect joy to Br. Leo (Armstrong *et al.* 2002, 579-581). St Francis alludes to the earlier parts of Chapter 13 of the First letter to the Corinthians where St Paul spells out the importance of love before going on to give his description of love. As St Paul spends much of his description telling us what love is not, so St Francis spends at least two miles of the

journey from Perugia to Assisi telling Br Leo what perfect joy is not before saying that it is to be found in patience.

Patience is an essential aspect of gradualism. Those working with people suffering from addiction and for those striving to recover from addiction need to be patient. In addition, as St. Paul and St. Francis have indicated, patience is one of the most important aspects of love. As Christians, we are called to love God and to love one another and we are called to have a special or preferential love for the poor (Vatican, 2005, 449).

In employing gradualism to care for people suffering from addiction, we acknowledge that a complete sudden transformation is extremely unlikely. It is exceptionally unusual for someone who injects drugs to be able stop abruptly and never relapse. In the case of alcohol addiction, not only would it be unusual for some who is dependent on alcohol to suddenly stop drinking but it would be dangerous. Sudden withdrawal of alcohol after prolonged excessive use can have serious and life threatening consequences. Recovery from addiction takes time and effort therefore patience is essential for both the person recovering from addiction and the people providing pastoral and clinical care in this situation.

Consequently, this affords the opportunity for the application of gradualism to the provision of an MSIF to be understood not just as a matter of moral compromise but as a positive opportunity to develop the moral virtue of patience.

According to Thomas Aquinas (Summa Theologica, Second Part of the Second Part) patience is both a virtue and a gift from God and it safeguards the mind from being overcome with sorrow. In the Letter to the Galatians (5:22), St Paul lists patience as one of the fruits of the Spirit. Aquinas distinguishes between the habit of patience, which he describes as a virtue, and the pleasure that patience affords which he describes as a fruit.

There is a danger that patience can lead to complacency. There is a subtle difference between being patient and being dormant. When trying to be patient, there is a temptation to rest, wait and work too slowly. Whereas, true patience involves doing an unreasonable amount of work over an unreasonable amount of time while resisting the temptation to do it too quickly. In order for patience to be effective, it needs to be linked with the virtue of hope.

5.3.3 Gradualism and Hope in the Treatment of Addiction

In his doctoral thesis, Martin Johnstone (2005) describes an encounter with a woman in the Sao Bernardo favela on the outskirts of Sao Paulo in Brazil. Johnstone asked the woman what the people in Brazil could offer the churches in Scotland. The woman replied "We can give you hope." When Johnstone looked confused and incredulous, the woman explained that there is a difference between hope and optimism. She went on to state that there in the favela there are no grounds for optimism but there are grounds for hope because hope comes from God.

The circumstances in which many PWIDs live gives them no grounds for optimism in any aspect of their lives. In many cases, the previous behaviour of PWIDs gives nurses very little cause for optimism. However, whether there are grounds for optimism or not, harm reduction work with PWIDs needs to be done hopefully; it needs to be spurred on by God's gift of hope.

Hope is one of the three theological virtues: faith, hope and love. According to the *Catechism of the Catholic Church* (Vatican 1994, 1814) faith is the theological virtue through which we believe in God and in what He has revealed to us. Faith is not merely an intellectual belief but has to be expressed through good works in order to have any meaning. For this to happen, faith needs to be united with hope and love.

Love is both a virtue and a commandment. We are commanded to love God above all things and to love our neighbour as ourselves. According to the gospels of Matthew (22:35-40) and Mark (12:28-31) these are the two greatest commandments. The *Catechism of the Catholic Church* (Vatican 1994, 1826 – 1827) reiterates the words of St. Paul that without love we are nothing and goes on to state that love animates and inspires the practice of all the other virtues.

Hope is the theological virtue through which we long for the Kingdom of Heaven and for eternal life and happiness. Through hope, we place our trust in Christ's promises rather than relying on our own strength. In exercising the virtue of hope, we respond to the aspirations to happiness that have been placed in our hearts by God. Hope keeps us from discouragement and sustains us in the difficulties of life (Vatican 1994, 1817-1818).

Without the gift of hope, it would be difficult for us to live out our faith through good works. Without the gift of hope, patience would become meaningless and drift into complacency but with the gift of hope, we are able to persevere in the situations, such as chronic addiction, where there is no cause for optimism.

The provision of an MSIF is a form of good work that expresses a preferential love for the poor. This good work is given spiritual meaning through faith in God and a reliance on the promises of Christ: this reliance is a concrete expression of the gift and the virtue of hope.

5.4 Summary

In Chapter 3, I used the principle of cooperation with evil to make a case that the provision of MSIFs is justified. However, I concluded that, although a strong case can be made from this principle, this may not be the most suitable tool on its own for the moral analysis of the provision of an MSIF. Therefore, in this chapter I applied the concept of gradualism to MSIFs.

Gradualism accepts that moral development is an incremental process and that even when one's current behaviour is imperfect it still has moral value. Gradualism aims to encourage positive behaviour rather than reprimand imperfect behaviour. Gradualism is open to accepting evil behaviour when a person seeks to gradually overcome or weaken the need to engage with that behaviour or to reduce the harm caused by it. Gradualism must involve a purpose of amendment. For a PWID, this would normally mean an intention to reduce and eventually stop injecting illicit drugs. However, a plan to make their drug injecting less harmful can be seen as an imperfect purpose of amendment.

The use of an MSIF by a PWID may show some assumption of responsibility and could indicate that the PWID is working to reduce the harm caused by their illicit drug injecting. When a PWID uses an MSIF to reduce harm, this can be seen as a step in the right direction. However, there is a danger that the clinicians running the MSIF may inadvertently encourage the PWID to continue to inject illicit drugs. It is therefore important that the MSIF staff respect the dignity of the PWID and establish a good therapeutic relationship that does not encourage illicit behaviour. This involves a high degree of patience and hope, both of which are traditional Christian virtues and gifts from God.

Having analysed the morality of MSIFs using gradualism and the principle of cooperation in evil, in the following chapters, I will analyse the arguments that have been put for and against the provision of MSIFs in the specific situations in Sydney, North America, Dublin and Glasgow. In Sydney in the late 1990s, there was considerable disagreement between the Roman Catholic Church authorities in the Vatican and a group of religious sisters on the front line working directly with PWIDs. There is considerable disagreement about MSIFs in the Roman

Catholic Church in North America. The Canadian bishops have taken a very sympathetic approach to the drug crisis in general and to the issue of MSIFs in particular. On the other hand, in the USA certain bishops and theologians have put together strenuous arguments against the moral permissibility of MSIFs. In Ireland there seems to be no open theological opposition to the operation of an MSIF by a Roman Catholic organisation. However, there has been considerable opposition from secular society to an MSIF being operated by a religious organisation. In Scotland the situation is different. The proposed MSIF in Glasgow would be operated and funded by the Scottish Government. However, this plan has come up against legal difficulties. Although the Scottish Catholic bishops do not appear to enthusiastically support the provision of an MSIF, the main objection in Scotland is legal and political. The cases in Australia and North America show how the Catholic Church is struggling with the morality of MSIFs. The situation in Ireland suggests that there has been some shift and development on this issue within the institutional Church. The situation in Scotland shows that it is not just the Church that is struggling with certain aspects of MSIFs, but secular society is also struggling with some of the same issues.

Chapter 6

The Situation in Australia

The Attempt by the Sisters of Charity to set up an MSIF and the Response of Congregation for the Doctrine of the Faith

6.1 Introduction

In previous chapters, I have set the scene by describing the historical background to the controversy surrounding the morality of the provision of MSIFs. I have shown that MSIFs can be clinically and economically effective in that they can achieve their aims of reducing drug related deaths and disease and reducing public drug related nuisance and that they can save more money that it costs to run them. I have provided an outline of how both the principle of cooperation in evil and gradualism can be applied to the ethical issues associated with MSIFs.

In the next four chapters, I will discuss four specific examples of MSIFs and the ethical decision making that has been applied in these cases. The aim of these chapters is to examine the history of how Catholic health care facilities and local archdioceses have dealt with harm reduction services for PWIDs including needle exchange and MSIFs and to evaluate the way in which this has been done. The following four chapters show that there are different Catholic approaches in different places and that there is no single authoritative Roman Catholic teaching on this matter. In these chapters, I will explore the roles, the experiences and expertise of Catholic practitioners in informing Catholic learning in this field.

In this chapter, I will discuss the proposal of the Sisters of Charity to run an MSIF in Sydney and the response of the Congregation for the Doctrine of the Faith (CDF) to this proposal. Although this happened more than twenty years ago, this case is still relevant for at least two reasons. Firstly, at the time of writing, it is the only publicised decision by the CDF on whether the operation of an MSIF by a Catholic organisation is morally justified. However, the determination of the CDF in this case was never published in full. Nevertheless, the Archdiocese of Sydney has made the determination available for use in this thesis. Unfortunately, I have not been given permission to include a copy of the determination as an appendix to this thesis but only refer to it. Secondly, the Sisters of Charity are currently considering an invitation to operate an MSIF in Melbourne. The CDF determination will have

to be taken into consideration in any ethical evaluation of the sister's involvement in the proposed MSIF in Melbourne.

6.2 Historical Background

The first religious sisters in Australia, five Religious Sisters of Charity, arrived on 31st December 1838. In 1857, they established St. Vincent's Hospital in Sydney that was free to all but was especially aimed at the poor. The hospital is located close to what is now Sydney's gay neighbourhood centred on Taylor Square and close to Kings Cross, which is also a red light district with a high number of people who inject drugs. As a result, the hospital was one of the first in Australia to treat people with AIDS and has been at the forefront of AIDS research and treatment since the early 1980s. As part of the hospital's commitment to stemming the spread of HIV, the first needle exchange in the southern hemisphere was established in St Vincent's in 1986. This was an illegal pilot scheme. Despite its illegality and there did not seem to be any record of objection from within the Church to the operation of an illegal needle exchange by a Catholic organisation.

According to St Vincent's own website, at the time of writing, a needle exchange service is still run in St. Vincent's; this is part of a wider drug and alcohol service that includes pharmacological treatment for opioid addiction and support for partners, families and friends. In addition, PWIDs attending the needle exchange can very easily be referred on to any of the other wide range of clinical specialities offered by St. Vincent's if needed. This includes mental health services and a specialist service for homeless people (St Vincent's, 2020).

6.3 St. Vincent's Proposed MSIF

A trial of an MSIF was originally recommended by the New South Wales Royal Commission into Police Corruption in 1997 (Wodak, 1999). After a considerable amount of political debate, in June 1999, the Sisters of Charity Health Service (SCHS) announced a plan to set up the first legal MSIF in the southern hemisphere in St. Vincent's Hospital in Sydney, in response to a request from the New South Wales Health Minister (Clifton, 1999).

The plan was for the MSIF to be run on a trial basis for a period of eighteen months after which it would be evaluated by a group of independent experts (Wodak, 1999). The proposal was an

extension to the harm reduction approach that was already practised in the needle exchange service at St. Vincent's. The aim of the MSIF was to reduce mortality and morbidity among people who inject drugs and to decrease the social nuisance associated with public injecting (Fisher, 2012, 80).

In setting out the aims of the proposed MSIF, Wodak (1999) made two surprising comments. Firstly, he stated that the MSIF would be unlikely to reduce the spread of BBV, as sterile injecting equipment was already widely available to PWIDs. However, Taylor *et al.* (2004) and my own unpublished MSc dissertation "An Investigation into the Sharing and Reuse of Injecting Paraphernalia" (University Of The West Of Scotland, 2014), show that even when supplied with sterile equipment a considerable number of PWIDs continue to take part in high risk injecting behaviour. Therefore, advice and supervision provided at an MSIF is intended to reduce such high-risk behaviour and subsequently reduce the spread of BBV among PWIDs and their sexual partners (Bayley *et al.*, 2017). Wodak (1999) then went on to state that the provision of an MSIF would reduce the opportunities for police corruption. In the Final Report of the Royal Commission into the New South Wales Police Service (Wood, 1997, 221) it was noted that the operators and owners of illegal "shooting galleries" in Sydney had established corrupt relationships with local police officers. However, Wood (1997) did not specifically link the establishment of an MSIF with a potential reduction in police corruption. This is a potential benefit of an MSIF that I have not seen mentioned anywhere else.

In addition to providing a harm reduction service, those attending the MSIF would have the opportunity to be referred to appropriate treatment services to help them give up illicit drugs. It was hoped that the provision of an MSIF would keep PWIDs alive until they were able to engage in treatment services and eventually free themselves from their addiction (Clifton, 1999).

The proposed MSIF was seen by the Sisters of Charity as a continuation of the work that they had been doing since they first arrived in Australia one hundred and sixty years previously. The sisters' first task in Australia was to look after the women incarcerated in Parramatta Female Factory, most of whom were convicts who had been transported to the colony of New South Wales. According to Clifton (1999) the situation faced by the women in the Female Factory and those using illicit drugs at the end of the twentieth century were similar. Both groups were lawbreakers and outcasts and both groups were being denied their dignity. The Sisters of Charity took up the challenge to treat the convict women with compassion in the

nineteenth century and at the end of the twentieth century, they were aiming to continue to take up the challenge of treating society's outcasts with compassion by providing an MSIF. The experience of the Sisters of Charity in working with marginalised groups in this neighbourhood and their expertise in HIV and addiction treatment, were the main reasons that the sisters were chosen to set up the MSIF in Sydney (Wodak, 1999).

6.4 Reactions to the Proposed MSIF

From the outset, the sisters were aware that there would be opposition to the planned MSIF and that it would come from a variety of sources including from within the Roman Catholic Church (Clifton, 1999). According to Fisher (2012, 80) the proposal provoked a mix of reactions. The Conference of Leaders of Religious Institutes and Catholic Health Australia were among the many individuals and organisations who voiced their support. On the other hand, critics protested that the establishment of an MSIF reduced drug abuse to a health problem that required containment and did not recognise the psychological, moral and spiritual aspects of the problem. This criticism failed to recognise that the proposed MSIF would have operated as part of a wide spectrum of services available to PWIDs within St. Vincent's. The proposed service would have been operating in a hospital which has a strong Catholic Christian ethos and has had a particular outreach to the poor and vulnerable throughout its history. In addition to harm reduction, St. Vincent's offers a specialist drug and alcohol treatment service. Furthermore, the drug and alcohol service is closely linked to the mental health service and homeless outreach team run by St. Vincent's. According to St Vincent's own website (https://www.svhs.org.au/about-us/welcome) they are part of a health service that aims to bring God's love to those in need through the healing ministry of Jesus.

Fisher (1999) quotes the bioethicist, Fr John Fleming, who argued that in sponsoring illegal activity, the MSIF would undermine the rule of law and that it would effectively abandon addicts to their addiction. In my experience, most PWIDs live in communities where the rule of law is not held in high esteem. There are many possible reasons for this; among them is the perception by many members of these communities that they do not have any influence over how decisions are made about their lives including how the law is made (McGarvey, 2017, 37). The rule of law is held is such low esteem is these communities that it would be difficult for it to be undermined even further. As one of the aims of an MSIF is to reduce the nuisance caused

by PWIDs injecting in public, the provision of an MSIF may actually improve law and order in these communities rather that undermine it.

Fisher (1999) continues Fleming's theme of abandoning addicts to their addiction. He argues that MSIFs are a declaration of despair that sends a message to PWIDs that says that society has no faith in them and that they are not expected to give up drugs; operators of an MSIF will just try to stop PWIDs killing themselves but do nothing to help them free themselves from addiction. Fisher (1999, 13) states that

> It is hard to see how injecting rooms can avoid communicating the message to drug abusers and potential drug abusers, especially young people: "To be honest, we don't have much faith in you, and we don't really expect you to give up drugs. It would be nice if you did and we'd help you if you were willing. But since you probably won't, we'll at least help you avoid killing yourself."

I submit that this is definitely not the message intended by those operating MSIFs. This comment seems to show a lack of understanding of the importance of keeping PWIDs alive; it is impossible to do any kind of therapy or rehabilitation with a dead patient. No dead patient has ever completed a rehabilitation programme. I submit that the intended message to PWIDs is that even if you do not value your own life, we value it and have put services in place to save it and protect you until you are able to begin to accept the help needed to become free from addiction; even if you do not recognise your own dignity, we recognise it and value it. We will not abandon you to die from your addiction (Clifton, 1999). Fleming went on to assert that there was no evidence that "shooting galleries" as he disparagingly referred to MSIFs, help people get off drugs. MSIFs aim to keep PWIDs alive and as healthy as possible until they are willing and able to accept the help that they need to get off drugs. However, as Fleming was writing in the late 1990s, it would have been true that there was no evidence that MSIFs help get PWIDs free from drugs, as there would have been so little research done on MSIFs at that stage that there would have been almost no evidence either for or against the effectiveness of MSIFs. This was one of the reasons that a trial of an MSIF was needed; the purpose of the trial was to determine the effectiveness of the MSIF in this particular location.

Among the critics of the proposal, some even claimed that since the non-therapeutic use of drugs is morally wrong, Catholics, especially nuns should not have anything to do with drug abuse (Fisher, 2012, 80). In chapters 3, 4 and 5 of this thesis, I have discussed the clinical and moral complexities of the provision of medically supervised injecting facilities. As I have

shown, particularly in chapters 4 and 5, the morality of the provision of MSIFs is considerably more complex than simply that the non-therapeutic use of drugs is wrong and so the Roman Catholic Church should have no contact with people who abuse drugs. The simplistic argument that nuns should have nothing to do with drug abuse does nothing to help either PWIDs or the sisters or anyone else involved with illicit drugs and verges on judgemental. Furthermore, Gleeson (1999) points out that some issues in life, including how to deal with drug addiction, are particularly difficult and that simplistic approaches have little to offer.

Having provoked both praise and criticism, the proposal was referred to the CDF by the then Archbishop of Sydney, Edward Cardinal Clancy. The CDF determined that it was not acceptable for a Catholic healthcare institution to operate an MSIF. In response, the Sisters of Charity decided to formally re-submit their proposal to the CDF as they believed that the decision was reached without an adequate understanding of their proposed work. A reply to the sisters, dated 9th August 2000, was sent to Cardinal Clancy on behalf of Cardinal Ratzinger – at that time Prefect of the CDF. This reply, which again determined that the sister's proposal was unacceptable, was never published in full. However, the archivist of the Archdiocese of Sydney has let me see a copy of the reply from the CDF. Unfortunately, as this official correspondence between the CDF and the Archdiocese of Sydney was never intended for publication, I am unable to include it as an appendix to this thesis.

6.5 The Response of the Congregation for the Doctrine of the Faith

The response from the CDF, dated August 2000, began with a brief outline of the proposed MSIF. It then went on to give some historical background to the communications between the Sisters of Charity, Cardinal Clancy and the CDF. The document then provided a moral evaluation of the sister's proposal.

The moral evaluation was given under the headings *Formal Cooperation, Material Cooperation, Hoped for Results, Other Available Means, Bad Side Effects* and seems to be based almost entirely on the principle of cooperation in evil. In addition to the moral evaluation, the CDF raised questions about the appropriateness of a Catholic organisation cooperating with the State Government of New South Wales.

6.5.1 Formal Cooperation

The first question addressed by the CDF is whether the proposed MSIF constituted *formal* cooperation in evil. The CDF acknowledged that the sisters abhor drug use and that the purpose of the MSIF is to preserve life and health rather than condone and or encourage the use of illicit drugs. Nevertheless, in discussing this determination from the CDF, Fisher (2012, 81) points out that people can formally cooperate in acts that they "do not like". This is implicit formal cooperation as the co-operator does not intend the evil itself but knowingly and freely intends an act that is intrinsically ordered to the evil act. If the sisters were operating an MSIF and in doing so were providing the equipment and premises *so that* PWIDs could inject illicit drugs, then this would be implicit formal cooperation.

The CDF noted that the proposed operation of an MSIF by the sisters was not "intrinsically ordered to illicit drug use" but to the preservation of life and health. Therefore, the CDF concluded that provision of an MSIF by the sisters is neither explicit nor implicit formal cooperation but that it does involve material cooperation.

6.5.2 Material Cooperation

In this section, the CDF began by pointing out that even if cooperation is not formal it may still be morally unacceptable and that material cooperation is undesirable. Material cooperation can only be justified if there is a proportionate reason for it to be undertaken. The reason clearly stated by the Sisters of Charity for material cooperation in the case of an MSIF is the preservation of life and health (Clifton, 1999, 3). MISFs contribute to the preservation of the life and health of the general public but they are specifically intended to preserve the lives and health of PWIDs, a group of people that the Catholic Church has a special responsibility for through the preferential option for the poor (Vatican 2005,184).

In discussing whether the preservation of life and health is a proportionate reason, the CDF stated that the intended benefits of the MSIF must be weighed against the act of cooperating in evil and the foreseeable bad side effects. Further on in its determination, the CDF stated that one of the most important bad side-effects is scandal. The CDF stated that the reasons for cooperation must be very strong indeed. I submit that the preservation of human life and health is a very strong reason for material cooperation in evil. Furthermore, I submit that the preservation of the lives and the health of the poor are even stronger reasons for material cooperation in evil through the provision of an MSIF and that to object to the provision of an

MSIF would be a source of scandal. However, the CDF seemed to have this left question unanswered and did not express an opinion as to whether or not the preservation of the life and health of PWIDs is a proportionate reason for providing an MSIF and for material cooperation in evil.

In writing about the principle of double effect, rather than cooperation in evil, Prusak (2011) discusses the difficulties of determining whether a proportionate reason exists. The good and bad effects can be weighed against each other and if the good effects outweigh the bad then it can be concluded that a proportionate reason exists.

This brings up several problems. Firstly, there does not seem to be a method for measuring the good and bad effects in order to be able to compare them meaningfully. The concept of the quality adjusted life year (QALY) used by health economists, could be used to quantify the good effects (Wonderling *et al.* 2005, 230). However, even health economists who use the QALY admit that it is of limited benefit (Sassi, 2006). Furthermore, the concept of the QALY cannot be applied to theological scandal in order to make a meaningful comparison.

Secondly, the weighing up of good and bad effects might give the impression of situating the decision about the MSIF within a consequentialist framework. Even though consequences are important, moral decision making is concerned with more than just weighing up the good effects and evil effects of an action but is also concerned with the reasons for the action. Are the reasons for the action sufficiently serious to cooperate in evil and to risk theological scandal? I submit that the preservation of the lives and the health of some of the poorest and most marginalised members of society is a sufficiently serious reason for cooperation and that theological scandal, although important, is of relatively little importance in comparison.

The CDF determination went on to discuss the concepts of *immediate* and *mediate* material cooperation stating that in immediate cooperation the actions of the co-operator are part of the evil action of the main agent; in mediate cooperation, the actions of the co-operator and the main agent are separate and can be distinguished. The CDF made the point that it is difficult to determine where one act ends, and another act begins. The CDF went on to point out that the operators of the MSIF do not provide clients with illicit drugs and they do not actually assist in the act of injecting illicit drugs. It would seem, therefore that the operation of an MSIF involves mediate rather than immediate material cooperation. The CDF hinted that the cooperation is mediate but did not state this explicitly. The CDF went onto consider proximity

of the cooperation. The CDF stated unequivocally that the cooperation is extremely proximate but did not explicitly state at this point, that this makes the cooperation morally unacceptable.

6.5.3 Hoped-for Results

This section of the CDF's determination began with a brief outline of the aims of the proposed MSIF and a comment that these aims are both good and urgent. The CDF then posed the questions as to whether these aims are likely to be achieved by the MSIF and if there is a means of achieving them that involves less proximate cooperation.

The CDF stated that there is a probability that the provision of an MSIF will reduce the incidence of death, disease and social nuisance associated with illicit drug use but there is nothing certain about this. The CDF made the passing comment that not every instance of illicit drug use will result in evil physical consequences. This is true. However, this could be interpreted as an attempt by the CDF to downplay the seriousness of the risks to the health of individuals and the risks to society in general that are caused by injecting illicit drugs. Consequently, this may give the impression to some people that the CDF is not as concerned with the health of marginalised PWIDs as it should be. This would be a source of scandal in that it would show a discordance between a decision of the CDF and the Roman Catholic Church's preferential option for the poor; it could lead people to the conclusion that the Roman Catholic Church does not care for the poor as much as it says it does. Furthermore, this passing comment is inconsistent with the statement in the previous paragraph stating that the aims of the proposed MSIF are urgent.

The comment by the CDF that there is no certainty that the proposed MSIF would have reduced the deaths, disease and public nuisance associated with drug abuse does not contribute anything to the arguments for or against a trial of an MSIF. At the time of the CDF's decision, very little research or evaluation had been published on the effectiveness of MSIFs and so there was a need for a trial. Since then, as I have shown in Chapter 3, extensive research and evaluations have been done on both the clinical and economic effectiveness of MSIFs. The published evidence strongly suggests that MSIFs are achieving their aims of decreasing drug related deaths and disease and decreasing the nuisance caused by public injecting of illicit drugs. Furthermore, the evidence indicates that this is being done in a cost-effective manner that, in the long term, saves rather than costs money.

This section of the CDF document goes on to state that there is only a hope that the PWIDs who use the MSIF will go on to treatment and rehabilitation voluntarily. The use of the term "voluntarily" is curious and could easily lead to a misunderstanding of the point that the CDF seems to be trying to make. With very few exceptions, almost every healthcare intervention requires to be entered into voluntarily. Any attempt to treat a patient without their consent in most circumstances is both unethical and illegal. However, despite using the term "voluntarily", the CDF seem to be making the point that there is no guarantee that the PWIDs who use the MSIF will seek out treatment and rehabilitation, rather than making a point about voluntary informed consent.

The comment from the CDF that there is only a hope that drug users will seek treatment and rehabilitation seems to suggest that the chances of a PWID seeking treatment as a result of their use of an MSIF, are so slim that it would not justify the provision of the MSIF. This could be interpreted as sending a message that PWIDs are not worth the expense and the effort involved in providing an MSIF; PWIDs might not seek treatment through their engagement with MSIF staff, so should not be given that opportunity. This gives the impression of the Roman Catholic Church abandoning PWIDs to their addiction. If this line of thinking by the CDF were to be made public, it would be a source of scandal.

The final statement made by the CDF in this section is that the hoped-for good results from the MSIF would only be possible if PWIDs made the MSIF their habitual place for injecting illicit drugs. The CDF gave the impression that it considered this unlikely with the comment that there is no assurance that this will happen but did not give any evidence to support this claim. However, the premises for this particular MSIF would have been in area of Sydney that was and is frequented by a high number of PWIDs. Even though this does not guarantee that any PWIDs will use the MSIF as their habitual site for injecting, it does increase the likelihood of this happening.

6.5.4 Other Available Means

This section began with the assertion that the benefits provided by MSIFs in other countries are dubious and debatable. However, the CDF did not give any details of the evaluations of MSIFs in other countries. This section continued with the suggestion that there are other means of achieving the aims of an MSIF with either less or no cooperation in evil. It is true that both needle exchange and the pharmaceutical treatment of addiction involve less cooperation in evil and that counselling and rehabilitation services can involve no cooperation in evil. As such,

this section made a very strong argument against the moral legitimacy of MSIFs. However, the research by Taylor *et al.* (2004) shows that even when provided with sterile injecting equipment and a safe means of disposal of contaminated equipment, many PWIDs still act in a manner that endangers both themselves and the public. This suggests that the CDF was wrong in its suggestion that there are other effective means of achieving the aims of an MSIF. However, this information would not have been available to the CDF as the research of Taylor *et al.* (2004) was published five years after the CDF made its determination.

6.5.5 Bad Side-effects

In this section, the CDF states that one of the most important bad side-effects is scandal. As Fisher (1999) points out through his description of a conversation with a taxi driver, this is a very real and serious issue. Fisher's taxi driver, who was not a Christian, was appalled that a Christian organisation, in this case the Wayside Chapel rather than the Sisters of Charity, was operating a "shooting gallery". The taxi driver's concern was that this was sending the wrong message to young people. As a parent, he felt that in providing an MSIF, the churches and the state were abandoning their duty to tell young people that drug abuse is wrong.

The CDF stated that the Sisters of Charity were aware of the scandal associated with the proposed MSIF and would take serious measures to address it. The CDF asserted that some people would be scandalised by the extreme proximity of the cooperation of a Catholic organisation in a serious evil. Furthermore, this proximate cooperation would give the impression to some that the sisters are taking part in formal cooperation.

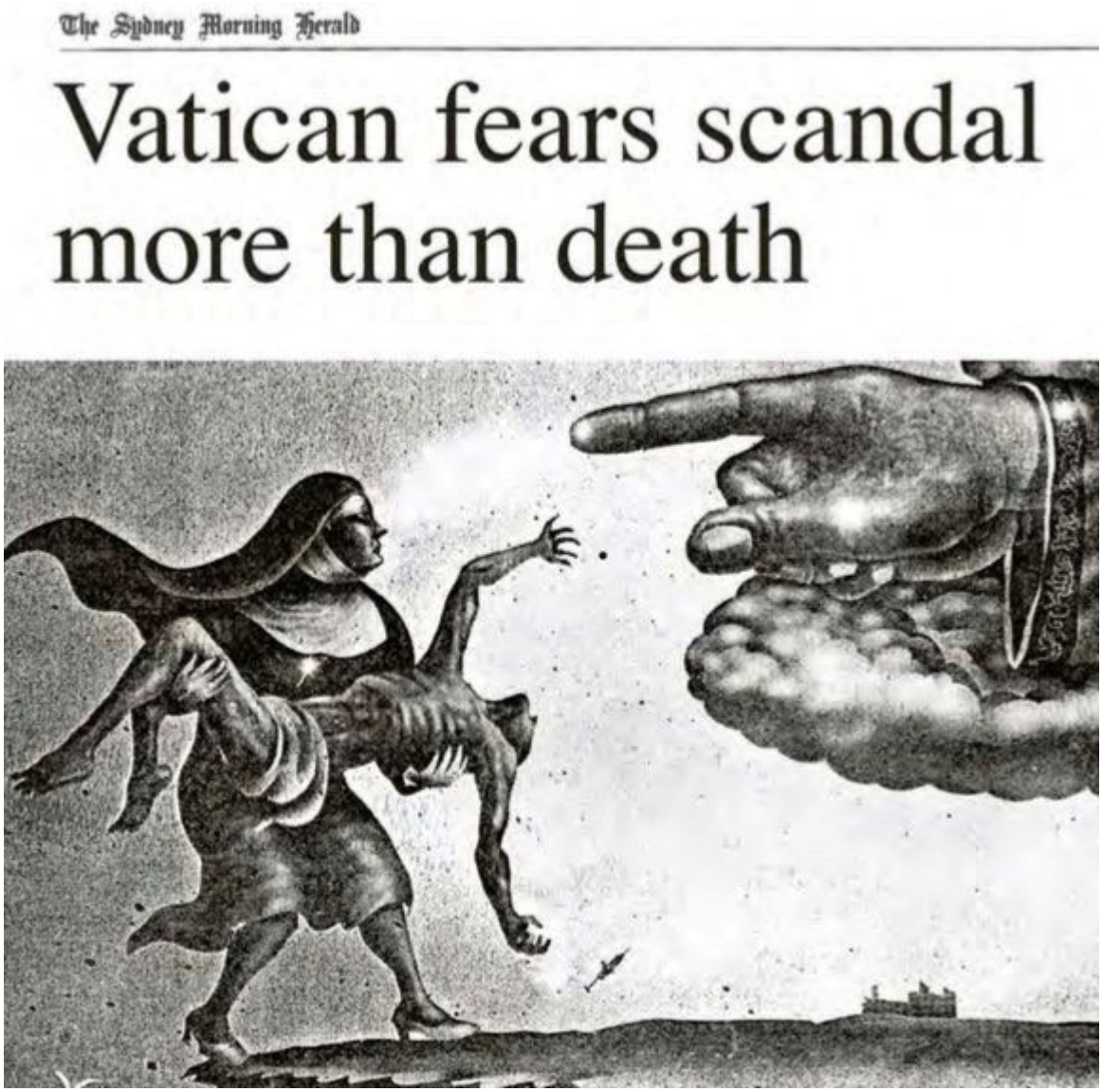
However, the CDF had already accepted that the proposed MSIF does not involve the sisters taking part in formal cooperation. It seems that rather than prohibiting Catholic organisations from operating an MSIF because of the risk of scandal, it would make more sense to ensure that the involvement of Catholic organisations in such services is fully explained to the public who may be scandalised by it. Thus, a service could be provided that would save lives and improve health among a very marginalised group and the potential scandal associated with this service could be averted.

In common with much that has been published about cooperation in evil, this CDF document described the scandal that could be caused by cooperation but did not mention the possibility of scandal being caused by not cooperating. The CDF did not seem to consider that scandal could be caused by not providing an MSIF, by not doing everything reasonable to prevent death

and illness among some of the poorest and most marginalised members of society. The CDF did not seem to take into account the possibility that disapproving of the provision an MSIF would be a source of scandal as it would show an inconsistency between what the Roman Catholic Church teaches about the dignity of all people and the preferential option for the poor on one hand and the action or inaction of the Roman Catholic Church on the other hand. The CDF did not seem to consider that preventing the Sisters of Charity running an MSIF could itself be a source of scandal.

Angela Senander (2012) distinguishes between two different meanings of scandal. In a sociological sense, scandal is the making public some perceived wrong doing to a negatively orientated audience. The idea of theological scandal is defined in the *Catechism of the Catholic Church* (Vatican, 1994, 2284) as "an attitude or behaviour that leads another to do evil". Whereas, in the sociological sense, a scandal is indicative of a failure in public relations. Throughout its entire history, the Roman Catholic Church has worked hard to avoid scandal. However, it sometimes seems as if the effort made to protect the Church's reputation has been justified as avoiding theological scandal when in fact it has been aimed at preventing sociological scandal. At times, particularly during sexual abuse crises, the Roman Catholic Church has given the impression that it is more concerned with protecting its own reputation than it is with protecting its most vulnerable members. This effort to protect the reputation of the Church, these attempts to prevent sociological scandal have in fact been a source of theological scandal that give the impression that the Church does not really believe what it says about human dignity and the preferential option for the poor.

The reaction of the local press to the decision of the CDF not to allow the Sisters of Charity to operate an MSIF seems to have caused both theological and sociological scandal for the Roman Catholic Church in Australia. According to Uniting Care (2014) the headline "Vatican fears scandal more that death" appeared in the Sydney Morning Herald over an image of a nun carrying an emaciated body with a large male hand pointing accusingly at her. This seemed to give the impression that the reputation of the Roman Catholic Church had been harmed and that there was a perception that the Church was more interested in protecting its reputation than in serving the poor and vulnerable. Thus, in trying to avoid theological scandal, the decision of the CDF appeared to have been a source of both theological and sociological scandal.


The Sydney Morning Herald

Vatican fears scandal more than death

6.5.6 Collaborating with Government Policy

At the end of the moral evaluation of the proposed MSIF, the CDF added a paragraph on the morality of a Catholic organisation collaborating with the drugs policy of the Government of New South Wales. The CDF reiterated the Church's teaching on the toleration of evil on the part of the state. An evil policy can be tolerated when it is necessary to prevent a greater evil. Toleration involves not impeding, not obstructing and not punishing the evil policy. According to Joseph Piccione (2015) it involves enduring or bearing with an evil policy but does not involve endorsing a policy that the Catholic Church has deemed to be evil.

According to the CDF, the provision of the proposed MSIF in Sydney would have gone beyond toleration and would have involved a Catholic organisation in facilitating illicit drug use.

Despite accepting that the intention of the sisters in planning to operate an MSIF was not intrinsically ordered to illicit drug use but to the preservation of life and health and that it would not involve formal cooperation, the CDF decided that the government policy of providing an MSIF cannot be ethically justified because it facilitates a behaviour that destroys life and health. This decision seems to be inconsistent with the previous comments in the document where the CDF stated that the aim of the MSIF was to save lives and improve the health of PWIDs and the general public.

6.5.7 Conclusion of the CDF Decision

The response of the CDF concluded that while the proposal of the Sisters of Charity to conduct a trial of an MSIF does not constitute formal cooperation in evil, it is not morally justifiable. The reasons given by the CDF were that the proposed MSIF would facilitate illicit drug use and would give an impression that the Church approved of illicit drug use. Furthermore, the CDF stated that the harm that would be reduced by the provision of an MSIF is accidental to the act of drug injecting rather than essential and necessary. The main aims of this proposed MSIF were to save the lives and improve the health of some of the poorest and most marginalised people in Australia and to improve public health in Sydney. The use of these categories could have given the impression that the CDF cared more about philosophical minutiae than it did about the lives of the poor. This is a further example of the thinking of the CDF being a potential source of scandal. In the conclusion, the CDF went on to state that the potential benefits of the proposed MSIF did not sufficiently outweigh the fact that it involved extremely proximate material cooperation in evil.

There seems to be some inconsistency in the response of the CDF. The CDF agreed that the aims of the proposed MSIF were both good and urgent. Furthermore, the CDF pointed out that there is nothing certain about the efficacy of the proposal. The fact that, at that time there was nothing certain about the benefits of the proposal, suggests that a trial of an MSIF would be needed to ascertain how beneficial the proposed MSIF would be. The potential benefits include saving the lives of PWIDs. I submit that such potential benefits are a sufficiently serious reason for extremely proximate material cooperation in evil. Consequently, I submit that the CDF came to an erroneous decision in this case.

6.6 Services in Australia since the CDF Decision

The Sisters of Charity Health Service is now known as St. Vincent's Health Australia (SVHA). Since the decision of the CDF, SVHA has continued to provide services for people with drug and alcohol problems not only in Sydney but also in Melbourne. In both of these cities, SVHA provides a wide range of addiction services including needle exchange.

In May 2001 the Uniting Medically Supervised Injecting Centre was set up in Kings Cross, Sydney, the same district where the St. Vincent's MSIF had been planned to operate. The Uniting facility was operated on a trial basis for ten years until it was granted permanent status by the New South Wales Government in 2010 (Thomas, 2010). From 2005 to 2007, The National Centre in HIV Epidemiology & Clinical Research (NCHECR) at the University of New South Wales produced four evaluation reports on the Uniting MSIF. The final report stated that there were 2,106 overdose related events in the MSIF during the first six years of its operation but none of these were fatal. In addition, there was a fifty percent reduction in the amount of discarded needles and syringes in the vicinity of the MSIF immediately after it was established; this reduction was sustained over the six year period of the evaluation. The report concluded that the MSIF reduces the impact of overdose events, reduces public injecting, provides access to drug treatment and other health services and has not led to an increase in crime in the local area (NCHECR, 2007). A further evaluation of the MSIF was done during an extended trial period. The final report of this evaluation concluded that the MSIF was successful in its aims of decreasing overdose deaths, providing a gateway to drug treatment, reducing public injecting and discarded needles and syringes and reducing the spread of BBV (KPMG, 2010).

For seventeen years, Uniting was the only MSIF in Australia. A second Australian MSIF was set up in North Richmond, Melbourne by the Victorian Government in 2018. The service in North Richmond was initially established for a two-year trial period and will be extended for a further three years based on the evidence gathered between 2018 and 2020. Since its establishment, SVHA has been working in partnership with the North Richmond facility providing allied health support enabling gateways into care provision for people using the MSIF that would not otherwise have existed. Furthermore, the Victorian government has accepted a recommendation that a second MSIF should be established in Melbourne (Victoria State Government, 2020). SVHA is seriously considering running this second service in

Melbourne. This would involve further ethical evaluation by SVHA, the Archdiocese of Melbourne and the CDF.

6.7 Summary

The Sisters of Charity have been providing healthcare for the most marginalised members of society in Australia for over 160 years. As part of this commitment to the marginalised, their hospital in Sydney was one of the first in Australia to treat people with AIDS and the first needle exchange in the southern hemisphere was established there in 1986. In 1999, in an attempt to develop their harm reduction services, the sisters proposed the establishment of an MSIF. There was a mixed reaction to this proposal and it was referred to the CDF by the Archbishop of Sydney. The proposal was rejected by the CDF in a determination that was based almost completely on the principle of cooperation in evil. The reasons given for rejecting this proposal have been critically analysed in this chapter. There seem to be some inconsistencies in the response from the CDF and I submit that the decision was erroneous.

The Sisters of Charity had no choice but to accept the decision of the CDF and abandon their plan for an MSIF. However, in 2001 the Uniting Church opened an MSIF in Sydney on a trial basis. Evaluations of the service have been positive and since 2010 the MSIF has been operating on a permanent basis.

However, SVHA have recently been working in partnership with an MSIF in Melbourne, providing access to addiction services and wider healthcare for people using this service. SVHA are seriously considering running a second MSIF in Melbourne that has been proposed by the Victorian Government. However, before the Sisters of Charity could go ahead with this, there would need to be further ethical evaluation by SVHA, the Archdiocese of Melbourne and the CDF.

Having discussed the Australian situation in this chapter, in the next chapter I will discuss the situation in North America.

Chapter 7

The Situation in North America

The Contrasting Positions of the Canadian and US Catholic Bishops

Some American Theological Objections to MSIF

7.1 Introduction

In the previous chapter, I discussed the attempts by a Roman Catholic organisation to establish and operate an MSIF in Australia and the objections to these attempts from within the Roman Catholic Church. In this chapter, I will describe the situation in North America comparing the very different views taken by the Canadian Conference of Catholic Bishops (CCCB) and the United States Conference of Catholic Bishops (USCCB) to the operation of an MSIF. I will go into some detail in examining the theological objections to the provision of an MSIF made by some American theologians and an American bishop.

7.2 Canada

In 2003, "Insite" the first MSIF in North America, was opened in Vancouver, Canada. Since then, approximately twenty-five more MSIFs have been opened in Canada. Two of these have close ties to Roman Catholic institutions.

One MSIF is in St. Paul's Hospital Vancouver, a hospital founded by the Sisters of Providence in 1894 and currently operated by Providence Health Care. Initially this MSIF was in the grounds of St. Paul's Hospital and was funded by Vancouver Coastal Health who contracted with RainCity Housing for the day-to-day management of the site. Providence Health Care provided premises within the hospital ground as well as facilities management. This was the first hospital based MSIF in Canada (Dogherty *et al*, 2022). According to Providence Health Care's website, they are a Catholic healthcare community that it is inspired by the healing ministry of Jesus Christ (https://www.providencehealthcare.org/about-providence/who-we-are/mission-vision-values).

The original MSIF in the grounds of St. Paul's hospital was moved to another location at the end of 2020. This move left a gap in services, which was exacerbated by the COVID-19 pandemic. In response, a nurse-led MSIF was established within St. Paul's Hospital in February 2021. Providence Health Care's Ethics Services team were consulted before a final decision was made to open the service. Following a detailed ethical analysis, it was determined that the operation of an MSIF within St. Paul's hospital would be ethically permissible. However, the findings of the ethical analysis emphasised that the provision of an MSIF should not be regarded as in any way promoting illicit drug use but as an extension of compassionate care for PWIDs in the line with founding values of St. Paul's Hospital (Dogherty *et al.*, 2022).

St. Michael's Hospital, founded by the Sisters of St. Joseph, is the largest Catholic hospital in Toronto. Although St. Michael's does not have its own MSIF, it collaborates with an MSIF in the local area (Perry, 2020).

I could find no mention of any theological objection to Catholic organisations being involved in the operation of either of these MSIFs in Canada. Furthermore, in the next section, I will show that the Canadian bishops cautiously accept the benefits of MSIFs and do not regard MSIFs as morally impermissible.

7.2.1 The Canadian Bishops and Drug Addiction

In April 2017, the Canadian Conference of Catholic Bishops published a Statement on Canada's Opiate Crisis and Drug Addiction (CCCB, 2017). This statement expressed the bishops' deep concern for the current high number of drug overdoses in Canada and the wider detrimental effects of drug addiction on both individuals and society. The bishops clearly linked the current opiate crisis in Canada with the overprescribing of opioid painkillers, a practice that has been going on for the last twenty years and has, according to the bishops, led to a high number of patients becoming addicted to their medication and has created an illicit market of opioids being sold for recreational use.

The Canadian bishops recognise the wide range of social factors that can cause susceptibility to drug addiction. In addition to the social factors, they recognise the part that many different mental illnesses can have in both precipitating addiction and making recovery from addiction more difficult.

The bishops recognise the complexity of addiction and show that they understand that there are no simple solutions to a problem that impacts the physical, psychological, social and spiritual

aspects of individuals. They acknowledge that this complexity makes the road to recovery more problematic and challenging.

The Canadian bishops cautiously accept the benefits of harm reduction services, including needle exchanges, and MSIFs. They warn that on their own, harm reduction services do not address the deeper problems of addiction and so should not become the centrepiece of any drug strategy. Consequently, the Canadian bishops do not condemn harm reduction, including MSIFs as morally impermissible.

7.3 USA

Even though there have been MSIFs operating in Canada since 2003, it was not until November 2021 that the first two legally tolerated MSIFs were opened in the United States. These are both in New York City and operated by OnPoint NYC.

In February 2019, the US Attorney for the Eastern District of Pennsylvania asked a federal court to declare that the provision of an MSIF was illegal under the Controlled Substances Act. In October 2019, US District Judge Gerald McHugh ruled that the provision of an MSIF is not in breach of the Controlled Substances Act and is legally permissible as it is intended to reduce illicit drug use rather than facilitate it. The response to this judgement by the then Archbishop of Philadelphia, is discussed below in 7.3.2. In February 2020, the court entered a Final Declaratory Judgement. This stated that the proposal by an organisation known as Safehouse, to operate an MSIF in Philadelphia did not violate federal law. However, this decision has been appealed and the plans to operate an MSIF in Philadelphia have been put on hold while legal arguments continue (Safehouse, n.d).

Despite the legal decisions in Philadelphia, OnPoint has managed to establish two MSIFs in New York City. These services may be in breach of federal law but according to Young (2022), the New York Police Department has agreed not to enforce drug laws in these two facilities. Even though these MSIFs are not legally sanctioned, they are tolerated by local law enforcement and are thus able to operate freely and openly.

7.3.1 United States Conference of Catholic Bishops and Harm Reduction

The history of the United States Conference of Catholic Bishops (USCCB) in relation to the prevention of the spread of HIV has developed in a nuanced manner over a number of years.

In response to the recently discovered threat of HIV, the Administrative Committee of the United States Conference of Catholic Bishops produced “The Many Faces of AIDS A Gospel Response” (USCCB 1987). This publication begins by saying that in HIV/AIDS the Church faces a significant pastoral issue. The bishops seem to make great efforts not to be judgemental about people who have been infected with HIV. They give examples of different people who were infected with HIV in widely different circumstances. Their description of a young man who injected drugs seemed to be particularly empathetic:

> he found his environment like a prison and sought to escape by turning to drugs.

The statement is divided into three main sections; The Facts about AIDS and a Commentary, The Prevention of AIDS, and Care for Persons with AIDS and Aids Related Complex (ARC). In the first section, the ways in which HIV can be transmitted are described; these include sexual transmission, vertical transmission from mother to baby and the sharing of contaminated needles and syringes in illicit drug use.

The second section emphasises the importance of the prevention of AIDS because, at the time that it was written, there was no effective treatment for this disease. Continuing their non-judgemental tone, the bishops state that their concern is the physical and moral welfare of people and they do not condemn those with whom they disagree. The bishops argue that the most effective ways of preventing the spread of AIDS must include an authentic and fully integrated understanding of human sexuality and must address the causes of intravenous drug use. In order for the spread of AIDS to be tackled, argue the bishops, there must be education that encourages change in behaviour. However, they are not completely naïve about the difficulties in changing behaviour and the reasons that people behave in ways that endanger them. Poverty, oppression, loneliness and alienation all have to be addressed to reduce the spread of AIDS. In addition, the bishops acknowledge that in the pluralist society of the USA, there are people of good will who do not agree with the Church’s understanding of human sexuality and people who will continue to engage in sexual practices and drug abuse that will risk them becoming infected with HIV.

“Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis” was published by the American bishops in 1990 as a more comprehensive response to the worsening HIV/AIDS crisis (USCCB 1990). At the outset, USCCB (1990) reiterates the main points of USCCB (1987) beginning with the statement that best medical and scientific information available must be used when dealing with HIV/AIDS. This is one of the earliest official Church

documents on HIV/AIDS specifically to make reference to Catholic Social Teaching when it quotes from the encyclical of John Paul II *Sollicitudo Rei Socialis* (1987). It points out that HIV/AIDS disproportionately affects people on the margins of society such as homeless people, homosexuals and ethnic minorities and that it is not just a pathophysiological condition but, a social reality strongly linked to human behaviour that is largely shaped by cultural and social structures.

This is also one of the first Church documents to mention needle exchange as a means of preventing the spread of HIV. The bishops recognise the major part that intravenous drug use plays in the spread of HIV. While being realistic and practical in describing drug abuse as "a chronic, progressive, life-threatening disease" rather than a moral problem, nevertheless needle exchange is rejected by the bishops for what they describe as both moral and practical reasons.

The American bishops argue that needle exchange might encourage more drug use and discourage drug users from seeking treatment. However, in a comprehensive review of the literature, Ritter and Cameron (2006) described some possible iatrogenic effects of needle exchange: increased drug use and drug injecting and a lowering of the perceived risks of injecting. Ritter and Cameron (2006) searched 10 databases and accessed "grey literature" and unindexed journals through specialist addiction libraries thus reducing any publication bias (Jackson, 2007). Despite this exhaustive search, no published research was found to show that any of these effects have actually taken place. On the other hand the "black swan problem" has shown that absence of evidence is not necessarily evidence of absence (Popper, 2002). Despite the exhaustive searches of Ritter and Cameron (2006), it is still possible that there may be some evidence somewhere that shows that these effects have taken place and that the American bishops were right about this issue. However, that seems very unlikely.

The bishops also argue that needle exchange could actually lead to an increase in the spread of HIV. However, since the publication of "Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis" in 1990, there has been a plethora of research published that demonstrates the effectiveness of needle exchange in preventing the spread of HIV (Wodak & Cooney 2006; Des Jarlais *et al.* 2005; Emmanuelli & Desenclos 2005).

The American bishops go on to suggest that needle exchange can cause a false sense of security by giving the message that intravenous drug use can be made safe. Thus the bishops show that they fail to understand that from the very beginning needle exchange has never been done as an isolated transaction but has always included advice on the dangers of injecting and how to

minimise the risks (Derricott *et al.,* 1998; Riley & O'Hare, 2000). Additionally, Ritter & Cameron (2006) failed to find any evidence that needle exchange gives any false sense of security.

The rejection of needle exchange in USCCB (1990) seems to be based on unsubstantiated opinion rather than on scientific evidence. This is unsurprising, as in 1990 there was almost no scientific evidence either for or against the efficacy of NX. However, the bishops also claim that their rejection of needle exchange is based on moral reasons as well as practical reasons. Nevertheless, they do not provide any moral justification for their rejection of needle exchange in their statements on the prevention of the spread of HIV.

Despite the rejection of needle exchange by the USCCB, the Diocese of Albany in New York State has been operating a needle exchange service known as Project Safe Point since 2008. This service was established with the approval of the then bishop of Albany, Howard Hubbard and has continued with the approval of his successor, Bishop Edward B. Schafenberger.

Furthermore, in 2000, James Keenan managed to persuade the Society of Christian Ethics, a non-denominational organisation, to pass a resolution in support of needle exchange (Burke, 2010). Additionally, the provision of needle exchange has been supported by several American Catholic moral theologians including Emily Reimer-Barry (2011), Mary Jo Iozzio (2011) and Daniel Sulmasy (2012).

Since 1990, there has been no publication from the USCCB giving any further opinion on the means of preventing the spread of HIV. The USCCB has not published any advice on the provision of MSIFs or made any comment on the efficacy or moral permissibility of MSIFs. However, the retired archbishop of Philadelphia and several American theologians have been outspoken in their arguments against the provision of MSIFs.

7.3.2 Philadelphia

Drugs related deaths have been dramatically increasing in Philadelphia from 311 in 2003 to 1,217 in 2017, a per capita death rate more than three times higher than in Scotland (Department of Public Health, 2020). In response to this, Safehouse planned to establish an MSIF in the city in 2019. The legal challenges to this plan were described above in 7.3. The plans to open an MSIF in Philadelphia have been put on hold due to legal challenges. However, the plan was initially accepted as legal by the federal court in Philadelphia in 2019. Charles Caput, at that

time Archbishop of Philadelphia, described this decision as saddening and as offering a dose of despair (Chaput, 2019).

7.3.2.1 Archbishop Chaput

Archbishop Chaput (2019) begins his argument against MSIFs by stating that people who support safe injecting facilities claim that they will save lives and lead to sobriety. I have never at any point in a career of over twenty years working with people who inject drugs, heard anyone argue that medically supervised injecting facilities on their own will lead to sobriety. Medically supervised injecting facilities are not a standalone service but an additional tool for clinicians working with clients who, for whatever reason, may not yet be ready, willing, or able to pursue full abstinence. However, they do keep people alive and relatively healthy until they are able to pursue abstinence. Harm reduction services, including medically supervised injecting facilities are aimed at people who are in the midst of the chaos of addiction and who are not yet able to move on and overcome the hold that addiction has over them. They aim to meet people where they are rather than where we think they should be.

The primary purpose of medically supervised injecting facilities is to prevent or reduce the physical harm associated with injecting illicit drugs, harm not only to the drug injectors but also to the general public. As I have pointed out in Chapter 3, there is a considerable body of scientific evidence that medically supervised injecting facilities are effective in reducing infections and fatalities due to overdose and that they reduce the amount of used needles and syringes discarded in public places (Logan *et al.* 2010; Strathdee & Pollini 2007; Kerr *at al.* 2020).

There is ample evidence that medically supervised injecting facilities save the lives of people who inject illicit drugs. I am sure that Archbishop Chaput would agree with me that it is impossible to do any kind of intervention aimed at sobriety with someone who has already died of an overdose or a drug related infection. Medically supervised injecting facilities themselves may not lead to sobriety but without them large numbers of people would die before they could attain sobriety. As Peter Krykant puts it “People don’t get any more opportunities after they’re dead” (McCann, 2020).

Archbishop Chaput specifically mentions the provision of narcan in his scathing description of medically supervised injecting facilities. “narcan” is the brand name for the drug naloxone. This is the same drug that I referred to in Chapter 3 (3.3.1) in my discussion of the effectiveness

of MSIFs. Archbishop Chaput states, “Ultimately, healing from addiction is found not in a clean needle or Narcan…” Although he does not explicitly condemn the use of narcan, Archbishop Chaput’s condemnation of medically supervised injecting facilities that provide narcan is an implicit condemnation. This is the primary medication used to treat opioid overdose. It can be administered by nasal spray, by intravenous injection or by intramuscular injection. It reverses the effects of opioids. Narcan is an extremely effective medication that is on the World Health Organisation’s List of Essential Medicines (WHO, 2021, 4). Without narcan many more people would have died of opioid overdose.

In accordance with World Health Organisation guidelines (WHO, 2014, 9) that people who are likely to come across an opioid overdose should have access to narcan and be trained how to use it, more than fifteen countries worldwide have implemented take home narcan provision for people at risk of overdose. Extensive evaluation has shown that this type of provision of narcan is extremely effective in reducing overdose mortality and has a very low rate of adverse events (McDonald & Strang, 2016). In addition, a trial in Scotland has recommended that police officers should be issued with narcan and trained in its use, in order to widen access to this life saving medication (Hillen *et al*., 2022).

A local organisation in Philadelphia, called Prevention Point, has been operating an NX since 1991. In addition to the NX, Prevention Point offers overdose reversal training that includes teaching members of the community how to use narcan. According to Perry (2020) a considerable number of religious sisters in Philadelphia have taken part in this training.

Archbishop Chaput does not make it clear why he objects to the use of narcan. Does he object to its use in general or only in specific situations? Why would he object to the use of a medication that is proven to save lives and has no known adverse side effects? Does he think that the availability of narcan may encourage people to inject opioids? If so, I believe that he shows that he completely misunderstands the nature of drug addiction. My clinical experience has convinced me that making injecting less dangerous will have little or no effect on the behaviour of people who are addicted. However, changing the social environment that precipitates addiction will reduce the number of young people who become addicted to illicit drugs (Boyd *et al.* 2016; Bryant *et al.* 2016).

Archbishop Chaput and I are both former Franciscan friars and both faithful members of the Roman Catholic Church and so we would be expected to agree with each other on some points. The archbishop states that “God did not create us to inject illicit drugs…” and goes on to quote

the *Catechism of the Catholic Church* to substantiate this statement. I agree completely with the archbishop and the *Catechism* on this point. The use of illicit drugs is evil and can seriously damage the health of both the individual taking the drugs and the health of the community in which they live.

The archbishop then goes on to state that enabling others to use illicit drugs that are life threatening clearly violates the divine law. This seems to suggest two things; firstly that the providers of safe injecting facilities intend to enable the use of illicit drugs and secondly that this is a simple problem with clear unequivocal solutions. The purpose of safe injecting facilities is not to enable people to use illicit drugs but to reduce the harm caused by injecting. All supervised injecting facilities aim to improve the health and wellbeing of people who inject drugs, reduce the spread of infections among drug users and the general public, reduce the injecting of drugs in public and reduce the number of deaths due to drug overdose (Boyd, 2013). If it was so abundantly clear that the provision of safe injecting facilities violates the divine law, then it would not be a topic for discussion among moral theologians and there would be no people of good moral intention suggesting that safe injecting facilities should be supported by the Church. Rather than a simple, clear case of right and wrong, the morality of safe injecting facilities is both complex and contested. I submit that none of these aims violates the divine law and that improving the health and wellbeing of some of the poorest and most marginalised people in our society is unquestionably in agreement with the divine law.

Undoubtedly, the provision of safe injecting facilities involves cooperation in evil. However, this cooperation is justified. The justification of the provision of an MSIF using the principle of cooperation in evil has been discussed in some detail in Chapter 4 and so I will not repeat the detail here.

The provision of an MSIF is not formal cooperation, as the provider of the facility does not share the same moral intention as the person injecting drugs. The person injecting drugs usually intends to become intoxicated while the person providing the safe injecting facility intends to reduce harm. It is contingent rather than necessary cooperation as it is possible to inject illicit drugs without using an MSIF; in fact almost all injecting of illicit drugs in both the UK and the USA goes on without the aid of an MSIF because, with the exception of New York City, these services are not available for PWIDs in the UK and the USA. It is proximate rather than remote cooperation, but the proximity is justified by the gravity of the situation. Therefore, the cooperation in evil involved in the provision of an MSIF is justified.

Archbishop Chaput continues to oversimplify the issues when he refers to the first principle of medical ethics, to do no harm. It is impossible to practise any healthcare profession without doing some harm to the patient. When giving an injection, the clinician breaks the patient's skin thus causing them harm. When a radiographer takes an X-ray, they usually produce very useful clinical information but at the same time do harm to the patient by exposing them to ionising radiation. Even when performing a procedure as innocuous as taking blood pressure, the clinician inflicts discomfort on the patient and so causes them harm. It is impossible to treat a patient without inflicting any harm whatsoever. Therefore, one of the most important skills in healthcare is to minimise harm and maximise the good done to the patient. This is precisely what clinicians providing medically supervised injecting facilities aim to do.

The archbishop states that medically supervised injecting facilities take away funding and resources that could be used in other forms of addiction treatment that he claims to be more effective. The archbishop's economic analysis is both naïve and ill informed. In Chapter 3, (3.4) I hope I have shown that MSIFs are economically effective and that MSIFs can save more money, by averting infections and other illnesses, than they cost to run.

The archbishop refers to research that shows that environmental stimuli can trigger cravings in an addict. Unfortunately, he does not give any references for this research and so its quality cannot be verified. He then seems vaguely to suggest that safe injecting facilities will trigger stimuli and increase the cravings experienced by addicts. However, the empirical research shows that rather than increasing drug use, safe injecting facilities lead to an increase in engagement with detoxification and other addiction treatment services (Logan & Marlatt, 2010).

Archbishop Chaput also refers to figures from Insite, the medically supervised injecting facility in Vancouver. He sees this facility as a failure because of the small number of clients who go on to receive addiction treatment. Writing in 2019, he states that the facility has been used by 3.6 million people since it was opened in 2003 with only 48,798 receiving addiction treatment. This is incorrect. According to Vancouver Coastal Health (2019) there have been 3.6 million visits to Insite between 2003 and 2019. Many clients visit Insite on more than one occasion and the true number of clients being seen is nearer 6,000 than 3.6 million. However, I believe that the number of people going on to addiction treatment is of limited value as a measure of the success of a service that has been set up to save the lives of drug injectors. A more meaningful

figure is the number of people who have been saved from overdose in Insite. Since it opened in 2003 until 2019, there had been 6,440 overdoses in Insite and no deaths.

Having spent much of the first half of his column oversimplifying the issues of addiction, harm reduction and the associated ethical conundrums, Archbishop Chaput then states that medically supervised injecting facilities oversimplify addiction. Professionals working in the addiction field are aware that addiction is a complex issue. It is often described as a chronic, frequently relapsing condition. There are many different reasons that people start to use illicit drugs, become addicted to illicit drugs and are motivated or not to stop using illicit drugs.

Archbishop Chaput recommends the 12-step recovery programme. This is an excellent programme for people who want to give up illicit drug use. However, there are a considerable number of people who are not motivated to give up injecting illicit drugs. For many people living in the margins of society, drugs are not a problem but a solution (McLaughlin, 2018). For many people drug use is what makes their life bearable. For people who have been conditioned into believing that they are the lowest of the low, the scum of the earth, the most wretched, servile, miserable, pathetic trash that was ever born, a £10 bag of heroin promises unbelievable happiness at least for an hour or so (Welsh, 2001). For many people in this situation there is very little incentive to give up injecting illicit drugs. Archbishop Chaput gives the impression, possibly inadvertently, that he is only interested in drug addicts who are motivated to give up.

Nevertheless, we have a duty to care for those who are not yet motivated to move away from illicit drug use. Many young people experiment with alcohol and illicit drugs but most of them do not progress from recreational use to addiction. Those who progress to addiction often come from families where they have been exposed to violence, sexual abuse and other traumas. Many of them have experienced homelessness and the vast majority have experienced some sort of poverty. As a Church that professes a preferential option for the poor, we have a duty to care for people while they are still injecting illicit drugs. This duty is not dependent on the person's motivation to change. When people are putting themselves at risk of serious harm through drug injecting, we have a duty to ensure that the harm is minimised. We have a duty to ensure that people injecting illicit drugs are kept alive and as healthy as possible until they are willing and able to address their addiction.

7.3.2.2 Fr. Douglas McKay

Two weeks before Archbishop Chaput's article condemning MSIFs, Gina Christian (2019) published an interview with Fr Douglas McKay in *Catholic Philly*. Fr McKay - a priest of the Archdiocese of Philadelphia - has been involved in ministry to people suffering from addiction for almost 50 years. In addition to his ministry, Fr McKay has personal experience of the tragic effects of addiction. In 1995, his brother Anthony died aged 30, probably from an overdose of crack. His other brother, Harry struggled with addiction after serving in Vietnam but remained sober for the last 25 years of his life. Fr McKay and I have both experienced drug deaths in our immediate families, yet we have radically different views on the provision of MSIFs.

According to Fr McKay, an MSIF is a form of euthanasia that provides a slower death, rather than preventing the deaths of PWIDs. He sees MSIFs as part of a "culture of death" that includes the provision of methadone. Fr McKay objects to prescribing methadone to PWIDs as he claims that long term use of this medication "burns out their brains" without healing addiction.

While acknowledging the good intentions of the proponents of MSIFs, Fr McKay states that they fail to understand the true nature of addiction and the most effective ways to deal with it. Fr. McKay claims that recovery from addiction requires a "moment of truth" in which the PWID is able to grasp the impact and destructiveness of their addictive behaviour. He goes on to argue that the provision of an MSIF steals away the "moment of truth" from its clients and takes away the opportunity for sufficient self-reflection. It is clear that a "moment of truth" can motivate PWIDs and help them on the first step in their journey of recovery. However, it is not clear that the provision of an MSIF steals away the "moment of truth". I submit that the provision of an MSIF enables PWIDs to stay alive long enough to experience the "moment of truth" and that without an MSIF many PWIDs will die before they can get to this stage.

Fr McKay recommends the 12-step approach, stating that it has a recovery rate of up to 70%. He compares this to the Insite MSIF in Vancouver arguing that the recovery rate at Insite is significantly lower than the 12-step programmes. However, he uses the same flawed figures for Insite as Archbishop Chaput. In addition, Fr McKay does not seem to recognise that the 12-step programme and MSIFs do not have exactly the same objectives and are aimed at PWIDs at different stages on their journeys. MSIFs are aimed at PWIDs who are not yet ready to give up injecting drugs. One of the main aims of an MSIF is to keep people alive until they are ready to take that step or as Fr McKay puts it, until they have experienced the "moment of truth".

They cannot experience the "moment of truth" if they have already died from a drug overdose. Dead people cannot take part in a 12-step programme.

Fr McKay criticises the provision of fentanyl screening at the proposed MSIF in Philadelphia. Fentanyl is a synthetic opioid that is estimated to be 50 times stronger than heroin and has been implicated in a significant number of opioid overdose deaths in the USA in recent years. A considerable number of these overdoses were caused by PWIDs injecting heroin contaminated with fentanyl (Chandra *at al.* 2021). Fr. McKay argues that the contamination of heroin with fentanyl is a good thing as it acts as a deterrent. The chances of overdosing on heroin laced with fentanyl are much higher than on heroin alone. Fr McKay seems to be arguing that the risk of death from a fentanyl overdose would deter people from using illicit drugs and the provision of fentanyl screening would remove this deterrent.

This reasoning seems to be flawed for two reasons. In my experience, the death of a PWID from an overdose does not deter any other PWIDs from injecting illicit drugs. In fact, it has the opposite effect. When a PWID overdoses, the rest of the PWIDs in the area want to know the source of the drugs because of their perceived good quality. Rather than act as a deterrent, an overdose can often encourage further drug use.

The second reason that I believe that Fr McKay's reasoning around fentanyl is flawed is that it is unethical. He seems to be arguing that the risk of death posed by fentanyl is a good thing because it may frighten some PWIDs into not injecting illicit drugs. He seems to be saying that the provision of fentanyl testing at MSIFs is a bad idea, as it will remove the deterrent. The *Catechism of the Catholic Church* (Vatican, 1994, 2291) states that the use of illicit drugs is a grave evil because of the harm inflicted on human health and life. Rather than reducing the harm, Fr McKay seems to want to use the potential harm to frighten PWIDs into not using. I submit that this is not ethical, and it does not represent true recovery for those who are frightened into not using. It is coercion rather than a "moment of truth".

Fr McKay states that those suffering from addiction are our brothers and sisters who reflect the suffering Christ. This is in harmony with the Church's social teaching. The Church invites all people to recognise everyone, especially the poor and the suffering as our brothers and sisters (Vatican, 2004, 105). I submit that our brothers and sisters deserve better than coercion. The Church teaches that everyone is created in the image and likeness of God. As such, every person has received an incomparable and inalienable dignity from God (Vatican, 2004, 105). The whole of Catholic social doctrine develops from the inviolable dignity of the human person

(Vatican, 2004, 107). Trying to frighten people into changing their behaviour runs the risk if disrespecting their God given dignity. Even though the non-therapeutic use of drugs is a grave offence, using coercion raises concerns and can contribute to undermining key goods and thus should only be carried out with great care if at all. Human dignity demands that people act according to free will that is personally motivated and not by external pressure or coercion (Vatican, 2004, 135). The Church has striven to defend human dignity (Vatican 2004, 107) and ensure that all people, especially the poor, are treated with the utmost respect. Therefore, coercion risks violating human dignity rather than defending it.

7.3.2.3 Steven Bozza

A week after the publication of the interview with Fr McKay, *Catholic Philly* published a short article by Steven Bozza (2019) that argued against the provision of MSIFs. Bozza (2019) begins by asserting that MSIFs are not effective in "getting people clean". This assertion seems to indicate that Bozza does not really understand the purpose of an MSIF. As I have previously stated, MSIFs are aimed at PWIDs who are not yet at the stage of trying to stop using illicit drugs but are nevertheless, still in need of care. Both professional ethics and Christian ethics, demand that patients are treated according to their need and not according to any moral judgement that is made about them or their behaviour. Patients who are highly motivated to give up illicit drug use and patients who are determined to continue to use illicit drugs both have a right to the best possible care.

Bozza (2019) seems reluctantly to concede that MSIFs save lives by reducing the prevalence of fatal overdoses and infections. However, he goes on to argue that the provision of an MSIF transgresses the ethical principles of autonomy and justice.

Bozza (2019) argues that MSIFs are designed to encourage PWIDs to continue to use illicit drugs and that they erode their autonomy that has already been diminished by addiction. Bozza (2019) has a very good point here. MSIFs are not deliberately designed to encourage the continued use of illicit drugs but they may do this inadvertently. Addiction diminishes the ability to make free decisions and so it is difficult for clinicians to gain informed consent from an addicted patient because their autonomy has been eroded. However, even when a patient's autonomy is eroded, even when they are not fully able to give consent, they are still entitled to treatment that may save their life or improve their health.

Bozza (2019) argues that MSIFs divert scarce funds away from resources that have been proven to be effective in offering a real hope of recovery. They therefore violate the principle of justice that demands that the benefits and burdens of healthcare should be shared fairly. However, I have argued in Chapter 3 (3.4) that MSIFs are economically effective in that they actually save more money than they cost to run. Furthermore, earlier in Chapter 3 (3.3) I showed that MSIFs are clinically effective in that they decrease drug related deaths and reduce the risks to public health.

Near the end of his article, Bozza (2019) states that MSIFs cannot claim to be the only way of reducing stigma. I agree completely and do not know of anyone who would argue that this is the case. Rather than being the only way of caring for PWIDs, MSIFs are part of a wide spectrum of services that are provided to PWIDs wherever they are in their journey, rather than where anyone thinks they should be.

7.3.2.4 Bozza and Berger

Bozza and his colleague Jeffery Berger followed this up with a more substantial article in the *Linacre Quarterly* (Bozza, Berger, 2020). After an introduction and a brief description of what an MSIF is, Bozza and Berger's article (2020) is divided into four sections entitled "Bioethical Principles", "Catholic Social Teaching", "The Common Good" and "Cooperation in Evil".

The section on bioethical principles begins by asking if the administration and consumption of illicit drugs in an MSIF offers reasonable hope of benefit to PWIDs. Bozza and Berger (2020) agree that the provision of an MSIFs does provide benefit for PWIDs as these facilities reduce the risk of transmission of disease and reduce the risk of overdose, reduce the suffering caused by withdrawal and the interaction with staff in the MSIF reduces the stigma associated with drug addiction. MSIFs do what they set out to do. However, rather than apply the question of a reasonable hope of benefit for the PWID to the provision of an MSIF, Bozza and Berger (2020) apply this question to the administration and consumption of illicit drugs. There is widespread agreement that the administration and consumption of illicit drugs involves considerable risk of harm. However, the aim of the provision of an MSIF is not to enable the administration and consumption of illicit drugs but to reduce the harm associated with such consumption. Bozza and Berger (2020) argue that MSIFs provide a safer way in which to use deadly drugs without providing the conditions needed to motivate PWIDs to stop using. Bozza and Berger (2020) even argue that MSIFs provide an endorsement of illicit drug use. This completely misrepresents the purpose and ethos of MSIFs. Bozza and Berger (2020) come to

the conclusion that MSIFs fail to offer any benefit to PWIDs despite the fact that they have already agreed that MSIFs reduce the risk of transmission of disease, reduce the risk of overdose, reduce the suffering caused by withdrawal and the interaction with staff in the MSIF reduces the stigma associated with drug addiction.

The section on bioethical principles continues with a brief discussion of the object, intention and circumstances of an act. Bozza and Berger (2020) argue that the administration and consumption of illicit recreational drugs is an intrinsically evil act. Selling (2016, 20) describes intrinsically evil acts as acts that by their very nature are morally unacceptable and should never be performed. They are evil in themselves and cannot be justified by good intentions or the circumstances in which they take place. Bozza and Berger (2020) quote the *Catechism of the Catholic Church* (Vatican 1994, 2219) to support the claim that the recreational use of illicit drugs is intrinsically evil. However, the Catechism states that the non-therapeutic use of drugs is a grave offence because of the harm done to human health and life. It does not state that the recreational use of drugs is intrinsically evil. Any evil attributed to recreational drug use is due to the harm that it can cause rather than an intrinsic evil.

Furthermore, Bozza and Berger (2020) claim that the object of an MSIF is the administration and consumption of illicit recreational drugs. This is not the object of the provision of an MSIF. The object, the actual act performed by the staff rather than the clients, is the provision of a safe space and sterile equipment not the injecting of illicit drugs. The intention in providing an MSIF is to reduce harm to both the PWIDs who use the service and to the general public. The circumstances are an environment where PWIDs and the general public are likely to suffer serious harm without the provision of an MSIF.

Bozza and Berger (2020) go on to apply the principles of beneficence – doing good - non-maleficence – doing no harm – autonomy and justice to the provision of an MSIF. In discussing beneficence, Bozza and Berger (2020) state that no one who is addicted stops using their addictive substance on their own. This is just not true. I have personal experience of someone drinking more than 20 units of alcohol a day, stopping without any help, and remaining sober for the rest of her life. According to Bai (2011) although many health experts recommend professional treatment for addiction, many if not most people suffering from addiction manage successfully to recover without any professional help. Even though recovery from addiction is difficult, most people recover, and most people do it on their own (Bai, 2011). Bozza and Berger (2020) give a long description of the services that are available to healthcare

professionals to help them recover from addiction. They argue that to provide anything less to anyone is to imply that they are not worth the resources that they need to recover. They conclude from this that MSIFs do not promote beneficence. The provision of an MSIF does not deny any services to people suffering from addiction and as Bozza and Berger (2020) have themselves pointed out MSIFs reduce suffering for PWIDs and for the wider society. In providing these benefits, MSIFs are in keeping with the principle of beneficence.

Non-maleficence, the injunction to do no harm can be traced back to "Of the Epidemics" written by Hippocrates around 400 BCE. Bozza and Berger (2020) state that this principle "obliges healthcare professionals to do nothing that would be detrimental to the patient". As I have already pointed out in earlier in this chapter when discussing the arguments of Archbishop Chaput, it is impossible to practise any healthcare profession without doing some harm to the patient. The risks and benefits from many healthcare interventions are difficult to judge because information is uncertain and prone to error (Schmerling, 2020). Therefore, one of the most important skills in healthcare is to minimise harm and maximise the good done to the patient. This is precisely what clinicians providing safe injecting facilities aim to do. Bozza and Berger (2020) argue that MSIFs cause harm by facilitating the injecting of dangerous illicit drugs. The injecting of these drugs happens in places where there is no MSIF. Therefore, the MSIF is not needed for illicit drug injecting to take place and it is disingenuous to assert that MSIFs facilitate an activity that is already happening without them. The purpose of the MSIF is to reduce the harm associated with injecting illicit drugs and so the operation of an MSIF is in keeping with the principle of non-maleficence.

The principle of autonomy is problematic when dealing with people suffering from addiction because their freedom to make decisions is impaired by their addiction. Bozza and Berger (2020) argue that, by their nature, MSIFs encourage drug use and so further impede the PWID's freedom and further diminish their autonomy. Bozza and Berger (2020) contrast MSIFs with places that provide, among other things, professional counselling, and peer support. Bozza and Berger (2020) seem to imply that these services are not available at an MSIF and that MSIF are not provided as part of a wide spectrum of services for PWIDs.

According to Bozza and Berger (2020), the principle of justice pertains to the healthcare delivery system. They argue that the money spent on MSIFs could be more effectively spent in drug rehabilitation centres. I have discussed the economics of MSIFs in Chapter 3 (3.4) and have argued on the basis of the evidence in the literature that MSIFs can actually save more

money than they cost to run. The literature that I used in chapter 3 showed that the cost of treating the diseases averted by the provision of an MSIF is typically more than three times the cost of running the MSIF. This cost saving can be used to fund the kind of drug rehabilitation centres recommended by Bozza and Berger (2020) and so contribute to justice in the healthcare system rather than reduce it.

The section on Catholic Social Teaching begins with a clear statement that the foundational principle of Catholic social teaching is the sacredness of human life and the dignity of every human person and goes on to pose the question do MSIFs threaten or enhance the life and dignity of the PWIDs who use them. Bozza and Berger (2020) argue that MSIFs hinder human freedom and are in essence interventions of despair that send the message that treatment is not worthwhile, does not work and the PWID is not worth the time and effort needed to recover. However, the rehabilitation services suggested by Bozza and Berger (2020) are aimed at and only suitable for PWIDs who are "willing to leave the cycle of addiction". It appears that Bozza and Berger (2020) are not willing to invest resources in people who are not yet at the stage of attempting to leave the cycle of addiction. The provision of an MSIF helps people stay alive and relatively healthy until they are able to take the next step. However, Bozza and Berger (2020) give the impression that until this step is taken, there is nothing that can be done. They give the impression of despair and that intervening to keep PWIDs alive until they can take the next step is not worthwhile; PWIDs who are still using illicit drugs, who are still injecting are not worth the time, effort, and resources to protect their health and their lives. This is not in harmony with the foundational principle of Catholic social teaching of the sacredness of human life and the dignity of all persons.

Bozza and Berger (2020) then go into some detail discussing the ideas of rights, human relationships, equality and the common good. Eventually, they conclude that harm reduction is a human right but that it can be accomplished by means other than an MSIF and so the provision of an MSIF is not a human right. One of the suggestions that Bozza and Berger (2020) make to reduce harm among PWIDs is to provide vaccines against hepatitis B. This is something that already happens in harm reduction services in the UK. Not only are hepatitis B vaccines provided but hepatitis A vaccines are also offered. In addition, clients of these services are offered testing for HIV and hepatitis. Wound care is also provided which includes antibiotics for infected wounds. These services are all currently provided at needle exchanges in the UK. All these harm reduction services can be provided at an MSIF. MSIFs are more comprehensive in the means used to prevent harm than Bozza and Berger (2020) seem to think.

The next section of Bozza and Berger (2020) is entitled “The Common Good”. This section begins with the question, do the governments that sanction MSIFs ensure that they contribute to the common good. Bozza and Berger (2020) point out that MSIFs offer safety and security to PWIDs. They then go on to suggest that the safety of the local community is overlooked when planning an MSIF. However, they then go on to quote MacGuill (2017) who reported that there was no significant increase or decrease in drug related crime in areas where an MSIF had been established. In fact, there was some evidence of a reduction in drug related crime in these areas. In Chapter 8, I will describe the proposal to establish an MSIF in Dublin. This has involved applying for planning permission from Dublin City Council and responding to the concerns of the local community. Within the response, there was a plan for liaison with the local Garda and the employment of a liaison officer to deal with any problems that the local community experience due to the MSIF. As I stated in Chapter 1 (1.3), one of the main aims of an MSIF is to improve public health and reduce public order problems associated with injecting illegal drugs in public places. By reducing the amount of injecting in public places, the amount of discarded injecting equipment is reduced and consequently the risk of needle stick injury to members of the public is reduced. Therefore, contrary to the arguments of Bozza and Berger (2020), the provision of an MSIF actually contributes to the common good.

The final section is entitled “Cooperation in Evil”. I have discussed the principle of cooperation in evil in some detail in Chapter 4 and will not repeat that detail here. However, I will briefly examine Bozza and Berger’s (2020) argument that the operation of an MSIF involves unjustified cooperation in the evil of drug abuse. Bozza and Berger (2020) argue that the staff running an MSIF are involved in formal rather than material cooperation as they are helping to facilitate a gravely evil act. I submit that the staff in an MSIF are only involved in material cooperation, as they do not share in the evil intentions of the clients. Bozza and Berger (2020) argue that the MSIF staff are involved in immediate cooperation, as their actions are indispensable for illicit intravenous drug use. However, it is clear that illicit intravenous drug use goes on in many areas without the help of an MSIF or any harm reduction service. Therefore, the actions of the MSIF staff are not indispensable; they are involved in mediate rather than immediate cooperation. I believe that Bozza and Berger (2020) are mistaken in their analysis and that the provision of an MSIF involves justified cooperation in evil.

7.4 Summary

The views of the bishops in Canada and the United States on the provision of MSIFs are remarkably different.

There are a considerable number of MSIFs operating in Canada, at least two of which have close ties with Roman Catholic institutions. I could find no theological objection to the provision of an MSIF or to the involvement of Roman Catholic organisations with MSIFs in Canada. In addition, I could find no evidence of these Roman Catholic organisations causing scandal by being involved with the provision of an MSIF. The Canadian bishops recognise the complexity of addiction and cautiously accept the benefits of harm reduction services for PWIDs including MSIFs.

The situation in the United States is different in several respects. At the time of writing, there are only two legally tolerated MSIFs in the USA, both in New York City. In October 2019, the US district Judge Gerald McHugh ruled that the provision of an MSIF did not breach the Controlled Substances Act and does not violate federal law. However, at the time of writing (April 2023), this decision is being appealed.

The first and so far, only mention of needle exchange by the United States Conference of Catholic Bishops (USCCB) was in the 1990 document “Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis” (USCCB, 1990). While the American bishops recognised the major part that intravenous drug use plays in the spread of HIV, they rejected the provision of needle exchange for what they described as both moral and practical reasons.

Although the USCCB has not made any statement on the provision of MSIFs, the retired archbishop of Philadelphia, a priest of the archdiocese of Philadelphia and two theologians closely linked to the archdiocese have opposed the establishment of an MSIF for moral reasons. Their arguments seemed to show a lack of understanding of what is provided at an MSIF. They also seemed to be unaware that MSIFs are normally provided as part of a wide spectrum of services for PWIDs. MSIFs are provided in addition to other services for PWIDs rather than instead of other services. In addition, none of them seemed to understand the heath economics of MSIFs. All of these writers wanted to offer services for PWIDs who were aiming to give up illicit drug use. However, none of them seemed to have anything to offer PWIDs who were still

injecting illicit drugs. The arguments put forward by these writers opposing the provision of MSIFs were flawed and based on false assumptions about the nature and purpose of an MSIF.

Having discussed the situation in North America in this chapter, in the next chapter I will discuss the proposed MSIF in Ireland.

Chapter 8

The Situation in Ireland

The MSIF at Merchants Quay and the Franciscan friars

8.1 Introduction

Having discussed an attempt by a Roman Catholic organisation to set up an MSIF in Australia more than twenty years ago and the situation in North America, in this chapter I will discuss current attempts by a Roman Catholic organisation to set up an MSIF in Ireland. I will begin this chapter by providing the historical background to the situation in Dublin. I will then discuss the controversy surrounding the establishment of a needle exchange by the Franciscan friars in Dublin in the late 1980s and early 1990s. I will then go on to discuss the practical objections to the establishment of an MSIF in Dublin and the response to the objections before concluding the chapter.

8.2 Historical Background

There have been Franciscan friars living and working on the south bank of the river Liffey since 1232, a year after the friars first arrived in Ireland. From the Reformation in the sixteenth century until Catholic emancipation friars worked secretly in this area with priests of the order saying Mass in the Adam and Eve Tavern. The present-day Franciscan Church of the Immaculate Conception on Merchants Quay is popularly known as “Adam and Eve’s” and was mentioned several times in James Joyce's novel *Ulysses* (McKeown, *et al.* 1993).

In 1969 two Franciscan lay brothers, Salvador Kenny and Sebastian Tighe opened up the Tea Rooms in the friary where they served tea and sandwiches to homeless men who took shelter in the church (MQI, 2022). During the 1980s, the clientele of the Tea Rooms became more diverse. This was when the first drug users and people with HIV began to come to the friary for help. Initially, the friars were unclear how they should respond to this new group. Some thought that the problems of drug abuse and HIV were outside of their competence and this group should be referred to the appropriate services.

However, one member of the community, Fr. Sean Cassin OFM had been a social worker before joining the order and had training and experience in working with drug users and people with HIV. In 1989, he was given the use of one of the parlours on the ground floor of the friary for a counselling and drop-in service. Soon Fr Sean needed the whole of the ground floor of the friary to provide a service to people with drug problems and their families (Brady, 2018).

An advisory team was formed in 1990 and in 1991 the Merchants Quay Project was registered as a limited company and granted charitable status the following year.

8.3 Current Services at Merchants Quay

In 2012, the Merchants Quay Project, by this time known as Merchants Quay Ireland, moved into newly refurbished premises, the Riverbank Open Access Centre, next door to the friary. The services provided by Merchants Quay Ireland have developed and expanded over the years. The homeless day service continues the work began by Br. Salvador and Br. Sebastian in 1969. However, rather than providing tea and sandwiches, it now offers homeless people breakfast and lunch six days a week and in 2019 served 81,727 meals. In addition to meals, homeless people are offered information and advice and a counselling service.

Health services are also provided at Merchants Quay including primary care medical, nursing, dental and mental health services. Additionally, hospital consultants are able to see their homeless patients at Merchants Quay.

Merchants Quay Ireland offers people who are dependent on drugs a pathway into treatment through various recovery services. A pre-entry group offers support and preparation before entry into the residential detox and rehabilitation services provided at St. Francis Farm and High Park. A variety of residential programmes are provided at St. Francis Farm; these include individual and group therapy, education and practical skills training on a site that includes a working farm. High Park is a 13-bed residential unit that provides a rehabilitation programme for people who may have difficulty in engaging with services, such as former prisoners and homeless people.

8.4 Harm Reduction at Merchants Quay

Needle exchange has been part of the service provided at Merchants Quay from an early stage. However, it is unclear how and when it actually started. According to an article in "The Irish Catholic" Fr Sean Cassin was illegally distributing condoms and sterile needles and syringes at Merchants Quay in the late 1980s (Brady, 2018). At that time contraception was still very restricted in the Republic of Ireland. According to Kelly (2020), contraception was outlawed in the Republic of Ireland in 1935 by the implementation of the Criminal Law Amendment Act. The law was relaxed with the introduction of the Family Planning Act of 1979 that allowed the prescription of contraceptives for *bona fide* family planning only; this was widely interpreted as restricting contraception to married couples and would not have been interpreted as allowing the distribution of condoms by a priest. In an interview in the "Irish Examiner", Tony Geoghegan, states that he and Fr Sean Cassin approached the Eastern Health Board with a proposal to set up a needle exchange in 1990. The health board rejected the proposal but despite this, a needle exchange was set up at Merchants Quay (O'Keeffe, 2018). As this needle exchange had not received the approval of the health board, it is likely to have been operating illegally.

Fr Sean was reported to the Papal Nuncio in Dublin, Archbishop Emanuele Gerada, who established a committee to examine the morality of needle exchange and condom distribution. Brady (2018) states that the committee found in favour of the harm reduction work being done at Merchants Quay. This was nine years before the Sisters of Charity attempted to establish an MSIF in Sydney. I can find no suggestion that the nuncio referred this matter to the CDF. Neither can I find any mention of this committee producing a report and any publication stating that they approved or disapproved of the harm reduction work going on at Merchants Quay.

By the time the friars were establishing a needle exchange in Ireland, the Sisters of Charity had been running a needle exchange in Sydney for four years. The provision of a needle exchange by a Roman Catholic religious order did not appear to be particularly controversial in either Australia or Ireland. There was no suggestion that the needle exchange in Sydney was illegal. However, as the needle exchange in Dublin had not been sanctioned by the Eastern Health Board, there was some doubt as to whether or not it was being operated legally. Supplies of needles and syringes for the needle exchange were being sent by post from London to Dublin. These were subsequently picked up from a sorting office in Dublin by an elderly nun and taken to the friary at Merchants Quay. An elderly nun picking up the packages from the sorting office

was presumably less likely to arouse suspicion about the contents of the deliveries (O'Keeffe, 2018). However, despite the doubts about its legality, I have not found any evidence to suggest that the Church authorities including the Archbishop of Dublin, the papal nuncio nor the CDF in any way objected to the friars operating a needle exchange in Ireland. Nor I have I found any evidence that the Church authorities objected to the sisters operating a needle exchange in Australia. This suggests to me that the Roman Catholic Church in both Ireland and Australia accepted the operation of a needle exchange by members of a Roman Catholic religious order, as morally permissible, possibly as a form of justified cooperation in evil. The fact that the legality of needle exchange was doubtful in Ireland at that time, further suggests that the Church authorities in Ireland considered work to save the lives of the poor and the marginalised and their families to be more important than keeping the law of the land.

It is remarkable that this there is no record of this being judged a source of scandal. Ordinarily, the Roman Catholic Church insists that citizens are in conscience obliged to obey legitimately established laws (Vatican, 1965a, 74). According to Laschuk (2019) the early Church had a complex relationship with the law but very quickly came to realise that any society needs rules. Laschuk (2019) goes on to state that from the first century onwards, the Church has recognised the legitimate authority of the nation state. This was expressed in the Letter of St. Paul to the Romans (13:1–3) and firmly reiterated by Pope John XXIII in the encyclical *Pacem in Terris* in which he emphasises the importance of legal authority for the benefit of all members of society (Vatican, 1963, 46). However, Laschuk (2019) explains that we are not bound by unjust laws and that Catholics can in some circumstances be required to disobey laws that are contrary to the moral order.

The fact that the operation of a potentially illegal needle exchange by a Catholic organisation was not condemned as a source of scandal seems to suggest that the Roman Catholic Church in Ireland may have considered the law that prevented the operation of a needle exchange to be unjust. Therefore, it was legitimate for the friars to break that law for the sake of justice and to fulfil their obligations to live out the Church and the Franciscan order's preferential option for the poor. However, the legality of needle exchange in Ireland at that time was unclear. It is possible that the Roman Catholic Church in Ireland took the view that the operation of a needle exchange was unlikely to be a serious breach of the law.

In 1990, the harm reduction service at Merchants Quay was not only operating a needle exchange but was also supplying condoms as a means of preventing the spread of HIV. This

was only five years after contraception has been legalised in the Republic of Ireland. From the identification of HIV as the causative agent of AIDS in 1983, right through the 1980s and into the 1990s, there was a debate within the Roman Catholic Church about the use of condoms to prevent the spread of HIV. In 1987, the Administrative Committee of the United States Conference of Catholic Bishops (USCCB) published "The Many Faces of AIDS: A Gospel Response". In this document, the USCCB stated that they opposed "safe sex" as an approach to the prevention of AIDS. In effect, the USCCB were reiterating the Roman Catholic Church's opposition to the use of condoms to prevent the spread of HIV. However, the USCCB (1987) compromised, stating that in a pluralist society such as the United States, they were willing to engage in educational programmes that provided accurate factual information about the prevention of AIDS including information on the use of prophylactics. The USCCB were clear that they were not promoting the use of condoms, only providing information. However, this document met with a public rebuke from the then Cardinal Joseph Ratzinger (1988), at that time prefect of the CDF. Cardinal Ratzinger (1988) expressed his concern that "The Many Faces of AIDS: A Gospel Response" may have caused confusion about the authentic position of the Catholic Church on the use of condoms. Cardinal Ratzinger (1988) states unequivocally that no Catholic organisations can in any way give the impression that they condone practices that are not in full fidelity with the moral doctrine of the Catholic Church; here is no room for compromise and the use of the principle of tolerance of the lesser evil is not appropriate in this particular case. Two years later, the full USCCB rather than the Administrative Committee, published "Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis" (USCCB, 1989). In this document, any advocacy of the use of condoms is strictly forbidden.

At a time when the use of condoms to prevent the spread of HIV was such a controversial issue in the Roman Catholic Church, and when the use of condoms was being so unequivocally condemned by the CDF, it is remarkable that the Papal Nuncio to Ireland appeared to approve of a service run by a Roman Catholic religious order that involved distributing condoms to PWID to prevent the spread of HIV.

According to the Merchants Quay website the first non-government organisation (NGO) needle exchange in Ireland was established in Merchants Quay in 1991. However, Cox and Lawless (2000) state that the needle exchange was set up in Merchants Quay in July 1992 and was known as the Health Promotion Unit.

Although the Health Promotion Unit still provides needle exchange, it now also provides PWIDs with a much wider harm reduction service that includes information about the risks associated with drug use and the means to minimize these risks.

8.5 MSIF at Merchants Quay

On 9th February 2017 the Irish Government published the Misuse of Drugs (Supervised Injecting Facilities) Bill. This bill passed through its various stages in Dail Eireann and Seanad Eireann and was signed into law by the President of Ireland on16th May 2017. In February 2018, the Irish Health Service Executive (HSE) announced Merchants Quay Ireland as the preferred bidder to operate the first MSIF in Ireland on an eighteen-month trial basis.

However, in July 2019 Dublin City Council refused planning permission for the MSIF at the Riverbank Centre, stating that the planned facility would undermine the local economy, be detrimental to the local residential community and would hinder the future regeneration of the area. Nevertheless, this decision was appealed and in December 2019, the appeal was granted paving the way for an eighteen-month pilot MSIF to be operated by Merchants Quay Ireland. However, a Judicial Review was lodged in February 2020 challenging the planning approval. Almost three years after Merchants Quay Ireland was announced as the preferred bidder, the MSIF is still not operational and still struggling with legal and political problems. Despite these setbacks, Merchants Quay Ireland is still committed to the development of an MSIF in the Riverbank Centre.

Of all those objecting to the establishment of an MSIF in Dublin, I could not find any objections from any religious organisation or any objections for theological or moral reasons. All the objections to the MSIF were practical rather than based on any theological principle. The objections were summarised as seven questions. Why does Dublin need a Medically Supervised Injecting Facility? Are there too many homeless and drug services in the city? Shouldn't we be investing in rehab and detox services, rather than an MSIF? Concerns around the MSIF being within 400 metres of a school. Could the MSIF create a "honey pot" effect and attract more PWIDs and dealers to the area? Is the Riverbank Building on Merchants Quay the best place for an MSIF? How will the MSIF operate? These concerns were addressed by Tony Geoghegan, the then CEO of Merchants Quay Ireland in short video clips posted on the Merchants Quay Ireland website (MQI, 2018).

8.5.1 Why does Dublin need a Medically Supervised Injecting Facility?

Ireland has a significant and persistent drug problem. At the same time, there is a housing crisis in Ireland. Both of these problems are particularly severe in Dublin where homelessness and drug problems have become enmeshed. According to Geoghegan, single homeless people with multiple problems, including drug addiction are the lowest priority for housing. Therefore, there are more vulnerable people on the streets of Dublin. Consequently, public injecting and discarded drug paraphernalia are a serious problem in Dublin. In addition, Ireland has one of the highest drug related death rates in Europe with only the United Kingdom and Sweden having higher rates (European Monitoring Centre for Drugs and Drug Addiction, 2021, 8).

Geoghegan point out that no one has ever died in an MSIF. The provision of an MSIF at Merchants Quay is intended to decrease drug related deaths, decrease the risks of disease transmission, and connect the most marginalised people with drug treatment services and healthcare services. Clearly, these are all aims that are in harmony with a Christian ethos.

8.5.2 Are there too many homeless and drug services in the city?

One of the main objections to the proposed MSIF at Merchants Quay is that many people believe that there are already too many homeless and addiction services in Dublin city centre. When asked about this, Tony Geoghegan agreed that there is a concentration of service is the city centre and that this has an effect on local businesses and on the people who live and work and study in the city centre. However, he pointed out that there are greater problems around drugs and homelessness in the city centre than in any other part of Dublin. It makes sense to have services in the city centre rather than in the suburbs when the people who would use the service are in the city centre. Once the housing crisis has been alleviated and there are fewer homeless people with drug problems in the city centre it might make more sense to have drug services in the suburbs where the former homeless PWIDs will have been housed. However, while there is a concentration of PWIDs with complex needs in the city centre, it makes sense to site an MSIF in the city centre.

One of the most important goals of the proposed MSIF is to provide an opportunity for healthcare for a marginalised community. In addition, an MSIF provides an opening for PWIDs to engage in treatment for addiction that includes detoxification and residential rehabilitation. The opportunity to introduce MSIF clients and engage them with these services would be lost if the MSIF was located in a different place from the rest of these services.

As I discussed in Chapter 4 (4.3.3), in order for an MSIF to fulfil the criteria for material rather than formal cooperation in evil, the intention of those operating the service must not be to facilitate illicit drug injecting but must be to reduce the risk to both the PWIDs who use the service and the general public. If the proposed MSIF in Dublin were to be operated in a different site from the rest of the services offered by Merchants Quay Ireland, it would be isolated. The opportunity to engage the most seriously addicted and those PWIDs with the most complex needs would be lost. There would be a very high risk that the MSIF would merely, but inadvertently, facilitate illicit drug injecting instead of providing a therapeutic service. If this were to happen, the operation of the MSIF could be interpreted as formal cooperation in evil and thus not morally permissible.

8.5.3 Shouldn't we be investing in rehab and detox services, rather than an MSIF?

In responding to this question, Geoghegan pointed out that this is not an "either or" situation. There is a need for a variety of approaches, each with their different strengths and weaknesses. People can only be rehabilitated if they are alive and one of the most important aims of the proposed MSIF is to save lives. Geoghegan agreed that Merchants Quay Ireland should be encouraging people to become drug free but stated that there are people who are not in contact with services dying on the streets. The proposed MSIF is aimed at hard-to-reach PWIDs who are often excluded at a time and a situation in their lives when they are at their most vulnerable. It is intended to be a first step in engaging them in the continuum of drug treatment and healthcare services.

Merchants Quay Ireland already provides a wide variety of services for PWIDs. These include residential detoxification and rehabilitation as well as physical and mental healthcare. The proposed MSIF would provide an opportunity to signpost these services. It would be part of a whole pathway from chaotic drug use to rehabilitation. Geoghegan argued that there is a need for investment in all of these services not just in one end of the spectrum.

Although not using the term gradualism and not referring to the ethics of MSIFs, Geoghegan's comments about MSIFs being at one end of a full spectrum of services for PWIDs reflect the gradualist approach that I described in Chapter 5. Rather than describing a moral idea, Geoghegan's comments describe a clinical and pastoral gradualist approach to working with PWIDs and dealing with drug addiction.

8.5.4 Concerns around the MSIF being within 400 metres of a school.

The Riverbank Centre, where the MSIF would be sited, is less than 400 metres from St. Audeon's primary school. Unsurprisingly, there have been concerns raised by the teachers and parents at the school about the operation of an MSIF so near the school. Tony Geoghegan responded saying that he fully understands the concerns raised and that no one wants children exposed to public drug use and to drug litter. He went on to state that unfortunately, children are already coming across drug use and drug litter because there is a major drug and homeless problem in the centre of Dublin. However, he went on to argue that the proposed MSIF could provide an effective solution rather than exacerbate the problem. The MSIF is not just for the benefit of PWIDs but is about making the streets safer for everyone including children and teachers. It is hoped that by providing an MSIF, there will be a reduction in public drug injecting and a reduction in the associated drug litter and so the local area will be safer and more pleasant for both children and teachers. Geoghegan emphasised that this would be a trial project and the management of Merchants Quay Ireland would continuously interact with the school and other local stakeholders; the operation of the MSIF would be amended and adjusted throughout the trial based on its impact on the local community.

Geoghegan seems to be arguing that the provision of an MSIF in this area will not only be in harmony with the Church's preferential option for the poor but that it will also contribute to the common good by improving the quality of life for all who live and work and study in this area.

8.5.5 Could the MSIF create a "honey pot" effect and attract more PWIDs and dealers to the area?

Geoghegan agreed that these were legitimate concerns. However, he stated that Merchants Quay Ireland would not be operating the MSIF in isolation but that it would be part of a programme for government. There would be a specific policy plan to deal with a potential "honey pot effect" and this would involve liaison with the local Garda who would have a specific policing plan to support the initiation of this service. Geoghegan went onto cite the international evidence from other MSIFs that show that there is neither an increase nor a decrease in crime when an MSIF is established.

8.5.6 Is the Riverbank Building on Merchants Quay the best place for an MSIF?

In answering this question, Geoghegan reiterated some of the points he had made in earlier answers; drug problems and homelessness are most evident in Dublin city centre and so it makes sense to site the service where the problem is. He states that they used to refer homeless PWIDs to hospitals in Dublin for treatment. However, many of them just did not have the wherewithal to keep appointments. Merchants Quay Ireland made the decision to co-locate all their services in the Riverside Building to maximise contact with the people that they serve. This echoes my own experience of providing healthcare for homeless people. For eleven years, I was based within a homeless hostel so that healthcare was provided where homeless people were living. Unless they were actually taken there, very few of my homeless patients would have been able to attend hospital appointments. Even if they did manage to attend the appointment, in many cases communication between the doctor and the homeless patient could be difficult. When accompanying homeless patients to appointments with doctors, my task was often to act as a translator. I would have to explain the patients' situation to the doctor in terms that he or she would understand, and I would have to translate medical terminology into a language that the patient would understand. Planning healthcare for marginalised people involves more than just deciding what services are needed. Where they are to be offered and how they are to be offered is very important. This is not just clinically important, but it is also morally important. In assessing the moral permissibility of an MSIF, one needs to take into account all who might be affected by it.

8.5.7 How would the MSIF operate?

The proposed MSIF will be in the Riverbank building but will have its own entrance and exit. This will enable clients of the MSIF to use this service without feeling under pressure to use any of the other services in the Riverbank building. When a new PWID attends, an initial assessment will be done to ascertain the appropriateness of the service for the individual. If appropriate, they will then go through to the injecting room where there will be a nurse in attendance. In addition to the nurse, there will also be a doctor available in the premises while the MSIF is operating. Once the PWID has used the injecting room, they can go to the aftercare area where there will be social care staff who will be able to signpost them towards recovery services. There will also be a medical room where people can be treated in private if they have an adverse reaction to the drug that they have injected. The service has been designed to maximise contact and to enable staff to build rapport with the people using the service.

8.6 Summary

Since the early 1980s, people with addictions and with HIV have been looked after at Merchants Quay. This care has included the first needle exchange in Ireland and a proposal for Ireland's first MSIF. Although the initial needle exchange at Merchants Quay attracted some controversy and the friar running it was reported to the Papal Nuncio to Ireland, it was never publicly condemned as morally unacceptable by the Roman Catholic Church authorities. Merchants Quay is the preferred bidder for a pilot MSIF supported and funded by the Irish Government. Despite the government support, the establishment of the MSIF has encountered multiple objections and has been stalled through the planning process. However, I have not been able to find any objections from the Church authorities or any objections made for theological or moral reasons. All of the objections are of a practical nature and have been addressed by Tony Geoghegan, the former CEO of Merchants Quay Ireland. Although Geoghegan is neither a priest nor a theologian, the way in which he addresses the objections to the proposed MSIF show a high degree of Christian moral thinking and show that all of the services provided by Merchants Quay Ireland are delivered within a Christian ethos.

Having discussed the situations in Australia, North America, and Ireland, in the next chapter, I will discuss the situation in Scotland. There is no official or institutional Roman Catholic involvement in the provision of an MSIF in the Scotland and the issues around the provision of an MSIF are more secular than theological.

Chapter 9

Attempts to Establish an MSIF in Scotland

9.1 Introduction

Having discussed the situation in Australia, North America and Ireland in the previous three chapters, in this chapter I will discuss the situation in Scotland. This chapter begins with a description of the historical background to the issue of provision of an MSIF in Glasgow. It then goes on to discuss critically the decision of the then Lord Advocate and the attempts to change the law in Scotland so that an MSIF could be legally operated. The response of one particular Scottish bishop to proposed changes in drug policy is discussed. The direct action taken by Peter Krykant is described before finally going on to outline the recent research on drug deaths in Scotland.

9.2 Historical Background

According to Tweed *at al*. (2018), there are 400-500 very vulnerable people regularly injecting drugs in public places in the centre of Glasgow. Most of these people are experiencing some kind of poverty including homelessness, mental health problems and recent imprisonment. They produce the majority of discarded needles and injecting paraphernalia found in alleyways, carparks, public toilets and tenement stairways in Glasgow city centre. This group of people has an increased risk of injecting related harm such as blood borne virus infection, overdose and bacterial infections including botulism and anthrax. In 2015, an outbreak of HIV began within this group of people, with 47 new infections within the group compared with an annual average of 10 new infections per year for the whole of the city of Glasgow. This outbreak has continued and by the beginning of 2020, there had been 160 new cases of HIV within this group of people representing more than a tenfold increase in less than five years (Deutsch, 2020).

In response to these problems, Glasgow City Alcohol and Drug Partnership (ADP) made recommendations to Glasgow City Integrated Joint Board (IJB), the body responsible for coordinating health and social care in the city. The recommendations were the introduction of a pilot medically supervised injecting facility, the extension of existing opioid substitution

therapy to include heroin assisted treatment and the development of a peer support network for harm reduction. These recommendations were approved by the IJB in February 2017.

9.3 Decision of the Lord Advocate and Attempts to Change the Law

Any medically supervised injection facility in the UK requires a local exemption from certain sections of the Misuse of Drugs Act 1971 in order to operate. The proposals for an MSIF in Glasgow were referred to the Lord Advocate, at that time James Wolffe QC, who stated that the granting of any exemptions from the Misuse of Drugs Act 1971 was beyond his powers and suggested that Glasgow IJB contact the UK Government with a request to devolve relevant powers to the Scottish Government. In his response, Wolffe stated that he can make decisions as to whether or not a crime should be prosecuted but the Lord Advocate cannot change which acts are and are not crimes.

I believe that Wolffe was mistaken. As the law officer responsible for prosecuting crime in Scotland, Wolffe could have used the sections on the public interest contained in the Prosecution Code (Crown Office, 2022). I believe that he could have exercised discretionary powers to instruct the Procurator Fiscal in Glasgow not to prosecute people found in possession of illicit drugs within and in the immediate vicinity of the medically supervised injecting facility and to provide letters of comfort to the healthcare professionals operating the facility to reassure them that they would not be prosecuted for permitting the possession and use of illicit drugs on the premises. Additionally, as Lord Advocate, he could have instructed the police not to arrest people for possession of illicit drugs in the vicinity of the facility.

Harm reduction services for PWIDs that involve needle exchange, have been operating in Glasgow since the late 1980s (Elliot, 1995). Any service offering needle exchange within Greater Glasgow and Clyde Health Board area is overseen by a harm reduction management group. The membership of these groups includes senior clinicians involved in providing the services and a police officer; they are usually chaired by a consultant psychiatrist. The input from the police officer is vitally important for a number of reasons. The police have agreed to avoid the immediate vicinity of the harm reduction services during operating hours unless specifically asked to attend an emergency incident. In order to be able to do this, they need to know where and when the services are operating. The police officer is given updates on the operation of harm reduction services at the meetings of the harm reduction management

groups. This information is passed on to the area commanders and used in operational planning. Conversely, the police officer provides intelligence reports giving details of types of drugs that have been seized. This information is useful for the harm reduction staff in providing specific health promotion advice to PWIDs.

This style of policing has evolved over a period of almost forty years and is in marked contrast to the style of policing in the 1980s in Scotland when drug-injecting first became a widespread problem. In the early 1980s, not only did the police take a heavy handed approach to drug misuse but so also did the Lord Advocate and Solicitor General in Scotland. Cases were frequently referred to the High Court and people convicted of relatively minor drug offences were given long custodial sentences (Robertson & Richardson, 2007). This had unforeseen consequences. As illicit drug use was driven further underground, it became more difficult for PWIDs to acquire sterile needles and syringes and so the sharing of injecting equipment became widespread. This in turn led to huge increase in HIV infections among PWIDs, particularly in Edinburgh (Johnston *et al*. 2021).

The link between illicit drug injecting and the spread of HIV was recognised in the McClelland Report that recommended among other things, the establishment of needle exchanges in Scotland (McClelland, 1986). Consequently, the Scotland's first needle exchanges began operating the same year that the report was published.

As part of the legal framework in which needles exchanges have continued to operate in Scotland, the Lords Advocate have issued guidance on who can operate them and on the numbers of needles and syringes that can be issued to clients. Previous Lords Advocate issued guidance on the operation of needle exchanges and instructions to Procurators Fiscal not to prosecute clinicians providing such services even when they may be breaching specific sections of the Misuse of Drugs Act. The Lord Advocate's guidance includes limits on the amount of needles and syringes that can be provided to PWIDs and states that the services should be run by registered healthcare professionals, normally pharmacists or nurses. Clinicians running needle exchanges are advised to request a letter of comfort from the local Procurator Fiscal, which the Lords Advocate had instructed the Procurators Fiscal to issue. The letters of comfort gave the clinicians the freedom to operate needle exchanges without interference from the police on the condition that they were abiding by the Lord Advocate's guidance.

I believe that when James Wolffe QC was Lord Advocate, he could have acted in a similar manner in regard to a medically supervised injecting facility. I believe that the Lord Advocate

is professionally and legally competent to issue guidance to operators of a proposed medically supervised injecting facility and to instruct Procurators Fiscal not to prosecute those clinicians even when they may be breaching specific sections of the Misuse of Drugs Act. I believe that the actions of previous Lords Advocate have set a persuasive precedent in regard to the competence of the Lord Advocate to exercise discretionary powers. The Prosecution Code (Crown Office, 2022) states that prosecutors in Scotland must take the public interest into account when deciding whether to proceed with a prosecution. This applies to all aspects of the criminal law not just drug offences. One local example is the instructions given to traffic wardens to use discretion in issuing parking tickets near places of worship on "faith days". This has led to cheerful traffic chaos in Rutherglen when Friday prayers in the mosque coincide with lunchtime Mass in the nearby Catholic church.

Being the government minister responsible for the prosecution of crime in Scotland, the Lord Advocate has the power to decide that under certain circumstances, the prosecution of PWIDs for possession of illicit drugs in and around an MSIF is not in the public interest. I submit that the Lord Advocate has the power to issue guidance on the operation of MSIFs in Scotland and to instruct Procurators Fiscal to offer letters of comfort to the operators of an MSIF in the same way that previous Lords Advocate did for the operators of needle exchanges.

While the legalities around the establishment of an MSIF anywhere in the UK are a matter reserved to the UK Government and the Westminster Parliament, both health and drugs policy are matters that have been devolved to the Scottish Government and the Scottish Parliament. In April 2018, the Scottish Parliament voted by 70 votes to 27 to support the Scottish Government's motion calling for the UK Government to make the necessary changes to the law to allow the introduction of a medically supervised injecting facility in Glasgow.

Furthermore, in May 2018 Glasgow City Council voted to write to the Home Secretary, the head of the UK government department with responsibility for drug policy. A reply was received from the UK government's Drug Legislation Team confirming that the relevant ministers were opposed to the plans for an MSIF. However, the Home Office Drugs & Alcohol Unit accepted that such facilities can be effective in protecting both drug users and the public but that there were no plans to change the law and that a range of offences are likely to be committed in the operation of such a facility.

In a response to the refusal of the UK government to support the introduction of an MSIF, the Scottish National Party passed a resolution at its conference in October 2019 stating that

substance misuse should be treated as a public health issue rather than a criminal matter and drugs policy should be devolved to Scotland so that all options for harm reduction, including the possibility of decriminalization can be considered.

Dorothy Bain QC succeeded James Wolffe QC as Lord Advocate in 2021 and appears to have a significantly different view on how the law related to illicit drugs should be implemented in Scotland. In September 2021, she made a statement to the Scottish Parliament in which she announced that the Police in Scotland would now have the option of issuing a recorded warning for possession of Class A drugs instead of arrest (Transform, 2021). This option had already been available for Class B and C drugs, but this decision extends that option to all drugs controlled by the Misuse of Drugs Act 1971. While the Lord Advocate emphasised that this was not decriminalisation, it challenges the idea that the best way to reduce the harms caused by illicit drugs is arrest and punishment. In November 2021, Bain told the Scottish Parliament's Justice Committee that she would consider precise and specific proposals for an MSIF in Scotland. She reiterated the point made by her predecessor, James Wolffe KC, that the Lord Advocate cannot change the law. She further stated that immunity from prosecution cannot be granted in advance. However, she went on to state that the question of whether prosecution is in the public interest is a different matter to immunity from prosecution. The Lord Advocate stated that if a precise, specific, and detailed plan for an MSIF with appropriate safeguards is brought to the Lord Advocate and that if it can be shown to be in the public interest that there should be no prosecutions, then this would have to be given fresh consideration. This represents a significant change in policy in regards to drug abuse in Scotland. However, at the time of writing (April 2023) such a precise and detailed plan for an MSIF has still to be brought before the Lord Advocate.

9.4 Response of the Roman Catholic Church in Scotland

Byron (2019) reported that the decision by the SNP to support the decriminalization of drugs was criticised by the Catholic Church in Scotland as dangerous and retrograde. The report went on to quote Bishop Stephen Robson of the Diocese of Dunkeld, which includes Dundee, the city with one of the highest drug-related death rates in Scotland. Bishop Robson was reported to have asserted that the SNP proposal was extremely retrograde and dangerous and not a solution for the horrific problems due to alcohol and drug use. Bishop Robson went on to say that the Church plays its part by supporting those in most need in its parishes. However, he did

not go into any detail about how the Church supports those suffering from drug addiction (Byron, 2019).

Bishop Robson appears to have latched on to the fact that the SNP resolution includes considering the option of decriminalization illicit drug use as one of several possible measures to contribute to the overall harm reduction strategy. He does not support his condemnation of the consideration of decriminalization with any evidence; he produces no scientific evidence to suggest that decriminalization is ineffective in reducing harm and he produces no evidence from moral philosophy or moral theology to show that decriminalization is morally unacceptable. Rather than add anything of value to the debate about the best ways to reduce drug related harm and drug deaths in Scotland, the bishop's comments seem to have only added to the confusion and misunderstanding around this subject.

Neither Bishop Robinson nor any of the other Scottish bishops have made any statement about the proposed MSIF in Glasgow.

9.5 Peter Krykant's Mobile Safe Injecting Facility

Frustrated by the lack of progress being made by the Scottish Government, Peter Krykant, a former outreach coordinator, decided to take matters into his own hands. In September 2020, he began providing a safe injecting facility in the back of a van parked in the centre of Glasgow close to the premises where Glasgow IJB had planned to open an MSIF. It would be inaccurate to describe Krykant's van as an MSIF as it does not employ any clinically qualified staff to supervise the injections that take place in the van and so I will refer to it as a safe injecting facility.

In the back of the van, there were two injecting booths. People using the van were supplied with all the sterile paraphernalia that they needed to inject safely and there were cinbins for the safe disposal of used paraphernalia. In addition, there was a defibrillator and a supply of naloxone to be used for resuscitation if a client overdoses in the van (McCann, 2020).

The van was parked in the city centre and available for PWIDs from 10am every Friday. Krykant is aware that having only two injecting booths available one day a week is not going to have a significant impact on drugs related deaths in Glasgow. Although it may help improve the situation for some PWIDs in Glasgow, the aim of the facility was to challenge drugs policy.

Krykant believes that the previous Lord Advocate could have provided legal cover in the form of a letter of comfort so that an MSIF could operate in Scotland without fear of prosecution. He points out that, as Lord Advocate, James Wolffe suspended the law around the supply of naloxone in Scotland during the Covid 19 pandemic. Although naloxone has always been a prescription only medicine, the Lord Advocate issued guidance stating that for the duration of the Covid 19 pandemic it would not be in the public interest to prosecute anyone supplying naloxone for use in an emergency so long as that individual was working for a service registered with the Scottish Government (Crown Office and Procurator Fiscal Service, 2020). Krykant argued that the Lord Advocate could have used discretionary powers that were used in relation to naloxone, to enable the operation of an MSIF in Scotland (McCann, 2020).

In November 2020, police officers charged Krykant with obstruction when he refused to open the van to allow the officers access. The charge was later dropped. Despite the charge, the police did not shut down the van nor did they make any arrests. This suggests that the police may have decided to tolerate the facility but are not willing to officially say so. When asked about the van, the Assistant Chief Constable of Police Scotland, Gary Ritchie stated that the establishment of a safe consumption facility is a breach of the Misuse of Drugs Act 1971 and that providing an unregulated and unlicensed facility may cause more harm than good to vulnerable people (McCann, 2020). ACC Ritchie did not give any indication as to whether or not Police Scotland intended to take any action to close down the facility or arrest Mr Krykant.

Despite the police intervention, Mr Krykant received support from several politicians including Alison Thewliss, the MP for Glasgow Central in whose constituency the van operated. In addition to politicians, support was expressed by Rev Brian Casey, Church of Scotland minister. Casey wrote to both the Crown Office and the police asking for an amnesty for those providing this service (Brooks, 2020).

Moreover, the Moderator of the General Assembly of the Church of Scotland, Rev. Dr Iain Greenshields has voiced his support for the provision of MSIFs in Scotland. In an interview in The Herald (Mackay, 2022), he was asked if he supports “safe consumption rooms for heroin users”. He stated that he supports the provision of MSIFs for people using drugs in hazardous manner and that these facilities should educate their clients on the dangers of illicit drug use and engage them in treatment that aims to move them away from the harmful use of drugs. In his reply, he made it clear that this was a personal view and that the Church of Scotland does not have an official position on MSIFs. Dr Greenshields has extensive experience of the

Scottish drug culture. He was brought up in Drumchapel and his first parish as a full-time minister was in Cranhill. These are both peripheral housing schemes where drug problems have been prevalent for several decades. He also spent eight years as a chaplain to a long-term prison and a young offenders' institution.

The interview with Dr Greenshields was published a few days before he took part in a service at Springburn Parish Church organised by Rev Brian Casey to commemorate all those who had lost their lives to drugs and to pray with their families, friends and members of the emergency services who have looked after them. The Scottish national police chaplain, Rev Neil Galbraith and the local community policing team also attended the service. Both Rev Galbraith and the commander of the community policing team expressed support for the establishment of an MSIF in Glasgow.

The service was initially provided in a converted Ford Transit van but was subsequently upgraded to a decommissioned ambulance. Krykant ran the mobile safe injecting facility for nine months. The ambulance was then handed over to the Transform Drug Policy Foundation and is touring the UK as part of a campaign to push for wider drug policy changes including the provision of MSIF.

The police in Glasgow did not arrest anyone using the mobile safe injecting facility. They did not arrest anyone for working in it or providing this service. The only person to be arrested in the nine months that the service was running was Peter Krykant who was arrested for obstructing the police rather than for operating the service. No charges were made as a result of this arrest. This strongly suggests that police in Glasgow would be willing to cooperate in the provision of an MSIF in the same way as they currently cooperate in the provision of other harm reduction services for PWIDs in Scotland.

9.6 Ongoing Research into Drugs Related Deaths in Scotland

Since the response of the former Lord Advocate to the referral from Glasgow IJB, research has continued on drugs related deaths in Scotland. Much of it has focussed on the reasons why so many people die from drug related problems in Scotland and what can be done to reduce this scandalously high death rate.

Although the recommendation of the Glasgow IJB to establish an MSIF in Glasgow was as a response to specific problems in Glasgow city centre, the Advisory Council on the Misuse of Drugs (ACMD) had previously recommended the establishment of an MSIF in the UK (ACMD, 2016). In the introduction to the ACMD's 2016 report "Reducing Opioid-related Deaths" a very obvious but important and often overlooked point is made, "Death is the most serious harm related to drug use" (ACMD, 2016, 3). The ACMD seems to be emphasising the importance of effective harm reduction; it is not just about reducing disease and public nuisance but also about saving lives. This report also states that by 2015, opioid related deaths alone outnumbered deaths in road traffic accidents in the UK. The ACMD (2016) states that there is very strong evidence that the provision of opioid substitution therapy, such as methadone or buprenorphine, is effective in reducing the risk of death among people who use opioids. However, they go on to state that other treatment options, including MSIFs should be developed to further reduce the risk of death particularly in opioid users who are homeless and / or have mental health problems.

ACMD (2016) points out that most people who enter treatment want to stop using illicit drugs completely but that the vast majority who do achieve abstinence will relapse at some point. Relapse after a period of abstinence is a high-risk time for overdose as tolerance would have been lost during the period of abstinence.

ACMD (2016) recommended firstly, that naloxone be made available to PWIDs, their families and friends to enable opioid overdoses to be quickly reversed. Secondly, ACMD (2016) recommended that MSIFs should be provided in places where there is a high concentration of injecting drug use. Injectable naloxone and training in its use has been offered to PWIDs, their families and other people likely to witness an opioid overdose in Scotland since 2011. Furthermore, as of August 2022, police officers in Shetland, Paisley and Inverclyde have been issued with naloxone intra-nasal sprays. However, the recommendation for the provision of an MSIF is stuck in a legal impasse.

Even though none of the administrations in the UK, neither the UK government in Westminster nor any of the devolved administrations, have implemented the ACMD recommendation to establish an MSIF, research continues into drug deaths in Scotland and the effectiveness of proposed ways of reducing drugs deaths.

Tweed, *et al.* (2018) published a health needs assessment of people who inject drugs in public places in Glasgow. This showed that, two years after the MSIF was proposed for Glasgow,

there were still up to 500 people injecting illicit drugs in public spaces in Glasgow city centre. These people were predominantly male between the ages of 30 and 50 with a high rate of homelessness and other social vulnerabilities. However, there was not a great deal of up to date evidence about the health needs of this group of people. According to Tweed *et al*. (2018), the reasons why people are injecting in public include a need to inject immediately after acquiring drugs to relieve withdrawal symptoms and fear of arrest or robbery. Additionally, many homeless people who inject in public do not have a private space to inject indoors. Most public injecting in Glasgow, takes place in the southeast of the city centre because this is where the local drug market is concentrated. Many of those interviewed by Tweed *et al.* (2018) showed that they had multiple health problems, but that health was a low priority during active drug use. The reasons given for this were the demands of addiction, adverse social circumstances, a fatalistic attitude to health and the stigma that they experience when they ask for help with their health. Tweed *et al.* (2018) agreed with previous research that showed that public injecting is associated with various higher risks including blood borne virus infection, bacterial infection, other injection related injuries, overdose, and death. One particularly interesting point made by Tweed *et al.* (2018) is reports from staff working with PWIDs that members of the local communities and operators of small businesses in Glasgow city centre have been asking for the PWIDs to be given a safe place to inject. This is in marked contrast to the attitude of local business operators in Dublin near the site of the proposed MSIF on Merchants Quay. The business operators in Dublin have actively campaigned against the establishment of an MSIF. This leads me to question the accuracy of reports of small business operators in Glasgow apparently asking for an MSIF to be established. Is this accurate reporting or is it wishful thinking on the part of the staff working with PWIDs in Glasgow city centre?

McAuley, *et al.* (2019) investigated the reasons for the rapid increase in the prevalence of HIV among PWIDs in Glasgow that began in 2015. They concluded that the rise in HIV prevalence was linked with homelessness, recent incarceration, and an increase in the intravenous use of cocaine. This is in agreement with the research done by Tweed *et al.* (2018) that showed a strong link between homelessness and public injecting.

In 2021, the Scottish Government published an evidence paper on MSIFs, in which it was pointed out that there is a particularly vulnerable group of street injectors in Glasgow city centre (Scottish Government, 2021). In addition to the ongoing increase in HIV in Glasgow, there have been outbreaks of both botulism and anthrax among PWIDs. As I have previously pointed out (3.3.1), the drug related death rate in Scotland has been increasing since records began in

1996. There is a very high level of public injecting in Glasgow and subsequently there is a serious problem with drug litter in the city centre. This includes used needles and syringes and other contaminated paraphernalia that put the public at risk of injury and infection.

Although the Scottish Government (2021) does not make any explicit recommendations, it does provide evidence that the operation of an MSIF in Glasgow city centre is likely to reduce public injecting, drug litter, drug related infections including HIV, and drug related deaths especially deaths from overdose. In addition, the operation of an MSIF would allow professionals working in this field to gain insights into the patterns of drug use and to engage with PWIDs and connect them with addictions services. Scottish Government (2021) points out the anomaly that while there are legal barriers to the establishment of an MSIF in Scotland, imposed by the UK government, both health and drugs policy are matters that have been devolved to the Scottish Parliament.

This same point is reiterated by Parkes *et al.* (2022) in a study that explores the family members' thoughts on the implementation of an MSIF. According to Parkes *et al.* (2022) there is ample evidence of the effectiveness of MSIFs but that measuring the precise impact that MSIFs have on the drugs related deaths is difficult due to the wide range of confounders. This has resulted in a lack of trial data and has been used as an excuse by the UK Government for blocking the introduction of MSIFs. However, the increasing drugs related deaths in Scotland has increased the pressure to introduce an MSIF. The research of Parkes *at al.* (2022) suggests that the introduction of an MSIF would be supported by the families of PWIDs and be seen as a useful addition to the range of services available to reduce drugs related deaths and other drug related harms.

Parkes *et al.* (2022) point out that the Scottish Government established a Drugs Deaths Task Force to examine ways in which drugs related deaths in Scotland could be reduced. The Scottish Drug Deaths Task Force (2022) argues that stigma and discrimination against people who use illicit drugs are increased by criminalising them. They go on to argue that there needs to be a cultural change away from stigma, discrimination and punishment towards care, compassion, and human rights. Stigma reinforces trauma and prevents people from seeking support and treatment (Scottish Drug Deaths Task Force, 2022, 8). The Scottish Drug Deaths Task Force (2022, 16) recommends that the UK Government should begin to review the law to enable a public health approach to drugs. In addition, the Scottish Government should

continue to engage with the UK Government to support these changes. Furthermore, the UK Government should consider a change in the law to support the introduction of MSIFs.

All of the research that I have found related to drugs deaths in Scotland and published since the decision of the former Lord Advocate not to allow a legal exemption for the provision of MSIFs, has pointed in the same direction. The research has shown firstly that public injecting in Glasgow city centre and the problems associated with it persist. Secondly, it has shown that the provision of an MSIF in Glasgow city centre is likely to have a beneficial effect in that it is likely to reduce the number of drugs related deaths in the city and to reduce the other harms associated with public injecting.

9.7 Summary

In response to a significant increase in the number of serious infections among people who inject in public places in the centre of Glasgow, Glasgow IJB proposed the establishment of an MSIF in the city. This required either legal exemptions or a change in the law. The Lord Advocate at that time was unwilling to provide the required legal exemptions and suggested that the Scottish government make a request to the UK Home Office. Officials at the Home Office made it clear that ministers have no intention of changing the law to permit the establishment of an MSIF.

The SNP have recommended that drug policy should be devolved to Scotland and suggested decriminalisation should be considered as part of a wide-ranging harm reduction strategy. Bishop Stephen Robson of Dunkeld stated that the SNP proposal was extremely retrograde and dangerous and that the Roman Catholic Church plays its part by supporting those in most need in its parishes. The Scottish bishops have not made any statement on the proposed MSIF in Glasgow. However, several Church of Scotland ministers, including the current moderator and the national police chaplain, have been supportive of a change in the law. In addition, support has been expressed by at least one senior policer officer in Scotland.

Frustrated by the lack of progress, Peter Krykant decided to set up a safe injecting facility in the back of a van. Although this may have some influence drug deaths on Glasgow, the main aim of this facility is to challenge drug policy.

Police Scotland charged Mr Krykant with obstruction. However, he was not arrested, and the police made no attempt to shut down the facility. This suggests to me that the police may have decided unofficially to tolerate the safe injecting space in Mr Krykant's van. Mr Krykant's safe injecting facility operated for nine months. The van was then handed over to the Transform Drug Policy Foundation and is touring the UK as part of a campaign to push for wider drug policy changes including the provision of MSIFs.

Ongoing research suggests that the provision of an MSIF in Glasgow would contribute to a reduction in drug related deaths and other problems associated with injecting illicit drugs in public.

Conclusion

I stated in the introduction that the aim of this thesis is to make a case for the view that medically supervised injecting facilities for people who inject drugs are morally permissible and that the Roman Catholic healthcare professionals should be involved in establishing and running such facilities if they feel called to do so.

The provision of an MSIF is morally contentious at least in part, due to cooperation with the morally illicit practice of injecting illicit drugs such as heroin. Opinion on this issue is divided and contested both within the Roman Catholic Church and in secular society.

In the course of this thesis, I have shown that:

1. There is ample evidence that the provision of medically supervised injecting facilities for people who inject illicit drugs is morally permissible within certain conditions.
2. The provision of medically supervised injecting facilities is not just morally permissible but is morally desirable.
3. MSIFs are particularly morally desirable because it is in harmony with the preferential option for the poor.
4. Opinion on the morality of the provision of MSIFs is divided in the Roman Catholic Church and in secular society.
5. Roman Catholic healthcare professionals should be involved in establishing and running medically supervised injecting facilities if they feel called to do so.

Each of these points will be discussed in more detail here.

1. The provision of MSIFs is morally permissible.

The provision of an MSIF for people who inject drugs is not morally wrong. Despite the contentiousness of the issue and the fact that it involves cooperation with evil, I have shown that there is ample evidence that the operation of an MSIF is morally permissible. Some writers, who are opposed to the provision of MSIFs, have argued that they are not effective in that they do nothing to improve the health of PWIDs and that they are a drain on resources that could be more effectively used elsewhere to deal with addiction. If this were true, there would be no moral argument in favour of the provision of an MSIF. It would be morally indefensible to provide an ineffective clinical service. However, in Chapter 3, I presented evidence that shows

that MSIFs are clinically and economically effective. MSIFs aim to decrease drug related deaths, decrease non-fatal overdoses, decrease public injecting, decrease the amount of improperly discarded drug paraphernalia, decrease infection among people who inject drugs and increase the number of people accessing drug treatment services. The evidence that I presented in Chapter 3, shows that MSIFs are achieving all of these aims. Furthermore, the evidence shows that this is being done in an economically effective manner. The provision of an MSIF can actually save more money than it costs to run. The infections averted by the provision of an MSIF would have cost more to treat than it costs to run an MSIF.

In Chapter 4, I used the principle of cooperation in evil to show that the provision of an MSIF is justified and morally permissible. There is no doubt that the provision of an MSIF involves cooperation in the morally evil act of injecting illicit drugs. However, this cooperation is justified because the main agent cannot be persuaded to desist from using illicit drugs; because the cooperation is material rather than formal; because the cooperation is contingent rather than necessary; because the proximity of the cooperation is justified by the grave reason that it saves lives; and because the cooperation is not a cause of scandal.

There is an underlying assumption in this analysis that PWIDs have sufficient moral agency to be able to choose whether or not to use illicit drugs. However, MSIFs are aimed at people who are addicted to the drugs that they inject, and addiction significantly diminishes their moral agency. In addition, many of those who become addicted to illicit drugs have experienced severe social disadvantage and emotional trauma that precipitates their first use of illicit drugs. Such social disadvantage and trauma also diminishes their moral agency and reduces their culpability for their first use of illicit drugs. That this underlying assumption is in doubt suggests that the principle of cooperation in evil may not be the most appropriate tool on its own, for the moral analysis of medically supervised injecting facilities.

Therefore, in Chapter 5, I used the idea of gradualism to strengthen my argument for the moral permissibility of MSIFs. Gradualism accepts that moral development is an incremental process and that even when an individual's current situation falls short of perfection it still has moral value. Gradualism acknowledges that it is better to encourage the positive aspects of a person's life rather than rebuke their flaws. It recognises the positive aspects of a person seeking to reduce the harm caused to themselves and others by their behaviour. The use of an MSIF by a PWID may show some assumption of responsibility and could indicate that the PWID is

working to reduce the harm caused by their illicit drug injecting. When a PWID uses an MSIF to reduce harm, this can be seen as a step in the right direction and is morally permissible.

2. **The provision of medically supervised injecting facilities is not just morally permissible but is morally desirable.**

The provision of an MSIF is more than morally permissible; it is morally desirable. At the beginning of Chapter 4, I discussed the nature of evil and distinguished between moral and non-moral evil. Non-moral evils are things that are harmful to humans but in themselves have no reference to morality or free human action. Examples of non-moral evils include disease, injury, suffering and hunger. The provision of an MSIF is good because it reduces the amount of non-moral evil. The *Catechism of the Catholic Church* (Vatican, 1994. 2291) states that the non-therapeutic use of drugs is morally wrong because of the disease, injury and suffering that it causes. As I showed in Chapter 3, the provision of an MSIF decreases the drug-related death rate, the number of infections suffered by PWIDs and the risk of infection to the general public. In addition, MSIFs reduce the risk of other harms to the public. Therefore, the provision of an MSIF reduces the evils of disease, injury and suffering not only to PWIDs but to the wider community and so is positively good.

3. **MSIFs are particularly morally desirable because they are in harmony with the preferential option for the poor.**

In Chapter 4, I showed that poverty was closely associated with drug addiction. Childhood abuse, neglect, institutional care, unemployment, and homelessness are all risk factors for addition and are all indictors of poverty. In describing the effects of living in poor quality housing in an area of high unemployment, McGarvey (2017, 42) states that illicit drugs give temporary relief from the bleak realities of poverty. Throughout discussions on the provision of MSIFs in Australia, North America, Ireland and Scotland, the link between poverty and drug addiction was apparent.

Everyone, including people who inject drugs, has been created in the image and likeness of God and so everyone has an inherent and immeasurable worth and dignity (Vatican 2005, 144). This dignity cannot be taken away, even by addiction. In discussing the Roman Catholic Church's preferential option for the poor, Gutiérrez (1992, 29) speaks of the early and unjust deaths of poor people. MSIFs make a significant contribution to reducing the number of early and unjust deaths suffered by PWIDs most of whom are poor. Therefore, the provision of an MSIF has extra moral value because it reduces the deaths and suffering of the poor and when

MSIFs are operated by Catholic agencies, they are a concrete way of expressing the Church's preferential option for the poor. The work of individual lay Catholics working in MSIFs which are not operated by Catholic agencies can still be understood as a concrete expression of the preferential option for the poor.

However, it has to be noted that the provision of an MSIF does nothing to reduce poverty, the root causes of poverty or societal structures that contribute to the oppression the poor. As I stated in Chapter 2 (2.3) this thesis examines a particular practical way of working that aims to alleviate the suffering of a certain group of marginalised people and assesses the moral desirability of this way of working. Although the provision of an MSIF can relieve the suffering of poor people, it does not reduce poverty or address the causes of poverty.

4. Opinion on the morality of the provision of MSIF is divided in the Roman Catholic Church and in secular society.

In Chapters 5-9, I explored several attempts to establish MSIFs in different parts of the world by both Roman Catholic and secular organisations. There was a mix of reactions to these proposals ranging from fully supportive to complete disapproval. Support and disapproval came from both Roman Catholic and secular organisations and was based on a number of considerations including moral theology, criminal law and commercial concerns.

In 1999, the Sisters of Charity were chosen by the Health Minister of New South Wales to set up an MSIF as a pilot project in Sydney. This provoked mix of reactions (Fisher, 2012, 80) and eventually led to a referral to the CDF. The CDF rejected the proposal pointing out that there was nothing certain about the efficacy of the proposed MSIF. This suggests that a trial of an MSIF would be needed to ascertain how beneficial the proposed MSIF would be. However, the CDF determined that a trial of an MSIF by a Roman Catholic organisation was not permissible.

In North America, there is a remarkable difference between the views taken by the Canadian Conference of Catholic Bishops (CCCB) and the United States Conference of Catholic Bishops (USCCB) to the operation of an MSIF. In April 2017, the Canadian Conference of Catholic Bishops published a Statement on Canada's Opiate Crisis and Drug Addiction (CCCB, 2017) in which they cautiously accept the benefits of MSIFs. However, they warned that on their own, harm reduction services are not sufficient to address the problems of addiction. There are approximately twenty-six MSIFs in Canada at least two of which have close ties to Roman

Catholic institutions. However, there are only two MSIFs in the United States neither of which have any connection to the Roman Catholic Church.

As far back a 1990, the USCCB rejected the use of needle exchange as a means of reducing the spread of HIV (USCCB, 1990). Since then, there has been no publications from the USCCB giving any further opinion on the means of preventing the spread of HIV and the USCCB has not made any comment on the moral desirability of MSIFs. However, the retired archbishop of Philadelphia, Charles Chaput OFM Cap, a priest from the archdiocese of Philadelphia and two theologians closely connected to the archdiocese have argued vigorously against the provision of MSIFs and any Catholic involvement in these services. All of them have argued from a position that sees MSIFs as an alternative to other services rather than an additional tool to help keep addicted people alive. All of them show that they care deeply for people who are caught in addiction and are very willing to help those who are making some attempt to break free from addiction. However, neither Archbishop Chaput nor his supporters seem to have anything to offer those who are not yet ready to take the first step and they give the impression, possibly inadvertently, that they are only interested in people who are motivated to give up their illicit drug use. They seem to have a lack of awareness that for some people in the margins, drugs are not a problem but a solution and so there is no perceived benefit in giving them up (McLaughlin, 2018). In addition, the arguments that they put forward opposing the provision of MSIFs were flawed and based on false assumptions about the nature and purpose of an MSIF.

The Franciscan friars at Merchants Quay in Dublin have been providing practical support to marginalised people for over fifty years and were the first NGO in Ireland to run a needle exchange. In 2018, Merchants Quay was chosen as the preferred bidder to operate the first MSIF in Ireland on an eighteen-month trial basis.

Although the original harm reduction work at Merchants quay was referred to the Papal Nuncio to Ireland in the early 1990s, the investigation ordered by the nuncio found in favour of this work and there is no evidence that the nuncio referred this matter to the CDF. I have not been able to find any objections to the Merchants Quay MSIF from any religious organisation or any objections for theological or moral reasons. All the objections to this proposal were for practical, mostly commercial reasons. Tony Geoghegan, the then CEO of Merchants Quay Ireland responded to the objections in a way that show a high degree of Christian moral thinking

and that all of the services provided by Merchants Quay Ireland are delivered within a Christian ethos.

In 2017, in response to the high levels of public drug injecting in the centre of Glasgow, a plan to establish a pilot MSIF was approved by Glasgow City Integrated Joint Board. This would have required an exception from certain sections of the Misuse of Drugs Act 1971 in order to be able operate. The Lord Advocate at the time, James Wolffe QC refused to grant a legal exception. However, his successor as Lord Advocate, Dorothy Bain KC, has stated that she is willing to consider precise and specific proposals for an MSIF.

In response to the original decision by James Wolffe, the Scottish National Party passed a resolution at its conference in October 2019 stating that substance misuse should be treated as a public health issue and that all options for harm reduction, including the possibility of decriminalization can be considered. The suggestion of decriminalising was condemned by Bishop Stephen Robson of Dunkeld, as a dangerous a retrograde step that would do nothing to help solve the problems of drug and alcohol addiction. However, there has been no specific comment on the proposed MSIF in Glasgow from any of the Scottish bishops.

Over a period of more than twenty years, Roman Catholic organisations providing services to PWIDs have attempted to set up MSIFs in different parts of the world. The responses to these proposals have been remarkably diverse. The highest-level response within the Church has come from the CDF. In their response to the proposal by the Sisters of Charity to run an MSIF in Australia, they stated that there is insufficient evidence that an MSIF would be effective. That was more than twenty years ago. Since then, there has been a considerable number of MSIFs operating in Europe, North America, and Australia. As I discussed in Chapter 3, the evidence shows that MSIFs are achieving their aims. Contrary, to the view expressed by the CDF, there is now ample evidence of the efficacy of MSIFs. Yet the provision MSIFs remains a morally and legally controversial matter.

5. Roman Catholic healthcare professionals should be involved in establishing and running medically supervised injecting facilities if they feel called to do so.

In the introduction, I noted that there is a proposal to establish an MSIF in Glasgow and I asked the question: what is the proper moral response to this proposal? Should Roman Catholic healthcare professionals be involved in establishing and operating this MSIF? Is this an appropriate way for healthcare professionals to live out their vocation?

I have come to the conclusion that Roman Catholic healthcare professionals who feel called to work in an MSIF should do so for several reasons. Firstly, the provision of an MSIF is morally permissible. Secondly, it is morally desirable because it reduces suffering and disease. Thirdly, it is in harmony with the preferential option for the poor.

However, there are some caveats. The MSIF must be aimed at people who are already addicted. The healthcare professions must be clear that they are working to prevent harm rather than facilitate drug abuse and so it would be ideal for the MSIF to be operated as part of a spectrum of services for PWIDs that aims ultimately for the PWIDs to be free from addiction. The MSIF must be operated in a manner that does not cause scandal. As such, its aims must be made clear to the public and to the people who may use the service. The PWIDs who use the service must be treated with the utmost respect. As sons and daughters of God, they have an inviolable dignity that must be cherished. The people who attend an MSIF are experiencing poverty in many different ways. They are the poor lowly ones of God, and all Christians have particular obligation to wards them. Christians must make a choice to live in a manner that lifts up the poor in real and concrete ways. The provision of an MSIF is a real and concrete way of living out the preferential option for the poor but only if the clients of the MSIF are giving that special respect that are entitled to a group specially beloved by God.

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Appendix

Sources of information

Chapter 6 Australia

In addition to the sources freely available to the public, I met online with the ethical advisor to St Vincent's Healthcare, Dr Alex Wodak. Dr Wodak discussed the ethical values of St. Vincent's and the plans for an MSIF in Melbourne. In addition, I contacted the archivist of the Archdiocese of Sydney who sent me a copy of the 1999 letter from the Congregation for the Doctrine of the Faith to the Archbishop of Sydney.

Chapter 7 North America

All the information in this chapter was taken from sources that are freely available to the public.

Chapter 8 Ireland

In addition to the sources freely available to the public, I met with the Irish Consul General to Scotland to discuss this chapter. The Consul General put me in touch with the doctor in charge of drug policy in the Irish Government. We exchanged emails and he provided me with some information on Irish Government policy in this area. I attempted to contact Merchants Quay Ireland several time but did not receive any replies.

Chapter 9 Scotland

In addition to the sources freely available to the public, I met with:

Rev Brian Casey, Church of Scotland minister in Springburn, Glasgow, advocate for a change in drug policy and former police officer.

Rev Dr Ian Greensheilds, moderator of the Church of Scotland 2022-23, former prison chaplain, and advocate for a change in drug policy.

The officer in charge of community policing for north Glasgow.