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ARTICLE

What Is the Point of Harm Reduction? A Relational Egalitarian Perspective

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Abstract

Harm reduction is one of the most controversial and widely discussed approaches in public health and social policy, addressing a broad range of pressing societal issues, including drug addiction, sex work, alcohol and tobacco use, and homelessness. Surprisingly, however, harm reduction has received very little philosophical scrutiny. In this article, I aim to fill this gap. First, I provide a systematic analysis of the core features and normative commitments of harm reduction. Second, I propose a novel, relational egalitarian justification for harm reduction. I argue that the provision of harm reduction services is not solely or primarily a matter of mitigating the negative consequences associated with high-risk behaviours. Rather, most fundamentally, it is the appropriate response to the status of vulnerable individuals as equal members of society.

Keywords: harm reduction; public health; relational equality; stigmatised behaviours; vulnerability.

Introduction

Harm reduction is a highly controversial and widely discussed approach to drug use. It is characterised by its opposition to both the criminalisation of drug use and abstinence-oriented policies, advocating instead for strategies that minimise the negative consequences of this high-risk behaviour. Proponents of harm reduction call for the provision of health and social services – such as needle exchange programmes, safe injection rooms, and naloxone distribution – that aim to reduce harm to affected individuals by preventing blood-borne illnesses and overdose deaths, as well as to society at large by tackling issues like discarded needles, economic impact, and criminal activity (Ball 2007; Collins et al. 2012).

Many governments and international agencies have integrated harm reduction policies and measures into their strategies to address drug-related challenges. In August 2023, the Office of the United Nations High Commissioner for Human Rights released a report urging the expansion of harm reduction programmes (United Nations Human Rights Council 2023). In March 2024, the former Biden-Harris administration launched the 'White House Challenge to Save Lives from Overdose', a 'nationwide call-to-action to stakeholders across all sectors to save lives by committing to increase training on and access to lifesaving opioid overdose reversal medications' (The White House 2024). Additionally, harm reduction is a cornerstone of the European Union's Drug Strategy, which aims to 'reduce the prevalence and incidence of drug-related infectious diseases and other negative health and social outcomes' (Council of the European Union 2021).

Harm reduction measures have also been applied in a variety of contexts beyond drug use, including alcohol use, homelessness, and sex work (Ball 2007, 686). For example, strategies such as low-barrier housing initiatives, which provide accessible living arrangements for individuals facing housing instability, and condom distribution programs that promote safer sex practices are designed to mitigate the harms associated with these social and public health challenges.

Given its influence and application in a wide range of important policy areas, it is surprising that harm reduction has received very little philosophical scrutiny.[1] This article aims to address this gap by exploring two key questions. First, the *analytical question*: what exactly is harm reduction? Clarifying this is crucial because the term 'harm reduction' is frequently used to justify a diverse array of public policies and practices. The lack of a clear and consistent definition, therefore, can lead to varied and at times conflicting interpretations, making it difficult for policymakers, practitioners, and scholars to evaluate the effectiveness and appropriateness of different initiatives. Thus, the first aim of this article is to resolve this ambiguity by providing a systematic analysis of the core features and normative commitments of harm reduction.

Second, the *normative question*: why should the state implement harm reduction policies and practices? This article proposes a novel, relational egalitarian justification for harm reduction. Examining harm reduction through the lens of relational egalitarianism is important for two reasons. First, harm reduction is often justified on a consequentialist framework, according to which what matters is to maximise (minimise) the good (bad) consequences of an act. However, most prominent relational egalitarian views rest on a deontological framework, which holds that an act is wrong if it fails to respect the moral status of the wronged.[2] Therefore, demonstrating that harm reduction is compatible with deontic relational egalitarianism challenges the common assumption that harm reduction must be grounded in a consequentialist moral outlook.[3]

Second, relational egalitarians have often argued that distributive views of equality (for example, luck egalitarianism) offer a mistaken picture of what it means to live in a society of equals, as they fail to address the concerns of real-life egalitarians, such as status hierarchy, marginalisation, oppression, and domination (Anderson 1999, 288; Lippert-Rasmussen 2018, 174; Schemmel 2021, 20). Yet, relational egalitarians have largely neglected the real-world struggles of vulnerable and disadvantaged individuals, such as persons with substance use disorders and sex workers, who face systemic marginalisation and exclusion. This article addresses this lacuna in the relational egalitarian literature.

The second aim of the article, thus, is to demonstrate that harm reduction advocates can find a more convincing justification for their approach within the relational egalitarian framework, and that relational egalitarians have compelling reasons to support harm reduction policies and practices.

This article is divided into two main parts. In the first part, I address the analytical question. First, I analyse what kinds of policies and practices are included within the framework of harm reduction. Second, I explore the primary objectives that harm reduction policies and practices seek to achieve. In the second part, I address the normative question. I begin by discussing the standard consequentialist justification of harm reduction. Next, I develop an alternative deontic relational egalitarian justification for harm reduction. I argue that, from a relational egalitarian perspective, the state should adopt harm reduction policies and practices because they (i) express equal respect and concern for persons and (ii) enable them to function as equals in society. The upshot is that the provision of harm reduction services is not solely or primarily a matter of mitigating the negative consequences associated with high-risk behaviours. Rather, most

[1]For a notable exception, see Dea and Weinstock (2020).

[2]See, for example, Anderson (1999) and Schemmel (2021).

[3]For deontological justifications of harm reduction, see also King (2020) and Stoljar (2020). However, my approach diverges from these views by offering a specific deontic *relational egalitarian* justification of harm reduction. See also footnote 14.

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fundamentally, it is the appropriate response to the status of vulnerable individuals as equal members of society.

Part I: The Analytical Question

Reducing greenhouse gas emissions from major sources such as industrial factories and the aviation sector helps mitigate the harmful effects of climate change. Similarly, providing welfare benefits alleviates the negative consequences of unemployment. However, few would classify these as 'harm reduction policies' in the specific sense of being based on the harm reduction approach. Thus, harm reduction cannot be defined merely by reference to the moral imperative to reduce harm – the latter is a necessary but insufficient condition for the former. Accordingly, to precisely delineate what constitutes a harm reduction policy or practice, I will address the following questions:

1. The question of the *scope*: what can be the object of harm reduction policies and practices?
2. The question of the *goal(s)*: what is the main goal(s) of harm reduction policies and practices?

I will proceed on the assumption that a plausible definition of harm reduction must satisfy the following two desiderata:

1. It must be sufficiently specific to advance the fundamental interests of vulnerable individuals effectively. By vulnerability, I refer to the state of being susceptible to harm due to situational factors, such exposure to high-risk behaviours (Mackenzie, Rogers and Dodds 2014). Thus, defining harm reduction as simply 'any policy that reduces harm' would result in an overly broad application, diluting its effectiveness and undermining its role in guiding a coherent set of public policies aimed at addressing the specific needs of vulnerable individuals.[4]
2. It must align at least to some extent with how harm reduction is understood and advocated by its proponents. This involves reflecting the core concerns of grassroots movements advocating for harm reduction policies and programmes, and excluding strategies or issues unrelated to their primary political and ethical agendas. This is crucial because proposing a definition that significantly deviates from how advocates understand harm reduction risks not only misrepresents the movement's goals, thereby undermining the policies and practices they have fought for, but could also sideline the voices and priorities of those most affected by these issues. Drawing on the grassroots perspective ensures that harm reduction is understood in a way that is faithful to its political origins and guiding principles, while allowing for refinements to its conceptual boundaries when necessary.[5]

The Scope of Harm Reduction

Harm reduction is often described as a social and public health approach aimed at mitigating the harmful effects of *individual behaviours*. However, not all individual behaviours can be the focus of harm reduction policies. For instance, while some might (plausibly) argue that voting for

[4]It is important to note that vulnerable individuals are often members of disadvantaged groups. For example, persons experiencing homelessness are particularly vulnerable to the harms associated with drug addiction. As a result, harm reduction policies and strategies will frequently be directed towards assisting people in disadvantaged groups.

[5]This is not to suggest that advocates of harm reduction uniformly agree on how its core idea should be understood. On the contrary, as we will see more clearly below, reasonable disagreements exist regarding certain aspects of its definition, highlighting the complexity and nuance inherent in the concept. A central aim of this paper is to clarify these areas of disagreement and examine the tensions they create.

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Kamala Harris in the last US presidential election would have minimised negative consequences, few would consider strategic voting to be a harm-reduction practice.

To identify the specific types of individual behaviours that are appropriate targets for harm reduction policies and practices, it will be helpful to recall the origins of the harm reduction social movement. Harm reduction emerged in the mid-1980s primarily as an alternative response to the outbreak of HIV/AIDS in Western societies, which disproportionately affected vulnerable individuals such as drug users and homosexuals. Faced with this public health epidemic, harm reduction advocates called for public policies aimed not at prohibiting or punishing behaviours that could lead to contracting the HIV/AIDS virus, such as drug use and sexual intercourse, but at providing individuals engaging in such behaviours with the tools necessary to minimise the risk of infection. For example, the efforts of grassroots movements like *Junkiebond* (the 'Junkie Union') in the Netherlands and the Vancouver Area Network of Drug Users in Canada played a pivotal role in establishing the first government-funded needle exchange programs (Klein 2020, 407). Likewise, advocacy from the gay community was instrumental in expanding health services for sexually transmitted infection prevention and treatment, including HIV screening and Pre-Exposure Prophylaxis. These efforts contributed to a significant decline in HIV morbidity and mortality (Andersen and Jarvinen 2007, 245; Hawk et al. 2017).

Thus, the term 'harm reduction' was originally used to describe policies and practices that target (i) *high-risk* and (ii) *stigmatised* (or *socially disvalued*) behaviours, such as drug use, homosexual sex, and sex work. I refer to this as the 'narrow understanding' of harm reduction.[6] This 'narrow understanding' satisfies both desiderata outlined above: it is sufficiently specific to underpin a coherent set of public policies and practices aimed primarily at addressing the fundamental needs of vulnerable individuals, and it aligns with the meaning attributed to harm reduction by its advocates. As such, it offers a plausible account of the scope of harm reduction.

Two comments, however, are in order. First, what constitutes 'high-risk and stigmatised' behaviour significantly depends on the social context in which such behaviour occurs. For example, smoking cigarettes was neither stigmatised nor deemed high-risk in the 1970s. However, perceptions have shifted significantly since then: smoking is now widely recognised as a high-risk and socially disvalued behaviour. Consequently, the scope of harm reduction varies according to prevailing social norms regarding what is considered 'high-risk and stigmatised' behaviour.

Second, some harm reduction theorists and advocates have recently argued that the scope of harm reduction should be broadened. According to this 'broad understanding', harm reduction policies address not only those behaviours that are high-risk *and* stigmatised but all high-risk behaviours.[7] For example, during the COVID-19 pandemic, harm reduction strategies such as social distancing and face masks were adopted to minimise negative consequences (Weinstock 2020).

Critics have argued that the 'broad understanding' is overly inclusive. For instance, on this understanding, the legal requirements of wearing seatbelts and installing guard rails on highways count as harm reduction policies, since they aim to reduce the harmful effects of high-risk behaviours such as driving (Stoljar 2020, 345). Yet, these issues are far removed from the main political concern of the harm reduction movement, which is to promote public policies and strategies that address the needs of the most vulnerable individuals.

This discussion highlights a genuine tension between the two desiderata that a plausible definition of harm reduction must satisfy. On the one hand, an overly broad understanding of harm reduction diminishes the concept's practical utility in addressing the specific political issues central to the harm reduction social movement. In particular, it risks diluting the strategic and political focus of harm reduction efforts, making it more difficult to advocate for targeted policies and practices that effectively advance the fundamental interests of vulnerable individuals. On the

[6]For a defence of the 'narrow understanding' of harm reduction, see also Stoljar (2020) and Kleinig (2008).

[7]For a defence of the 'broad understanding' of harm reduction, see Collins et al. (2012) and Weinstock (2020).

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other hand, the term 'harm reduction' should not be too detached from the meaning attributed to it by its advocates. The challenge for any plausible definition of harm reduction lies in balancing these potentially competing desiderata.[8]

For our purposes, however, it is not necessary to resolve the reasonable disagreement between the 'narrow' and the 'broad' understandings of harm reduction. This is because the relational egalitarian justification developed in the second part of this paper is compatible with either conception. Accordingly, I will focus on the narrow understanding of harm reduction. Demonstrating that there are compelling moral reasons to adopt 'more controversial' harm reduction policies – such as those targeting high-risk and stigmatised behaviours like drug use and sex work – will also strengthen the case for promoting 'less controversial' harm reduction policies that address high-risk behaviours more broadly.

The Goal(s) of Harm Reduction

The general goal of harm reduction is to reduce or minimise the harm associated with high-risk and stigmatised behaviours. However, harm can manifest in various forms, occur at different levels, and be reduced in different ways. In this section, I discuss each of these aspects to clarify further the main goal(s) of harm reduction.

Types of harm. Harm reduction policies are commonly associated with the reduction of *health-related* harms. For example, the provision of condoms and clean needles minimises the risk for sex workers and persons with substance use disorder to contract potentially life-threatening infections. However, harm reduction policies also aim to address *social-related* harms, such as the social exclusion and marginalisation experienced by individuals who engage in high-risk and stigmatised behaviours. For instance, advocates argue that safe injection rooms not only reduce the number of drug overdoses but also provide persons with substance use disorders with a place where they are accepted for 'who they are' (Stoljar 2020, 349). Therefore, harm reduction consists of a set of policies and practices that aim to reduce the health- *and* social-related harmful effects of high-risk and stigmatised behaviours.

Objects of harm. Harm does not only vary in kind, but it also occurs at different levels. Consider drug use, for example. Typically, persons using drugs are primarily affected by it. Yet, they are not the only ones: their community and society at large are also harmed by drug use (Collins et al. 2012, 8). Therefore, harm reduction policies aim to mitigate harm at both the individual and the social levels. For example, proponents argue that needle exchange programmes benefit drug users by reducing the incidence of blood-borne diseases and soft tissue infections, while also benefiting the larger society by addressing the public nuisance of discarded needles. Similarly, safe injection rooms not only reduce the number of overdoses but also decrease public disorder by, among other things, reducing public injection drug use (Pauly 2008, 6). Thus, harm reduction policies adopt a comprehensive approach to reducing 'harms', addressing not only those affecting individuals but also those impacting the broader public.

Different ways of reducing harm. Finally, harm resulting from risky behaviours can be reduced either by eliminating the behaviours themselves or by focusing on minimising the negative consequences that arise from them. This dichotomy raises an important question: is harm reduction compatible with abstinence, that is, the practice of completely refraining from engaging in harmful behaviours?

It has been argued that harm reduction is incompatible with abstinence. This view positions harm reduction as an alternative to two prevailing abstinence models. On the one hand, the 'moral model' holds that high-risk and stigmatised behaviours, such as sex work, are morally wrong and therefore should be prohibited. On the other hand, the 'disease model' maintains that high-risk

[8]For further discussion of the conceptual distinction between the 'broad' and 'narrow' understandings of harm reduction, see also Ball (2007).

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and stigmatised behaviours, such as drug use, are 'diseases' and therefore should be treated. By contrast, harm reduction affirms that high-risk and stigmatised behaviours are neither morally wrong behaviours that should be prevented or punished, nor diseases that should be treated (Newcombe 1992).

However, I argue that this view draws too sharp a contrast between harm reduction and abstinence. Instead, harm reduction is incompatible with abstinence in some ways but compatible in others. First, harm reduction is incompatible with abstinence as a *requirement* for accessing assistance or treatment. At the core of the harm reduction approach is the belief that help and support for individuals engaging in high-risk and stigmatised behaviours should not be conditional upon the cessation of those behaviours. To use a famous harm reduction slogan, people can come 'as they are' (Marlatt 1996). Thus, unlike the 'high-threshold' services favoured by the abstinence models, harm reduction advocates for 'low-threshold' services that do not require abstinence for access or continued treatment, such as safe injection rooms and Housing First programmes providing housing to persons with substance use disorder without mandating abstinence (Hawk et al. 2017, 2).

Second, harm reduction is also clearly incompatible with abstinence as *the only* desirable *goal*. According to the harm reduction approach, minimising the negative consequences resulting from high-risk and stigmatised behaviours is a valuable goal. Therefore, the achievement of abstinence is not the only valuable goal from a harm reduction perspective.

However, I argue that harm reduction is compatible with abstinence as *a* desirable goal:[9] holding that reducing the harmful effects of behaviour, X, is a desirable goal is consistent with maintaining that extinguishing X is also a desirable goal, at least if the benefits of extinguishing X are not outweighed by the harmful effects caused by extinguishing X. This has three significant implications: first, harm reduction need not be *anti*-abstinence. In fact, some harm reduction strategies can facilitate abstinence. For example, research evidence shows that the use of nicotine patches increases sustained abstinence (Schuurmans et al. 2004). And others can provide important pathways to it. For instance, safe injection rooms often provide information and referral services, connecting individuals with substance use disorders to health and social services. This enables them to explore options for reducing the harmful effects of drug use and, ultimately, overcoming addiction.

Second, the harm reduction critique of abstinence-oriented policies need not rest on a rejection of abstinence itself. Instead, it can assert that, even if abstinence is a desirable goal, the benefits of achieving it are outweighed by the harmful effects caused by enforcing it. For example, the 'war on drugs', whose goal is to stop substance use by criminalising such behaviour, has consistently faced strong opposition from harm reduction advocates. However, contrary to what is often suggested, this opposition need not be based on the belief that unrestricted drug use should be permitted. Instead, it can be grounded in the argument that the harmful effects of coercively enforcing abstinence outweigh its (presumptive) benefits. As Maia Szalavitz puts it:

> In the name of 'sending the right message' about certain drugs, we have caged people for decades, separated them from their children, taken their property, and denied them scholarships, medical care, housing, and other benefits, including food. We have deliberately allowed the spread of fatal diseases like HIV by denying access to clean needles and even information about how to reduce risk (Szalavitz 2021, 7–8).

Third, and relatedly, the harm reduction *priority claim*, whereby the moral priority is to reduce the harmful effects of high-risk and stigmatised behaviours, need not depend on an anti-abstinence commitment. As harm reduction advocates point out, abstinence is generally not a feasible

[9]For further discussion of why harm reduction is not necessarily incompatible with abstinence as a goal, see also Dea (2020) and Hoffman (2020).

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short-term goal (Szalavitz 2021, 159). Consequently, even if abstinence is considered a desirable long-term goal, the moral priority in the short term is to equip individuals who are unable or unwilling to refrain from engaging in high-risk and stigmatised behaviours with the tools necessary to reduce the negative consequences caused by such behaviours.

Based on this analysis, we are now able to provide a clear definition of harm reduction:

Harm reduction. Harm reduction is a social and public health approach that informs a set of public policies and practices whose primary goal is to reduce the health- and social-related harmful effects caused by high-risk and stigmatised behaviours at both the individual and social levels without necessarily attempting to extinguish the causing behaviours.

Part II: The Normative Question

Having addressed the analytical question by clarifying the scope and goals of harm reduction, we can now turn to the normative question: why should the state adopt harm reduction policies and practices? While harm reduction is commonly defended on consequentialist grounds, I will propose an alternative, relational egalitarian justification. My aim is not to reject consequentialist views of harm reduction but to demonstrate that harm reduction does not necessarily depend on a consequentialist framework. Instead, I will argue that relational egalitarianism offers additional and stronger reasons for why the state should support and promote harm reduction policies and practices.

The Consequentialist Justification for Harm Reduction

In this section, I introduce the standard consequentialist justification for harm reduction. Having the consequentialist justification more firmly in view will help us appreciate the different deontic relational egalitarian reasons in favour of harm reduction, which will be discussed in the subsequent sections.

Consequentialism is the view according to which 'what is best or right is whatever makes the world best in the future' (Sinnot-Armstrong 2023). It is therefore not surprising that many theorists have turned to consequentialism to justify harm reduction:

1. Harm reduction policies and practices effectively reduce the health- and social-related harmful effects caused by high-risk and stigmatised behaviours at both the individual and social levels.
2. Hence, by reducing harm, harm reduction policies and practices make the world better.
3. Therefore, harm reduction policies and practices are justified from a consequentialist standpoint.[10]

Consequentialism, however, is a family of views combining several distinct claims and commitments. For our purposes, it is important to highlight two key aspects of the consequentialist justification for harm reduction:

Instrumentalism. First, the core commitment of consequentialism is that 'whether an act is morally right depends only on consequences' (Sinnot-Armstrong 2023). Accordingly, an act, A, is justified only if and because A promotes the good or minimises the harm. A consequentialist framework, therefore, provides an *instrumental justification* for harm reduction policies and practices based on their positive consequences: specifically, they are justified only if and because they reduce the harmful effects of high-risk and stigmatised behaviours. Therefore, this justification of harm reduction is contingent upon empirical findings regarding whether these policies and practices lead to the intended positive outcomes.

[10]For consequentialist accounts of harm reduction, see Aceijas (2012), Dea (2020) and Marlatt (1996).

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Cost-benefit analysis. Second, when choosing between two acts, A_1 and A_2, consequentialists say that we should aggregate all costs and benefits of A_1 and A_2. That is, we should combine and weigh the benefits and costs to all individuals affected by A_1 and A_2 and choose the act that minimises the costs and maximises the benefits for the greatest number of individuals (Hansson 2007; Kelleher 2014). The commitment to cost-benefit analysis entails that harm reduction policies are justified only if the benefits of reducing harm outweigh its costs. As a proponent of consequentialist harm reduction puts it, 'each policy or programmatic decision is assessed for its expected impact on society. If a policy or program is expected to reduce aggregate harm it should be accepted; if it is expected to increase aggregate harm, it should be rejected' (Marlatt 1996, 780). Therefore, from a consequentialist perspective, harm reduction policies are justified only if they bring about the greatest benefits for the greatest number of individuals at the lowest cost.

In conclusion, from a consequentialist standpoint, the value of harm reduction policies and practices is instrumental and conditional on their consequences. More precisely, they are justified if and only if they are a cost-effective way to minimise the overall harm for the greatest number of individuals.

A Deontic Relational Egalitarian Justification for Harm Reduction

In what follows, I develop an alternative, deontic relational egalitarian justification for harm reduction. First, I introduce deontic relational egalitarianism. Next, I explore the various deontic relational egalitarian rationales for why the state should implement harm reduction policies and practices.

Deontic Relational Egalitarianism

Relational egalitarianism holds that the state must treat all its members as equals, and individuals must relate to one another as equals (Anderson 1999; Floris 2024a; Lippert-Rasmussen 2018; O'Neill 2008; Scheffler 2003; Schemmel 2021). For our purposes, it is important to distinguish between two versions of relational egalitarianism. *Telic* relational egalitarianism holds that 'it is, in itself, good (bad) if egalitarian (inegalitarian) relationships between people exist'. *Deontic* relational egalitarianism, instead, maintains that 'it is morally required that people relate as equals, not unequals' (Bengtson and Lippert-Rasmussen 2023, 392). From the deontic perspective, therefore, relational equality is not a personal or impersonal value that ought to be promoted. Rather, it is a view about justice: persons are moral equals and therefore should be considered and treated as such (Anderson 1999; Schemmel 2021). On this deontic framework, then, the state has a *duty of justice* to treat persons as equals. Or, equivalently, persons have a *right* to be treated as equals by the state, which cannot be violated to promote the common good.

This distinction highlights a significant difference between the consequentialist and deontic relational egalitarian justifications of institutional actions. The consequentialist framework justifies institutional actions based on a cost-benefit analysis to minimise costs and maximise benefits for the greatest number of individuals. By contrast, the deontic relational egalitarian approach holds that what matters is that institutional actions appropriately respond to persons' status as equals, regardless of whether they bring about the greatest benefits for the greatest number.[11]

At this point, the relevant question is: what is required of the state to treat persons as equals from a deontic relational egalitarian perspective? I argue that the state treats persons as equals if and only if its institutional actions satisfy the following two requirements:

1. *The expressivist requirement*. First, the state treats persons as equals if it *expresses* the appropriate or morally required attitudes towards persons as equals. As Schemmel puts it: 'What

[11]This is not to say that deontic relational egalitarianism denies that a policy should be 'cost-effective', other things being equal. However, cost-effectiveness is neither necessary nor sufficient for a policy to be justified.

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is primarily justice-relevant about the way institutions treat people is the *attitude* toward individuals and groups, and their standing toward each other, that is *expressed* in institutional action' (Schemmel 2021, 23).

To express attitudes means 'to take or reject certain considerations as reasons for action' (Anderson and Pildes 2000, 1520). Consider, for instance, racial segregation. In Jim Crow America, people of colour were prohibited from accessing certain facilities (for example, restaurants and restrooms) and were relegated to separate institutions (for example, schools and churches). These institutional actions were based on a racist principle that denies the equal moral worth of all persons. They assigned a position of inferiority to persons of colour within the social status hierarchy and subjected them to objectionable attitudes, including outright contempt and hostility. From the expressivist perspective, therefore, the wrongness of racial segregation lies not only in its causal consequences, such as the lack of opportunity for persons of colour to dine in certain restaurants, but also in its failure to express appropriate respect for individuals' status as equals (Anderson and Pildes 2000, 1542).

2. *The causal requirement*. Second the state treats individuals as equals if it provides them with the social conditions necessary to relate to others as equals. As Elizabeth Anderson puts it:

> Negatively, people are entitled to whatever capabilities are necessary to enable them to avoid or escape entanglement in oppressive social relationships. Positively, they are entitled to the capabilities necessary for functioning as an equal citizen in a democratic state (Anderson 1999, 316).

Therefore, from a deontic relational egalitarian perspective, institutional actions are justified if they enable persons to function as equals. Thus, the state should ensure that persons are not vulnerable to oppressive and unequal relationships, including domination, exploitation, and exclusion. Additionally, it should provide them with what they need to fully participate in society by exercising their political rights, engaging in social cooperation, and establishing meaningful social relationships.[12]

Overall, then, we can formulate the deontic relational egalitarian notion of equal treatment as follows:

> The state treats persons as equals if and only if it (i) expresses the appropriate and morally required attitudes towards them as equals (*expressivist requirement*), and (ii) enables them to function as equals (*causal requirement*).[13]

Based on this, I will now argue that harm reduction policies and practices satisfy both the expressivist requirement and the causal requirement. Accordingly, from a relational egalitarian perspective, the state should support these policies and practices not because they are a cost-effective way to minimise the harmful effects caused by high-risk and stigmatised behaviours, but because they are the appropriate response to the status of vulnerable individuals as equal members of society. I address the requirements of equal treatment in reverse order.

[12]I examine in greater detail what the state must do to enable persons to function as equals in Floris (2024b, forthcoming).

[13]Some might observe a potential tension between these two requirements, suggesting that relational egalitarians might have to endorse policies that better express equal concern and respect, even when their impact on individuals' ability to function as equals is minimal or inferior to alternative policies that are more effective but less expressively egalitarian.

Two points are worth noting in response: first, while there may indeed be a theoretical tension between the expressivist and causal requirements, as I will show below, in real-world contexts, most harm reduction policies tend to satisfy both requirements to a sufficient degree, thereby minimising the practical significance of such conflicts. Second, when these requirements come into conflict, relational egalitarians are not necessarily committed to prioritising a policy that better expresses equal concern and respect but has minimal impact on individuals' capability to function as equals. Instead, they should favour the policy that best balances and satisfies both requirements, other things being equal.

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The Causal Requirement

In this section, I argue that harm reduction policies and practices enable persons to function as equals in society. Therefore, the causal requirement provides an *instrumental* relational egalitarian rationale for harm reduction policies.[14]

To determine whether harm reduction policies and practices satisfy the causal requirement, we must first clarify what it means to function as equals in society. Anderson distinguishes three aspects of individual functioning: (1) as a human being; (2) as a participant in a system of cooperative production; and (3) as a citizen of a democratic state (Anderson 1999, 317). In what follows, I argue that harm reduction policies and practices contribute to each aspect of individual functioning, thus enabling persons to function as equals in society. I discuss these aspects in turn.

Most fundamentally, to function as a human being, an individual must have access to the means necessary to sustain their biological existence (Anderson 1999, 317). Therefore, by providing the tools necessary to minimise health-related harms caused by high-risk and stigmatised behaviours, harm reduction initiatives promote individuals' ability to function as human beings. For instance, ensuring that persons with substance use disorders have access to clean needles and that sex workers are provided with condoms significantly reduces the risk of infection by diseases like AIDS/HIV. Safe injection rooms offer a secure environment where people can inject drugs under medical supervision, thereby minimising the risk of overdose. Housing First programmes provide unconditional access to housing, eliminating requirements such as sobriety or participation in mental health treatment. This model mitigates numerous harms associated with homelessness, including exposure to violence, health complications from prolonged exposure to harsh environmental conditions, and an elevated risk of infectious diseases (Busch-Geertsema 2013; Collins et al. 2012, 23–24; Hawk et al. 2017, 2). These harm reduction services effectively assist vulnerable individuals in sustaining their biological existence; accordingly, their provision is essential for enabling them to function as human beings.

However, as outlined in Section 3, harm reduction policies aim to address both the health and social harmful effects of high-risk and stigmatised behaviours. Therefore, I argue that these policies also enhance individuals' ability to actively participate in social cooperation and engage in society as political agents.

Firstly, harm reduction policies provide persons who engage in high-risk and stigmatised behaviours with the opportunity to make meaningful social contributions by enabling them to contribute not only to their survival and well-being but also to the survival and well-being of others.[15] For instance, naloxone distribution empowers individuals to sustain others by saving their lives. Needle exchange sites allow drug users to protect themselves from infectious diseases by using clean needles while also making a significant contribution to the well-being and survival of others by preventing the reuse of used needles. Similarly, providing sex workers with condoms enables them to safeguard their health while also preventing the transmission of diseases to others. As they do so, drug users and sex workers play an active role in promoting public health within society, thus making a significant contribution to an important societal goal.

Secondly, harm reduction initiatives foster the active involvement of persons who engage in high-risk and stigmatised behaviours in the 'development, implementation, and delivery of

[14]This reveals that, contrary to what is sometimes suggested, a deontological perspective does not necessarily offer a *non-instrumental* justification for harm reduction policies independent of their consequences. For example, Natalie Stoljar's deontological account posits that harm reduction policies are justified because they promote dignity and autonomy. Stoljar argues that this deontological justification is preferable to a consequentialist one due to the latter's reliance on inconclusive empirical evidence about the effectiveness of harm reduction in achieving its goals (Stoljar 2020, 344). However, Stoljar's justification remains instrumental: it hinges on empirical findings about whether harm reduction policies effectively promote autonomy. Therefore, the independence of empirical evidence cannot serve as a valid reason to favour Stoljar's deontological justification over a consequentialist approach. As we will see in the next section, a genuine non-instrumental justification for harm reduction policies must focus on the attitudes expressed by such policies, independently of their consequences.

[15]On the need for human beings to contribute to the survival and well-being of others, see (Brownlee 2020, Ch. 3).

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policies and programmes' (Hoffman 2020, 340–341). First, the 'experiential knowledge' of affected individuals is recognised as a valuable source for developing policies and interventions. For example, the International Guidelines on HIV/AIDS and Human Rights stress the importance of drug users' participation in the policy design process (Klein 2020, 410). Furthermore, empirical evidence indicates that the experiential knowledge of former drug users enables them to 'identify "what works" in their communities, particularly where policymaking excludes such perspectives' (Klein 2020, 408). Second, empirical research shows that 'peer participation' is crucial to successfully implementing healthcare and social services targeted to persons who engage in high-risk and stigmatised behaviours. Specifically, peers' active role in service provision facilitates access to hard-to-reach populations, enhances users' engagement in services, and improves service outcomes (Chen, Yuan and Reed 2023).

Harm reduction initiatives, therefore, reduce the social-related harmful effects caused by high-risk and stigmatised behaviours by contributing to individuals' ability to participate in social cooperation and engage in society as political agents. In particular, they empower vulnerable individuals to make meaningful social contributions, including promoting public health within society, through individual actions or participation in the planning and delivery of social services, and contributing to the development and implementation of effective public policies.

However, harm reduction policies and practices support individuals' ability to function as equals in more ways than just enhancing social participation. They also serve as a vital source of *self-respect* and *social esteem*, shaping both how individuals engaging in high-risk and stigmatised behaviours perceive their status within society as well as how their status is perceived by other members of society. This is essential to achieving a society of equals, where everyone has a secure and robust belief in their equal standing and is valued as an equal by others. Let me discuss both aspects in turn.

It is common to distinguish between two kinds of self-respect: *recognition self-respect* and *evaluative self-esteem*. Recognition self-respect pertains to acknowledging one's moral status as an equal, while evaluative self-esteem involves a positive evaluation of one's own abilities and accomplishments (Dillon 1997; see also Rawls 1971, 440; Schemmel 2019).

Harm reduction policies can positively affect both kinds of self-respect. On the one hand, by providing support and empowering individuals engaged in high-risk and stigmatised behaviours to manage their health and survival, harm reduction policies reinforce recognition self-respect by allowing them to see themselves as equal members of society who are deserving of care (Szalavitz 2021, 171). On the other hand, by enabling individuals to make significant contributions to societal goods – such as enhancing public health and participating in the development and implementation of social policies – harm reduction policies help them recognise the importance of their roles and contributions. Consequently, these policies reinforce the notion that their involvement and impact matter, thereby bolstering their sense of self-esteem as individuals who contribute meaningfully to the well-being of others in society (Bathje et al. 2019, 126).

Relatedly, harm reduction policies enable individuals who engage in high-risk and stigmatised behaviours to become recipients of social esteem. Social esteem consists in 'the recognition of particular qualities of individuals insofar as these qualities can be recognized as capacities and achievements that contribute to socially shared goals' (Jutten 2017, 259). By facilitating individuals' engagement in activities that make positive and significant contributions to society – including saving lives through overdose prevention, and actively contributing to the delivery of social services like community support and education – harm reduction initiatives allow them to challenge and overcome negative stereotypes. These activities highlight their valuable role in addressing critical social issues and demonstrate their ability to contribute constructively to society. Therefore, harm reduction initiatives help vulnerable individuals, such as persons with substance use disorders, to be regarded not as burdens or useless members of society, but as knowledgeable and skilled individuals who can effect positive change and contribute to the well-being of the broader community (Chen, Yuan, and Reed 2023, 14).

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Respecting oneself as an equal and being recognised as a valuable social contributor are necessary conditions for standing in relations of equality with others. Accordingly, by providing important bases for self-respect and social esteem, harm reduction policies foster individuals' ability to relate to others as equals.

It might be objected that the implementation of harm reduction policies and strategies might face significant challenges that could undermine individuals' self-respect. For example, local communities might oppose the establishment of a needle exchange site in their area, leading to disrespectful treatment of individuals with substance use disorders and negatively affecting their sense of self-respect.

These challenges, however, do not undermine the argument in favour of the implementation of harm reduction policies for two reasons. First, rather than serving as a reason to reject harm reduction initiatives, these challenges highlight the state's broader responsibility not only to provide harm reduction services but also to create an environment where these services can succeed. This entails, for example, taking proactive measures to protect participants from disrespectful encounters and addressing community opposition through thoughtful planning and collaboration with local stakeholders. Second, it seems reasonable to hold that the moral significance of achieving the long-term benefits of harm reduction policies – such as reducing health risks and fostering individuals' capability to function as equals – often justifies enduring the initial resistance they may encounter, all things considered.

To conclude, from a relational egalitarian perspective, institutional actions are justified if they enable individuals to function as equals in society. In this section, I argued that harm reduction policies and practices satisfy this causal requirement: they provide individuals with the tools necessary to sustain their biological existence, make meaningful contributions to important societal goals, and participate in society as political agents. Furthermore, they serve as important sources of self-respect and social esteem, helping vulnerable individuals to consider themselves as equals and to be considered as equals by others. Accordingly, from a relational egalitarian standpoint, the state should implement harm reduction policies and practices to enable individuals who engage in high-risk and stigmatised behaviours to stand in relations of equality with other members of society.

The Expressivist Requirement

In this section, I argue that harm reduction policies also express the appropriate and morally required attitudes towards persons as equals. Therefore, the expressivist dimension provides a *non-instrumental* justification for harm reduction policies, independently of their consequences. This is an important finding because critics and sceptics of harm reduction often highlight the inconclusive or limited nature of the scientific evidence regarding its purported positive outcomes (Lancaster, Treloar, and Ritter 2017; May, Holloway, and Bennett 2019). Thus, by demonstrating that there are also intrinsic expressivist reasons for endorsing such policies – regardless of their expected positive effects – this finding offers a more robust and principled basis for supporting them.

To start with, it will be important to explain what kind of attitudes the state must express to treat persons as equals. As Anne-Sophie Greisen Hojlund points out, we can distinguish between two dimensions of treating persons as equals (Hojlund 2021, 522–523). First, the *interest dimension*: persons are treated as equals if their basic interests are given equal weight. For example, consider a society where buildings and public transport are not accessible to disabled people. By failing to require the public authorities and private sector to meet accessibility requirements, the state expresses an attitude of neglect towards disabled people's basic need for mobility. Therefore, the state does not treat disabled people as equals because it does not take their physical impairment as a reason for action.

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Second, the *agency dimension*: persons are treated as equals if their agency is equally respected. For instance, consider a society where individuals without a university degree are required to complete a politics course before the election period to ensure they have the necessary political knowledge to vote in their best interests. This paternalistic policy singles out some individuals as incapable of furthering their own interests, thereby failing to express equal respect for them as agents. Hence, it is incompatible with the ideal of relational equality.

Accordingly, the state treats persons as equals if it expresses (i) equal concern for their basic interests and/or (ii) equal respect for their agency. Based on this, I now argue that harm reduction policies treat persons as equals according to both dimensions. Let me address them in turn.

As discussed in Section 3, individuals engaging in high-risk and stigmatised behaviours, such as drug use and sex work, face significant risks that impact their health and well-being, including life-threatening diseases, mental health issues, and physical injuries. Therefore, I argue that refraining from enacting harm reduction policies that would minimise their vulnerability entails disregarding their basic interests as a reason for action, thereby failing to express appropriate concern for them as equals.

To illustrate this point, consider the following example. Imagine a person who intends to walk across a damaged bridge. Without any support, they are at risk of falling due to unstable footing or gaps in the bridge structure. Although you cannot prevent them from crossing, you can provide them with a rope, thus offering a means to stabilise their movement. They can hold onto the rope for balance, reducing the likelihood of losing their footing and falling into the gaps or off the bridge entirely. This additional support increases their safety by providing physical aid that mitigates the risks associated with crossing the damaged bridge.

If you do not provide the person with the rope, you fail to show appropriate concern for them because you refrain from taking their vulnerability to serious harm as a valid reason for action. Consequently, you convey objectionable attitudes of neglect and indifference towards their basic interests.

Similarly, I argue that when the state acknowledges that some individuals are particularly vulnerable to suffering from serious harm but fails to provide them with the necessary tools to mitigate these risks, it disregards their basic interests as a reason for action, thereby expressing a lack of appropriate concern for them as equals. In other words, by neglecting to or deliberately refraining from adopting harm reduction policies that reduce the risks for individuals who engage in high-risk and stigmatised behaviours, the state fails to treat them as equals. Instead, it displays a range of objectionable attitudes, from indifference and neglect of their basic interests at best to outright contempt for them at worst. As a harm reduction advocate puts it:

> In fact, one of the things that most infuriated me before I first got tested for HIV was the notion that what would ultimately kill me was my ignorance about how to protect myself, not just the virus itself. This was especially offensive to me for its being deliberate. [. . .] The information was being kept quiet on purpose out of fear that letting us avoid AIDS might possibly encourage some future children to try drugs. We were useful only to suffer and die as bad examples. (Szalavitz 2021, 11)

The promotion of harm reduction services, however, not only expresses equal concern for persons' basic interests but also conveys appropriate respect for them as agents. In particular, I suggest that, by implementing harm reduction policies, the state shows an attitude of *trust* in the volitional and cognitive abilities of persons who engage in high-risk and stigmatised behaviours to effectively advance their own interests.

To appreciate this, consider again the example of the person crossing a damaged bridge. If you throw a rope at them, you not only demonstrate concern for their basic interests but also show respect for them as an agent. Specifically, you display trust towards their basic agential capacity to make decisions in their interests, such as opting for the safer route. Indeed, if you were aware that

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the person lacked the ability to deliberate, or that, for some reason, they could not bring themselves to use the rope even if they understood it was the rational thing to do, providing it would be futile. This is because they would not possess the necessary cognitive and volitional abilities to make the right decision based on reasons and evidence.

Analogously, by providing people who engage in high-risk and stigmatised behaviours with the tools necessary to minimise the harmful effects of their behaviours, the state treats them as individuals who have the necessary agential capacities and willingness to choose safer options when faced with varying degrees of risk – such as using clean needles instead of used ones for drug injection, or practising safe sex with condoms rather than engaging in unprotected sex – thereby conveying an appropriate attitude of respect for their equal status as agents capable of effectively advancing their own interests.

This expression of respect is crucial because individuals who engage in high-risk and stigmatised behaviours are typically regarded as lacking basic agency altogether. For example, drug users are often treated as individuals who do not possess any capacity for control, deliberation, and the necessary willpower to pursue their interests. Consequently, they are seen as incapable or unwilling to make informed choices about their well-being or interests. By adopting harm reduction policies, however, the state recognises them as 'health conscious citizens' (Andersen and Jarvinen 2007, 243), capable of making informed decisions based on public advice and scientific evidence to mitigate harmful consequences. Therefore, such policies convey an appropriate attitude of respect for their equal status as agents who can successfully pursue their own interests.

At this point, however, it might be objected that it is often difficult to determine the attitudes expressed by specific policies. For instance, a government might adopt harm reduction policies as a means of reducing healthcare costs, without explicitly indicating concern for the interests of vulnerable individuals. Similarly, the provision of clean needles to individuals with substance use disorders might not necessarily express trust in their agency. It could instead convey an objectionable attitude of distrust towards their ability and willingness to overcome addiction – 'addicts will always be addicts, so the best we can do is to provide them with clean needles'.

In response, it is important to note that assessing the expressive dimension of institutional actions involves determining their shared public understanding and meaning. This meaning does not depend (exclusively) on the intention of the policymakers, but (also) on the broader social and political context in which these actions are implemented (Anderson and Pildes 2000, 1512–1513). For example, consider the practice of providing clean needles to individuals with substance use disorders. In a society where clean needles are provided, but individuals with substance use disorders are denied access to basic healthcare, this practice may not reflect a genuine concern for their welfare; rather, it could be seen as a cost-minimisation strategy. By contrast, in a society where clean needles are part of a comprehensive healthcare system that includes free and accessible treatment, the same practice would likely be understood as expressing genuine concern for the basic interests of individuals with substance use disorders.

It follows from this that while harm reduction policies and practices, like other institutional actions, might not always express the appropriate attitudes, they do express appropriate concern and respect for individuals as equals in certain social contexts – specifically, when integrated into a broader framework of comprehensive healthcare and social policies aimed at addressing the systemic disadvantages faced by vulnerable and marginalised individuals.

To conclude, in this section, I argued that harm reduction policies and practices express the appropriate and morally required attitudes towards persons who engage in high-risk and stigmatised behaviours *qua* equals. These measures display equal concern for them by taking their basic interests as valid reasons for action. They also convey equal respect for them *qua* agents by showing trust in their cognitive and volitional abilities to further their own interests. Therefore, by implementing harm reduction policies, the state responds appropriately to their status as equals.

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Conclusion

Harm reduction is one of the most controversial and widely discussed approaches in public health and social policy, addressing a broad range of pressing societal issues, including drug addiction, sex work, alcohol and tobacco use, and homelessness. Surprisingly, however, harm reduction has so far received very little philosophical scrutiny. In this article, I attempted to address this lacuna.

First, I clarified what harm reduction exactly is by providing a systematic analysis of its core features and normative commitments. I argued that harm reduction is a social and public health approach that informs a set of public policies and practices whose primary goal is to reduce the health- and social-related harmful effects caused by high-risk and stigmatised behaviours at both the individual and social levels without necessarily attempting to extinguish the causing behaviours.

Second, I developed a novel, deontic relational egalitarian justification for harm reduction. I argued that the state should adopt harm reduction policies and practices because (i) they express equal concern and respect for persons, and (ii) enable them to function as equals in society. The upshot is that the provision of harm reduction services is not solely or primarily a matter of mitigating the negative consequences associated with high-risk and stigmatised behaviours. Rather, most fundamentally, it is the appropriate response to the status of vulnerable individuals as equal members of society.

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