Ethics in Substance Use Disorder Treatment

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Substance use disorders (SUDs) constitute one of the most prevalent, destructive, and urgent public health problems facing American society today. According to the National Survey on Drug Use and Health 22.3 million people amounting to 9% of the population met DMS-IV criteria for substance abuse or dependence (excluding nicotine) in 2006, with 3.2 million abusing or dependent on both alcohol and illicit drugs, 3.7 million with only illicit drug abuse or dependence, and 15.5 million diagnosed with alcohol abuse or dependence. For psychiatrists it is significant that the rate of serious psychologic distress (SPD) during the year before the survey was 5.4 million (22%) among those adults also diagnosed with substance abuse or dependence in the past year. The comparable figure for SPD among adults who did not have substance use disorders was 15 million (7.6%).\textsuperscript{1}

In economic terms, illicit drug–related costs were estimated at $180.9 billion in 2002. This figure encompassed expenditures due to use of health care and criminal justice resources and lost productivity because of disability and death.\textsuperscript{2} The estimated cost to society of alcohol abuse and dependence in the United States for the year 1998 was $184.6 billion, including treatment services, medical consequences, lost earnings, and criminal justice costs.\textsuperscript{3} Although staggering, the financial expenses pale before the human toll of tobacco, alcohol, and drug abuse. McGinnis calculated that one quarter of all the deaths in the United States (590,000) are attributable to substance abuse and dependence (including nicotine dependence), and 40 million injuries and illnesses a year compound mortality by morbidity.\textsuperscript{4}

In the realm of mental health and psychosocial consequences the numbers are equally distressing. Thirty-one percent of America’s homeless are believed to suffer from drug or alcohol problems.\textsuperscript{4} Perhaps 60% of adults in federal prison are incarcerated for drug-related crimes\textsuperscript{4} and half of adults arrested for major offenses, such as

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homicide and theft, are under the influence of drugs at the time of the crime. Some 10% to 20% of motor vehicle accidents according to the National Traffic and Safety Administration involve alcohol. SUD is a well-recognized risk factor for suicide, particularly for Native Americans. Between 40% and 60% of those who commit suicide are intoxicated at the time of death.

Given the pervasiveness of substance use disorders, nearly all mental health professionals in the country are at some time in their careers and in some aspect of their practices confronted with ethical dilemmas related to the care of people who have SUDs. Clinicians working in specialty substance use facilities may face conflicts between protecting the confidentiality of patients who engage in violent behavior on the premises and ensuring the safety of staff. General psychiatrists are likely treat patients who consent to treatment with medications or therapy for SUDs but request that those diagnoses and prescriptions not be documented in the record or reported to an involved third party, such as insurer or employer.

The ethics of SUD treatment are based on the principles and theories, virtues and values of the broader category of medical or clinical ethics, itself a division of the general discipline of bioethics. There are, however, important nuances in the application of the core principles of medical ethics to the field of addictions or substance abuse treatment that create distinctive ethical dilemmas summarized in Table 1.

These distinctions are less in content than in application and are grounded in the complex cultural, political, social, and religious matrix in which addiction has been historically embedded, particularly in the United States. Three salient features of that distinctiveness frame this review of ethics in substance use disorders treatment. The first is social stigma and the way it has influenced confidentiality protections in substance use treatment and research. The second is the role of autonomy and personal responsibility as it relates to informed consent and decisional capacity. The third is social justice as manifested in the struggle for parity. These features are examined through an analysis of three key areas of substance abuse treatment, which are among the most ethically laden and the most commonly encountered in clinical care: confidentiality, informed consent, and social justice.

CONFIDENTIALITY

Link has defined stigma as “a negative social value associated with a personal attribute that has consequences in thoughts, emotions and/or behaviors.” Religious beliefs, cultural attitudes, legal views, and political policies all contribute to the stigma attached to most mental health conditions but in particular to substance use disorders. Stigmatization and its political expression in discrimination negatively affect all aspects of addiction care from diagnosis to treatment and from education to funding. Studies show that stigma adversely affects the well-being of people who have addiction even after recovery and that large segments of society, despite public education campaigns, view individuals who have SUDs as unpredictable, dangerous, and responsible for their afflictions. Because of disparaging cultural stereotypes stigma is particularly intense and painful for women who abuse substances. Legal action has been taken against pregnant women and mothers who abuse substances, and they risk losing their children and their freedom.

In recognition of the detrimental effect of addiction-related stigma, confidentiality rules and regulations are stricter and more protective even than those applied to mental health information. Two main statutes determine the circumstances and conditions under which information pertaining to addictions treatment may be disclosed. The first regulation is the Confidentiality of Alcohol and Drug Abuse Patient Records,
Part 2 of Title 42 (Public Health Code) of the Code of Federal Regulations (CFR). The second is the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), Parts 160 and 164 of Title 45 (Public Welfare) of the Code of Federal Regulations. These regulations have precedence over all other state, federal, local and institutional rulings and policies. The rationale for these tighter safeguards is to encourage patients to discuss their substance use and its deleterious consequences fully and honestly as a means of facilitating accurate diagnosis and effective treatment. Without protection of confidentiality, disclosure of substance abuse information could lead to criminal action, loss of employment or insurance, disruption of close relationships, or family conflicts. It is incumbent upon mental health professionals working in the area of addictions to familiarize themselves with these regulations and applicable state law and to have ready access to legal advice for instances in which the regulations are unclear or contradict other legal requirements.

At first glance the rigor of these regulations may seem to impede high-quality clinical care, which requires obtaining collateral information, coordinating mental health and medical treatment, and obtaining social services for people who have addiction. Clinicians may also wonder how they are to manage competing ethical demands, such as respect for people and autonomy, nonmaleficence, truth-telling, beneficence, and justice, because these principles apply to both the patient and the public. Cognizant of these competing demands, the regulations do allow for the type of public health exceptions that mental health clinicians expect, such as reporting of the abuse of children and incompetent elders, suicidal and homicidal threats, true medical emergencies, and infectious disease reporting. The standard HIPAA provisions that apply to medical care, such as appropriately authorized research, program auditing or

<table>
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<th>Application</th>
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<td>Autonomy or self-determination</td>
<td>A patient in the medical ICU for her fifth admission for an upper gastrointestinal bleed in 1 year refuses admission to an inpatient addiction psychiatry unit.</td>
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<td>Beneficence</td>
<td>An addiction therapist is counseling a patient from a rural area who must travel several hours to the sessions. He believes it is in the best interest of the patient to be admitted to a residential program, which is restricted to patients who have failed outpatient treatment. The therapist advocates for the patient's admission.</td>
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<tr>
<td>Nonmaleficence</td>
<td>A patient who has ADHD and methamphetamine dependence asks his psychiatrist to prescribe a stimulant so he won’t self-medicate with illicit drugs.</td>
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<tr>
<td>Justice</td>
<td>A patient who has cocaine dependence who has failed outpatient treatment several times is denied admission to a long-term residential program because his insurance company states it is not clinically indicated.</td>
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<tr>
<td>Respect for people</td>
<td>An Iraq veteran who has PTSD and chronic pain from an intermittent explosive device requests a refill of his opioids 2 days early and is told he is a “drug addict.”</td>
</tr>
<tr>
<td>Truth-telling</td>
<td>A nurse on a geriatric ward is abusing opioids and promises she will enter monitored treatment if her nurse manager does not report her to the nursing board.</td>
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| Abbreviations: ADHD, attention deficit hyperactivity disorder; PTSD, posttraumatic stress disorder. |
evaluation, disclosure to a qualified service organization assisting the program, communication among treatment staff for purposes of care, and communication with outside entities that support the program, are permitted for substance abuse information as well.\textsuperscript{16}

Many ethical dilemmas can be avoided or at least attenuated if practitioners educate and counsel patients at the start of treatment regarding the limitations of confidentiality particularly when the legal system is involved. Such a dialog can build a spirit of trust while honoring the letter of the law. Similarly, when releasing substance abuse information, even with patient consent, awareness of the greater stigma and potential adverse impact of such releases cautions the provider to document with prudence and discretion and to report only those data necessary to achieve the purpose of the disclosure. Collaborating with patients at the initiation of treatment and on the occasion of any significant disclosure to determine the content of disclosures, alternative treatment options, and means of minimizing the harm respects patient interests even when the involvement of third parties limits privacy and autonomy. Patients who have security clearances, high-profile social or professional positions, or those who have strained family relationships may at times request that clinicians keep a “shadow chart” or “doctor the record.” While empathizing with the patient’s concerns, professionals should avoid such “work-arounds” because they render the professional legally vulnerable and ethically suspect. Important medical and psychiatric information that directly affects clinical care should always be documented in the medical record in a nonjudgmental and factual manner.\textsuperscript{17}

The most ethically problematic disclosures involve exceptions specific to addictions treatment. Once a patient initiates contact with a substance use treatment facility, his identity as a person with an addictive disorder cannot be disclosed unless the circumstances meet the exceptions mentioned earlier. This restriction applies even if the patient does not appear for the initial intake or subsequently leaves the program. One of the most difficult confidentiality situations is when a client of a substance abuse program threatens a staff member or commits a crime on the premises of the facility. In such cases the identity of the patient and his status as a patient in substance abuse treatment can be reported to law enforcement. But no past criminal activity can be disclosed even if the information pertains to unsolved cases.\textsuperscript{16} Another problematic and all too common situation occurs when patients present intoxicated to substance use programs and staff must balance privacy considerations with the need to protect the public from impaired drivers. Patients can be given the opportunity to stay at the facility until safe to drive or be provided with safe transport home. Should patients refuse all reasonable options, staff can report patients to the local motor vehicle department or notify police without revealing that the patients suffers from an addictive disorder.\textsuperscript{18}

This legally heightened duty to respect the confidentiality of substance-abusing patients frequently comes into conflict with the equally important obligation to truth telling. Nowhere are these conflicts more challenging than in the intersection with the criminal justice system. Here the regulations provide immense help to clinicians because they protect even patients whose treatment is mandated unless a prior formal waiver of the restrictions is obtained as part of the judicial process in adjudication, probation, or parole. To safeguard the integrity of the therapeutic relationship, clinicians are well advised to limit disclosures to criminal justice entities to treatment participation reports or homicidal or suicidal threats.\textsuperscript{13} Clinicians often experience moral distress when confronted with patients for whom failure to adhere to treatment, whether through positive toxicology screens or missed appointments, results in adverse personal, occupational, social, or legal consequences. In attempting to
resolve such ethical dilemmas, it is often helpful for health professionals to remember that their primary commitment is to the good of the patient, whereas the primary obligation of police and the courts is to protect public safety and enforce the law. This recognition allows practitioners to approach lapses in treatment in a therapeutic context while not inappropriately shielding patients from the short-term ramifications of their own behavior that may in fact benefit them their recovery in the long run.\textsuperscript{19}

**INFORMED CONSENT AND DECISIONAL CAPACITY**

The legal and ethical mandate to obtain informed consent from patients for all medical treatment, including psychotherapy and counseling, is grounded in the ethical principles of respect for people and autonomy. True informed consent requires the clinician provide adequate patient-centered information, including at minimum the diagnosis, proposed treatment with its attendant risks and benefits, and alternatives to the treatment, including no intervention. Informed consent also necessitates that patients have intact decision-making capacity and voluntarism to process and act on the information.\textsuperscript{20} The traditional model of decisional capacity assesses the patient’s ability to communicate a choice, to comprehend information, to reason about options, risks, and benefits, and to appreciate the effect of choices on their life course and values.\textsuperscript{21} The patient must also possess voluntarism, the capacity to exercise self-determination without undue internal or external coercion.\textsuperscript{22} SUDs present specific challenges for this established formulation of informed consent in the key areas of cognitive deficits related to information processing and neurobiologic and psychosocial threats to decisional capacity and voluntarism.

Research is increasingly recognizing addiction as a biobehavioral disorder that calls into question the long-held moral view of addiction as either a character flaw or a social problem, each with its own ethical valence.\textsuperscript{23} Although this medicalizing of substance abuse does have the potential to reduce personal stigma and social shame, it also calls into question the assumptions of autonomy and personal responsibility that underlie many forms of treatment and recent drug control policy with its forensic emphasis. These advances in the biology and psychology of addiction also suggest that individuals who use substances chronically or heavily may have cognitive and volitional impairments that reduce their ability to provide informed consent or refusal for treatment and research, and may even diminish their free will to reduce or stop abusing substances despite recognition of their devastating consequences.\textsuperscript{24–26}

In a 2007 presentation, Nora Volkow, director of the National Institute of Drug Abuse, discussed the results of a 2006 study published in the *Journal of Neuroscience*, which explored craving and conditioned responses to drugs of abuse operating on the reward pathway.\textsuperscript{27} Eighteen subjects who had cocaine addiction were tested using PET scanning and a dopamine D2 receptor radioligand that competes with endogenous dopamine. Comparative changes in specific dopamine binding when subjects watched a video of people smoking cocaine were measured to elucidate further the mechanisms of cocaine cuing triggering dopamine release and craving. Binding of the radioligand in the dorsal, but not ventral, striatum was significantly reduced in the cocaine cue condition, indicating increased dopamine receptor binding, and the degree of reduction correlated with self-reported craving. Volkow and others have demonstrated that subjects with the highest scores on measures of withdrawal symptoms and addiction severity had the most dramatic changes in dopamine.

In commenting on these and similar findings of earlier studies Dr. Volkow stated, “We have come to see addiction as a disease that involves the destruction of multiple
systems in the brain that are more or less able to compensate for one another." Volkow further commented that, "When the pathology erodes the various systems, you disrupt the ability to compensate, and the addictive disease erodes and destroys the life of the individual." Chronic addiction may diminish, and even perhaps eliminate, the individual's capacity for rational and voluntary choice so critical for informed consent and the motivation and ability to change integral to addiction treatment.

Compounding these deficits in cognition are many of the behavioral manifestations of addiction that may adversely affect motivations and choices underlying patient participation in treatment and research, calling into serious question the degree to which participation is voluntary or susceptible to coercion. Craving, sensitization, withdrawal states, and habituation all can reduce subjects' ability to exercise free will. Various potentially coercive forces impinge on people with addictions, including legal pressure, family and social stressors, uncontrollable craving, withdrawal symptoms, desperation, feelings of powerlessness with respect to authority figures such as care providers and researchers, social stigmatization, depression, anxiety, and poverty. At least four studies have examined participants' reasons for participation in addiction treatment, shedding some light on the question of voluntarism in consent. Wild and colleagues surveyed 300 participants entering SUD treatment. Not all mandated participants experienced their participation as coercive, whereas many self-referred participants did identify coercive psychologic factors. The degree of substance dependence did not correlate with the level of coercion perceived. The authors concluded that coercion has multiple determinants, including social and psychologic variables that undermine individual autonomy. Marlowe and colleagues developed a coding algorithm for reasons for addiction treatment participation. A total of 260 cocaine-dependent participants were interviewed using open-ended questions about advantages of quitting cocaine, disadvantages of continuing to use, and reasons for seeking treatment. The study found that 69% of responses represented non-coercive reasons, and that there were highly significant differences in the proportion of coercive pressures among the psychosocial domains.

Understanding how coercive factors may affect the voluntarism of patients in addiction treatment is salient for the development of assessments to detect impairments in self-determination and for the formulation of procedures to maximize patient autonomy that may contribute to the success of addiction treatment. One study in a substance abuse rehabilitation program investigated characteristics of patients who consented to randomization versus those who refused. Patients who consented had a longer history of drug abuse, less occupational stability at intake, and poorer outcomes after treatment than those who refused randomization but continued in the experimental assessment. Identifying and understanding how these and other patient and clinician factors influence informed consent is the first step to designing approaches to individualize and optimize consent for addictions treatment.

The ancient philosophical controversy regarding free will and determinism has been recast in neurobiologic terms as philosophers and neuroscientists debate whether and to what degree people addicted to substances of abuse are responsible for their disorders and those detrimental actions resulting from addiction. Among the most controversial implications of this paradigm shift is in the areas of court-ordered treatment of addiction and involuntary commitment for SUDs. The controversy is reflected in the wide variety of state laws regarding the matter. Some jurisdictions permit the involuntary commitment of people who have drug addiction and alcohol dependence who are a danger to themselves or others under either mental health codes or separate statutes. Other states do not allow commitment for inpatient treatment of SUDs but do permit protective custody of acutely intoxicated individuals.
The inconsistency of the legal response underscores the need for clinicians to be familiar with the statutes of their local jurisdiction and to have access to legal counsel. An allied and equally contentious ethical debate surrounds mandated treatment of SUDs often as an alternative to incarceration or as a condition of probation or parole. Even experts in the field disagree about the effectiveness of enforced treatment and whether external coercion to receive addiction treatment can and does eventually produce internal motivation to change choices and behaviors.\textsuperscript{35,36} Under the social construction of addiction as a character flaw and even to some extent in the disease model people should be responsible for the consequences of their actions, such as losing their license for drunk driving or being fired for using drugs in the workplace, precisely because they have free will and choose to exercise poor judgment.\textsuperscript{37,38} Under the same philosophical assumptions, however, drinking and using drugs are voluntary actions of a person who has decision-making capacity, and respect for autonomy, privacy, and individual rights means the only warrant for clinical or forensic intervention is to prevent harm to others, with the exception of explicit suicidality.\textsuperscript{39}

The emerging neurobiologic discoveries regarding the intensity of craving and the power of compulsion in addiction suggest that analogous to other serious mental illnesses, such as schizophrenia, people who have severe addiction may have extremely diminished capacity to choose any other priorities over substances even in the face of the most deleterious medical and personal consequences, including death. The fiduciary duty of the clinician, the principle of beneficence, the doctrine of \textit{parens patriae} would argue that mandated or even enforced treatment maybe necessary to protect the life and health of the person who has such advanced addiction. Autonomy, although operative in the early stages of the disease process, may become so damaged that the control of substances over self-determination can only be released through coerced treatment. Kaplan and others have argued that the soundest ethical warrant for enforced treatment is not a public health justification but the potential to recover self-determination. “It may be possible to justify compulsory treatment for finite periods of time that could rectify this situation and restore the capacity for autonomy.”\textsuperscript{39}

The quote from Kaplan is from an article arguing for the mandated use of the opioid antagonist naltrexone in people who have opioid and perhaps alcohol addiction, because its anti-craving properties may free patients who have addiction from coercive habits and thus free them for more autonomous and healthy choices.\textsuperscript{39} This novel ethical issue underscores that the past decade has seen the advent of exciting and effective treatments for addictions, including new psychopharmacologic interventions. The research reviewed here highlights that many important questions remain concerning the ethical participation of patients at various stages of addiction in clinical treatment. There are almost no data that address these issues directly, however, and the few published studies related to informed consent and addiction are drawn from research rather than clinical contexts. McCrady and colleagues\textsuperscript{40} surveyed 91 federally funded clinical investigators conducting research in addictions. Fifty-seven percent of investigators reported recruiting subjects who were susceptible to coercion. At least half of the subjects possessed vulnerabilities, and researchers reported dealing with suicidal and intoxicated subjects. Two thirds of the investigators used objective assessments of decisional capacity and comprehension of consent forms. Only half of the investigators who obtained data from collateral sources obtained informed consent from those sources. The paper recommended that informed consent guidelines for substance use research be developed.\textsuperscript{40}

In addition, almost nothing is known about the actual informed consent processes that are used in research settings and the knowledge and attitudes of clinicians of
various disciplines about informed consent in the context of addiction research. One of the few extant studies was conducted with the National Institute on Drug Abuse Clinical Trials Network. A total of 115 staff members from community-based addiction treatment programs participated in an educational session on human subject protections in addiction research, which covered informed consent among other topics. On the pretest 56% of respondents agreed or were unsure whether a patient could participate in a clinical trial without understanding what would ensue in the protocol. After a 90-minute education presentation, 24% of the participants still concurred or were uncertain that a patient could be involved in a clinical trial without understanding what would occur. The study does indicate instructional interventions can be modestly beneficial once deficits are identified.

Because human subject protections are more strenuous and structured in research than clinical care, it is likely that similar or more serious knowledge and attitude deficits are present in that context. A 2005 background article on informed consent to undergo substance abuse treatment documents the paucity of information on informed consent in addictions treatment and the need to develop an empiric ethics understanding of the nature and degree of informed consent issues in clinical care. Currently the professional organizations for psychologists and addiction counselors require a prescribed number of ethics hours, as do some state medical licensing boards, all testimony to broad concern about inadequate understanding and adherence to ethical practices among clinicians.

Closely related to the issue of voluntarism in informed consent are studies suggesting that interventions to enhance patient autonomy can have a positive influence on engagement in, and outcome of, treatment. A study examining the determinants of treatment climate in 89 psychiatric and substance abuse programs found that emphasis on autonomy improved the program milieu and client adjustment.

To our knowledge no formal guidelines have been issued regarding appropriate informed consent for addictions treatment and there is little evidence-based guidance for practicing psychiatrists and other mental health professionals on how to identify clinically and address constructively diminished or impaired decisional capacity and voluntarism. Assessment instruments, educational approaches, and safeguarding strategies drawn from the clinical ethics and research literature provide the best practice guidance available at this juncture. These are summarized in Box 1.

PARITY AND SOCIAL JUSTICE

Parity may be defined as equitable treatment and access to resources according to some consistent criterion. Parity is thus primarily related to the ethical principle of fairness. In this context, the resources in question are those related to allocation of resources treatment of addictions, although it is also possible to consider parity related to allocation of prevention and research dollars.

Unfortunately there is no general agreement about what constitutes fairness in health care, because there are several approaches that different people might consider fair, for example, the utilitarian principle of maximizing benefit to individuals and to society; prioritization on the basis of need, with care going preferentially to those with more severe disorders or urgent treatment needs; or allocation determined by ability to pay (for insurance or directly for services). The current health care system in the United States includes elements of all three of these models, without a coherent organizing principle.

It is difficult to justify discrimination against treatment of SUDs because they represent valid, treatable disorders that often have a genetic basis. Outcomes for SUDs
are as good if not better than many other chronic diseases. Historically insurance plans have not offered coverage for mental health and SUDs equal to that provided for medical and surgical problems. In the past substance abuse treatment was often not covered, and when benefits were offered they tended to require higher out-of-pocket costs and more restrictive treatment provisions than benefits related to medical care. In recent years many states have implemented parity laws. On October 6, 2008, President Bush signed into law a mental health parity bill requiring most health plans to cover psychiatric disorders (including SUDs) at the same level as other medical disorders. This law takes effect a year after it was signed and is intended to end the inequity among health insurance benefits. The act amends the Mental Parity Act of 1996 to require that a group plan of 51 or more employees that provides health benefits must ensure that the financial requirements and treatment limitations are no more restrictive for substance abuse and mental health disorders than for medical or surgical conditions. Although significant gaps remain, this law goes a long way toward eliminating disparities in health insurance coverage for addictions and other psychiatric disorders.

Even with the significant move toward equity and fairness, which the Mental Health Parity Act represents, there remain many unjust areas of substance use disorder policy and care delivery in the United States that present formidable obstacles to the provision of adequate access and treatment. The first is an education deficit in health professions training regarding the diagnosis and treatment of SUDs. This lack of knowledge and associated skills in working with patients who have SUDs leads to missed opportunities to constructively intervene, especially in general hospital, primary care, or emergency department settings where most addiction patients are seen. Research shows that educational initiatives can improve the attitudes and behaviors of trainees, enhancing respect for people and improving quality of care.

Closely related to the question of adequate training is the dissemination of evidence-based treatments for SUD. More than ever before, safe and effective pharmacotherapies, such as buprenorphine for opioid dependence and naltrexone for alcohol dependence, are available and yet still not widely accessible. A 2006 study found that use of medications for alcohol use disorders was less likely for programs lacking integrated treatment of patients who had co-occurring psychiatric disorders, criminal justice involvement, or lack of commercial insurances, all conditions with considerable relevance for social justice. Illicit drug use and HIV are highly
stigmatized and underserved conditions in the United States, and studies have shown that although this is a marginalized population that could greatly benefit from buprenorphine, there are substantial barriers to its use in this population.54

Other examples of ethical problems in the delivery of SUD care are the low rates of available treatments in the criminal justice system despite continued drug policy that considers drug use a crime rather than a disease. A 2007 study of state addiction programs for adult offenders found that less than a quarter of inmates in prisons and jails and less than 10% of those in community correctional facilities have daily access to SUD services, and most of these programs offer only drug treatment, not comprehensive clinical care.55 Other vulnerable groups that do not receive equitable treatment of abuse of substances are patients living in rural areas,56 certain minority groups, and women. Ethically it is to be noted that all of these cohorts have overlapping and multiple vulnerabilities that warrant more, not less, intervention. Roberts and colleagues in a study of 1558 medical and mental health providers in New Mexico and Alaska identified significant ethical challenges in the treatment—including substance abuse treatment—of rural and minority patients because of health disparities. The study found four areas of ethical relevance, all of which are highly salient for SUD: attaining treatment adherence, assuring confidentiality, establishing therapeutic alliances, and engaging in informed consent practices.57

There is also a concerning gender gap in the delivery of addiction services for women, with marked failure to provide child-care options and to recognize the lower socioeconomic status of women and the role of intimate partner violence and trauma in women’s use of substances.58,59 Few programs adopt feminist approaches to treatment that may prioritize relationships and values of caring over considerations of strict autonomy and a legalistic sense of accountability.60 Women who are mothers or pregnant and abuse substances confront intense social discrimination, compounded by obstacles to obtaining both prenatal care and addiction treatment, and in some jurisdictions even legal action.50 More than half of surveyed obstetricians, pediatricians, and family practitioners endorsed the presumption that women have a legal and moral responsibility to protect the health of newborns, and a similar number supported a statute to remove children from a women abusing drugs or alcohol even if there was no direct evidence of neglect.61 Such attitudes may have an adverse effect on the trust between physician and patient and deter women from seeking prenatal care but they reflect doctors’ legitimate concerns about how to negotiate the often conflicting obligations to mother, fetus, and society.62

These views reflect a deep underlying social valuation that the life and health of the unborn and of children must be protected. These salient values poignantly conflict with the equally important need to respect the self-determination, confidentiality, and human dignity of pregnant women abusing substances. Studies have shown significant discrimination in the reporting of positive toxicologies for pregnant women, with 10 times as many African American as compared with white women being reported.63 Research indicates that the threat of criminal charges, incarceration, or transfer of children to foster care are not effective deterrents, particularly when compared with allowing women to retain custody and providing parenting assistance and treatment, which has been demonstrated to benefit mother and child.64 Several legal rulings have overturned statutes requiring mandatory reporting of toxicology tests obtained without patient permission or criminal charges of child abuse brought against substance-abusing women. The courts have so far upheld a woman’s right to privacy and confidentiality within the physician–patient relationship.65

The American College of Obstetrics and Gynecologists (ACOG) Committee on Ethics does not support legally mandated testing reporting or other punitive measures.
The position of the ACOG committee is that “Such measures endanger the relationship of trust between physician and patient, place the obstetrician in an adversarial relationship with the patient, and possibly conflict with the therapeutic obligation.”66 The report emphasizes primary and secondary prevention through universal screening, brief interventions, and referral for comprehensive treatment as the most ethical means of safeguarding the welfare of the unborn and children.66

These and many other examples indicate that passing of the Parity Act is only the first step to obtaining truly equitable, accessible, and appropriate treatment for disadvantaged populations. It behooves all those involved in health care and especially those in the addiction community to work through their professional organizations, specialty societies, and the legislative process to continue the momentum to make addiction treatment an integrated aspect of mainstream medical care.

EMERGING ETHICAL ISSUES IN ADDICTIONS

The previous discussion presents several areas, such as the need for parity in treatment and stricter confidentiality protections, in which professional and legal resolution is emerging. There are other questions, such as the moral status of addiction and to what extent the burgeoning neurobiology of choice and compulsion affect decisional capacity and personal responsibility and the associated legal and political responses, about which there is still considerable controversy. There are other ethical issues in addictions, which for lack of space cannot be covered here, for which the differing perspectives and ethical valences are only now developing (Table 2). These dilemmas will only reach equilibrium in the coming decades as the relevant ethical values and principles, their specification, weighting, and contextualization are clarified through empiric evidence, stakeholder dialog, and conceptual progress.

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SUMMARY

The coming decades will see exciting breakthroughs in the treatment of SUDs, such as further elucidation of the genetic mechanisms of addiction. Yet if the past is any guide to the future, each new discovery will bring with it new challenges to the core ethical obligations of honoring informed consent, protecting confidentiality, and respecting justice, while also protecting the public from harm and ensuring the good of the individual patient. For the emerging scientific shift to a biobehavioral model of addiction to transform cultural attitudes and enhance treatment and research will require the scientifically rigorous and ethically sound agency of ethicists and addiction professionals to influence public policy. The growing body of neurobiologic evidence that contests traditional assumptions about free will and responsibility will evoke more deliberate and nuanced approaches to informed consent and treatment participation and dispute the forensic orientation in drug policy. If this unprecedented paradigm change can influence health care decision making in a reasoned and balanced fashion, there is real hope that the cultural stigma, which has warranted highly stringent confidentiality protections, and the disenfranchisement underlying health disparities in addiction treatment may move in the direction of compassionate and competent care for all those who suffer from addiction.

REFERENCES