Moral Injury, Permissive Drug Policy, and the Misuse of Harm Reduction:

A Synoptic Review of the Impact

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Abstract

Moral injury is typically defined as the psychological, social, and spiritual harm that follows perceived violations of deeply held moral beliefs or obligations. In the arena of substance use, the concept has begun to appear not only as an outcome of trauma-related coping, but also as a direct feature of substance use disorder itself, especially where drug-seeking, intoxication-related conduct, betrayal, neglect, violence, and parental failure collide with a person's moral commitments (Van Denend et al., 2022).

At the policy level, this framework raises a pressing question:

> **CAN PERMISSIVE DRUG POLICY, OR THE MISUSE OF HARM REDUCTION POLICY AS AN IDEOLOGY OF NORMALISATION, INTENSIFY MORAL INJURY IN USERS, FAMILIES, NEIGHBOURHOODS, AND FRONT-LINE WORKERS?**

Existing evidence does not justify a wholesale rejection of harm reduction because major agencies such as the World Health Organization and the United Nations Office on Drugs and Crime treat it as one part of a broader public-health response. A policy practice rightly placed and utilised in a continuum of care that should sit alongside prevention, treatment, recovery, and social reintegration *(United Nations Office on Drugs and Crime [UNODC], 2024; World Health Organization [WHO], 2014).* However, the literature does support a narrower but serious claim: where harm reduction is detached from the continuum of care, specifically, recovery-oriented care, and tacitly underwrites cultural normalisation, or becomes a substitute for demand reduction and treatment, it can contribute to an environment in which drug-related harms are socially managed rather than genuinely reduced, with downstream moral and communal consequences *(Erickson & Hathaway, 2010; UNODC, 2024; WHO, 2014).*

Introduction

Public discussion of drug policy is often polarized between prohibitionist and libertarian frames, with harm reduction either celebrated as humane pragmatism or criticized as tacit surrender. This binary obscures an important distinction between evidence-based harm reduction as a limited public-health intervention and the misuse of harm reduction rhetoric to normalise drug consumption, weaken moral norms, and lower policy ambition regarding recovery, abstinence, and family stability *(Erickson & Hathaway, 2010; WHO, 2014)*.

The emerging literature on moral injury provides a useful lens for analysing these questions. *Van Denend et al. (2022)* argue that moral injury in substance use disorders may arise when compulsive substance-seeking and substance-related conduct collide with a person's own moral code, producing guilt, shame, worthlessness, impaired self-forgiveness, and loss of meaning. Their review found only a small body of direct studies, but it identified plausible mechanisms by which addiction can generate recurrent morally injurious experiences, including acts committed while intoxicated, interpersonal harms, failures of care, and chronic shame *(Van Denend et al., 2022)*.

If drug policy settings alter the prevalence, visibility, acceptability, or management of such behaviours, they may also affect the burden of moral injury carried by individuals and communities *(Erickson & Hathaway, 2010; Van Denend et al., 2022)*.

Moral injury and substance use disorders

Moral injury was first elaborated in military settings, where individuals experience profound distress after perpetrating, witnessing, or failing to prevent actions that violate core moral commitments. The concept has since been extended to health care, education, law enforcement, refugee experience, and other civilian domains where institutional pressures and survival needs can force action against conscience *(Van Denend et al., 2022)*. In substance use disorders, the same structure appears when the drive to obtain and consume a drug collides with obligations to children, spouses, employers, neighbours, and the self *(Van Denend et al., 2022)*.

The most significant review currently available found five directly relevant manuscripts on moral injury arising within substance use contexts, most of them qualitative and small in scale *(Van Denend et al., 2022)*. Yet even this limited literature identified recurring patterns: persons in treatment or long-term recovery described guilt and shame about actions taken while intoxicated, harms caused to others, and a sense that substance use had violated their deepest commitments *(Van Denend et al., 2022)*.

The review also noted that social stigma, housing instability, hospitalisation, food insecurity, and unemployment may intensify this moral burden by compounding the interpersonal and social fallout of addiction *(Van Denend et al., 2022)*.

This matters for policy because moral injury is not reducible to measurable morbidity alone. A drug policy may lessen one acute harm while leaving intact, or even obscuring, the slow accrual of guilt, betrayal, relational fracture, and civic disorder that reshapes a community's moral world. Policy analysis that counts overdoses, infections, or arrests but ignores shame, grief, parental fear, and normalised disorder captures only part of the social cost of addiction *(Van Denend et al., 2022; WHO, 2014)*.

Harm reduction: what the evidence does and does not support

> ***WHO (2014)* DESCRIBES DRUG USE DISORDERS AS COMPLEX CONDITIONS WITH PSYCHOSOCIAL, ENVIRONMENTAL, AND BIOLOGICAL DETERMINANTS THAT ARE BEST MANAGED WITHIN A PUBLIC-HEALTH SYSTEM, AND IT ARGUES THAT EFFECTIVE RESPONSES SHOULD INTEGRATE PREVENTION, TREATMENT, AND CARE IN WAYS THAT REDUCE HARMS TO INDIVIDUALS, FAMILIES, COMMUNITIES, AND SOCIETIES.**

UNODC (2024) similarly presents harm reduction as one component of a comprehensive system, not as a complete philosophy of drug policy, and links it to reduced HIV transmission, improved health outcomes, and broader social benefit when properly embedded in treatment and public-health responses. These positions do not support caricatures that dismiss every harm reduction measure as permissive capitulation *(UNODC, 2024; WHO, 2014)*.

At the same time, the literature on normalisation warns that an “affinity” between harm reduction and drug normalisation is often assumed rather than rigorously examined *(Erickson & Hathaway, 2010)*. *Erickson and Hathaway (2010)* argue that by concentrating policy attention on the most serious harms among the highest-risk subpopulations, harm reduction discourse may neglect broader questions about substance use, risk, and social context across the wider population.

Their analysis is especially important because it shows that harm reduction can function in two different registers: as a bounded set of interventions to keep people alive, or as a cultural script that shifts public expectations from discouraging drug use to accommodating it.

That distinction is pivotal. Evidence-based harm reduction includes interventions such as overdose reversal, needle and syringe programs, and treatment access for opioid dependence; these respond to real morbidity and mortality and are consistent with a humane public-health ethic *(UNODC, 2024; WHO, 2014)*. The misuse of harm reduction begins when the language of compassion is used to mute judgment about growing drug consumption, to underinvest in prevention and recovery, or to portray social tolerance of open drug use as evidence-based simply because some individual harms are mitigated. These have been found to be key drivers in increasing permission models all continuing to normalize substance use – a clear agenda of many pro-drug using lobbies. *(Erickson & Hathaway, 2010; WHO, 2014)*.

Permissive policy and the production of moral injury

A permissive policy environment does not create addiction by itself, but it can alter moral ecology: the network of norms, sanctions, expectations, and institutional messages that shape how communities understand vice, vulnerability, responsibility, and repair. Where policy signals imply that persistent drug use is an ordinary lifestyle choice rather than a destructive disorder requiring interruption and treatment, users may receive less external pressure toward recovery while families bear greater pressure to accommodate recurring chaos, theft, fear, and neglect *(Erickson & Hathaway, 2010; Van Denend et al., 2022)*

On the individual level, this may prolong the cycle described in the moral injury literature. The substance-dependent person continues to act against conscience, harming relationships and self-respect, while also receiving public messages that soften the seriousness of the conduct or recast it as merely one variant of consumer behaviour *(Erickson & Hathaway, 2010; Van Denend et al., 2022)*. This mismatch can deepen fragmentation rather than heal it: the conscience is not quieted by rhetorical normalisation, because guilt and shame arise precisely from the person's awareness that real duties to family, employer and/or community have been violated *(Van Denend et al., 2022)*.

On the familial level, permissive policy may intensify moral injury through chronic exposure to betrayal and helplessness. WHO (2014) notes that untreated drug use disorders impose costs not only on individuals but also through social welfare burdens, criminal justice costs, lost productivity, and other social consequences, while effective care is an investment in the safe development of families and communities. The inverse is therefore also plausible: when policy settings tolerate entrenched disorder (or open greater entrance to this space with permissive drug policy) without adequately expanding treatment and recovery pathways, spouses, parents, children, and neighbours are left to absorb repeated harms that are not easily captured in standard epidemiological indicators (Van Denend et al., 2022; WHO, 2014).

On the communal level, permissiveness can normalise visible disorder and weaken confidence that authorities still recognize shared obligations. UNODC's World Drug Report 2025 states that organized drug trafficking groups continue to adapt, exploit global crises, and target vulnerable populations (UNODC, 2025).

Where local policy communication emphasises accommodation more than prevention, enforcement, or exit pathways from dependence, communities may experience a form of collective moral injury: the sense that institutions charged with protecting the vulnerable have ceased to contest destructive norms with sufficient seriousness (Erickson & Hathaway, 2010; UNODC, 2025).

Misusing harm reduction for drug use ‘normalisation’

The strongest evidence-based criticism is therefore not that harm reduction is intrinsically wrong, but that it is easily distorted when removed from a balanced harm-minimisation framework in the continuum of care. *WHO (2014)* expressly supports comprehensive approaches that reduce demand, relieve suffering, and decrease drug-related harm, which implies that treatment and prevention remain integral rather than optional. *UNODC (2024)* also situates harm reduction within a wider architecture of health responses and does not present it as a rationale for cultural indifference to drug use itself.

Misuse occurs in at least four ways.

→ First, harm reduction is misused when emergency measures become the dominant moral horizon of policy, so that ‘keeping people alive’ is treated as sufficient even when little is done to restore responsibility, treatment access, and social functioning *(UNODC, 2024; WHO, 2014).*

→ Second, it is misused when reduced acute harms are rhetorically inflated into evidence that broader permissiveness is beneficial, despite the literature’s own warning that normalisation and harm reduction are not straightforwardly aligned *(Erickson & Hathaway, 2010).*

→ Third, it is misused when officials invoke compassion selectively, showing concern for the user's immediate safety while neglecting the spouse, child, elder, shopkeeper, or neighbour who bears the cumulative burdens of intimidation, theft, exposure, disorder and often violence *(Van Denend et al., 2022; WHO, 2014)*.

→ Fourth, it is misused when it displaces moral language entirely, as though every appeal to virtue, abstinence, self-command, or communal norms were necessarily punitive rather than potentially protective and restorative *(Erickson & Hathaway, 2010; Van Denend et al., 2022)*.

This argument requires careful qualification. The evidence gathered here does not show that needle exchange (not needle distribution – a distorted and unaccountable drug use enabling and equipping vehicle), overdose prevention, or medication-assisted treatment inherently normalise drug use; on the contrary, major health bodies treat these as legitimate interventions within a comprehensive care model *(UNODC, 2024; WHO, 2014)*.

The problem arises when political actors, service systems, or advocacy cultures treat such interventions as sufficient in themselves, or reinterpret them as proof that long-term drug use can be indefinitely stabilised without profound moral, relational, and civic cost *(Erickson & Hathaway, 2010; Van Denend et al., 2022)*.

Communities, families, and intergenerational injury

One of the central weaknesses in drug policy debate is the under-description of family harm. *WHO (2014)* states that untreated drug use disorders generate lost productivity, health expenditure, criminal justice costs, social welfare burdens, and other social consequences, and it explicitly frames effective treatment as an investment in the healthy and safe development of families and communities. This recognition should be expanded conceptually: family members do not only experience burden; they often endure repeated moral injuries through deception, intimidation, financial exploitation, emotional abandonment, and forced complicity in another's self-destruction *(Van Denend et al., 2022; WHO, 2014)*.

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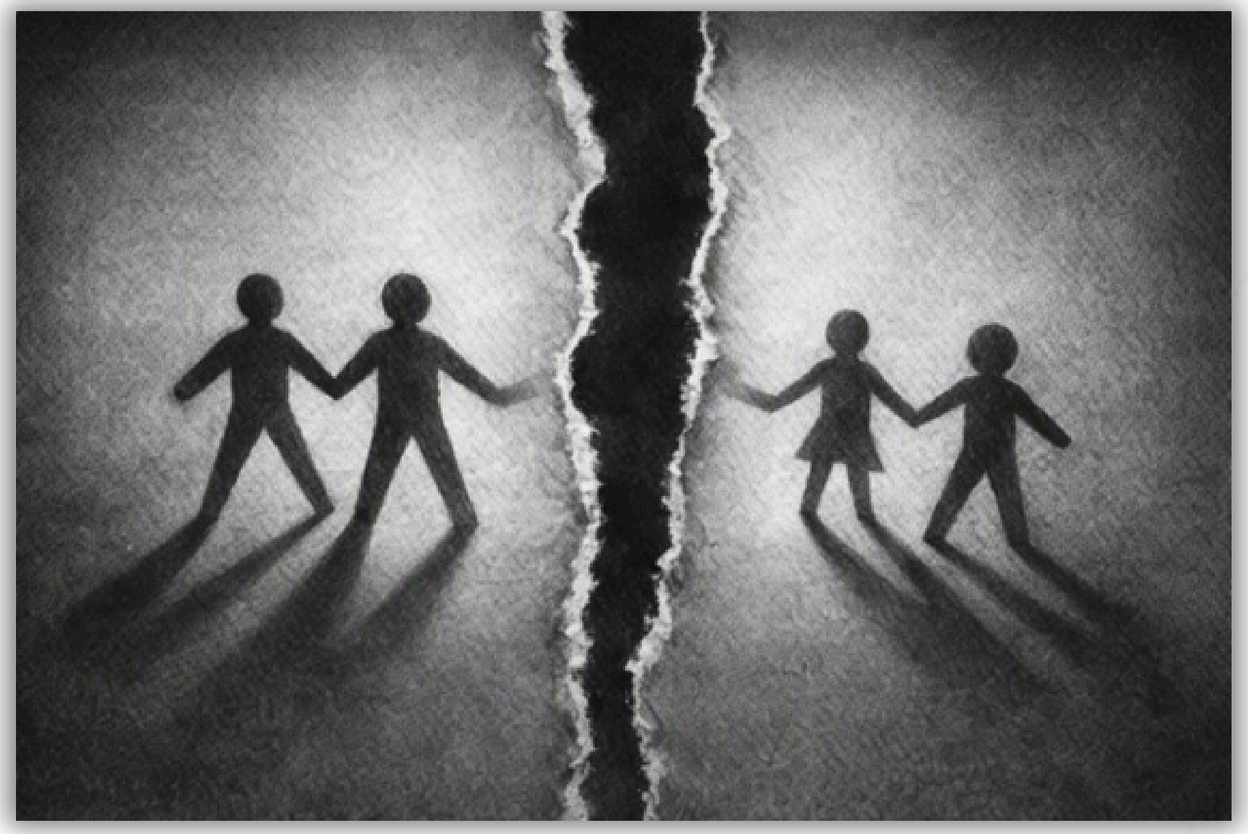
This does not deny the harms of overly punitive systems. It instead argues that the opposite error is equally possible: a sentimental or managerial approach that reduces persons to risk profiles and communities to sites of service delivery, while failing to defend the goods of sobriety, fidelity, safety, work, and trust that make communal life possible *(Erickson & Hathaway, 2010; UNODC, 2024; WHO, 2014).*



Policy implications

An evidence-based position should reject both simplistic prohibitionism and simplistic permissiveness. The available sources support a comprehensive framework in which harm reduction remains available for acute risk reduction, but is explicitly subordinated to wider goals of prevention, treatment, recovery, family preservation, and community restoration *(UNODC, 2024; WHO, 2014)*. Such a framework would better address moral injury because it neither abandons people to overdose and infection nor resigns them, their families, or their neighbourhoods to endless managed dependency *(Van Denend et al., 2022; WHO, 2014)*.

Several policy implications follow.

→ Harm reduction services should be structurally tied to treatment assessment, recovery planning, and assertive pathways into care rather than operating as morally and clinically self-contained endpoints *(UNODC, 2024; WHO, 2014)*.
Exiting substance use into abstinence which ends the contagion for ongoing harms (and the centre of all seven Adverse Childhood Experiences) is the continuum of care's Gold Standard end point, not mere managed decline in ongoing substance use.

- Public messaging should distinguish clearly between reducing immediate harms and endorsing ongoing drug use; failure to maintain this distinction risks reinforcing normalisation *(Erickson & Hathaway, 2010; UNODC, 2024).*

- Outcome evaluation should include family and community indicators, not merely individual biomedical measures; otherwise major social and moral harms remain invisible *(Van Denend et al., 2022; WHO, 2014).*

- Research agendas should examine moral injury in spouses, parents, children, service providers, police, educators, and local residents in high-burden settings, because current literature is still narrow and underdeveloped *(Van Denend et al., 2022).*

- Drug policy should recover moral language in a non-stigmatizing form, naming destructive conduct truthfully while also preserving the dignity and treatability of persons with substance use disorders *(Van Denend et al., 2022; WHO, 2014).*

Conclusion

The current evidence does not support the blanket claim that harm reduction itself is a driver of social decay. It does, however, support a substantial and academically defensible argument that permissive drug policy, and especially the misuse of harm reduction as a vehicle for normalization, can deepen moral injury in users and diffuse that injury across families and communities *(Erickson & Hathaway, 2010; UNODC, 2024; Van Denend et al., 2022; WHO, 2014).* The clearest lesson from the available literature is that humane policy must do more than prevent death in the moment; it must also contest the social conditions, institutional messages, and moral evasions that allow addiction to become chronic, normalized, and civically inherited *(Erickson & Hathaway, 2010; UNODC, 2025; Van Denend et al., 2022).*

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