



HEROIN ADDICTION AND VOLUNTARY CHOICE: THE CASE OF INFORMED CONSENT

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Keywords

addiction,
informed consent,
voluntary choice,
irresistible desire

ABSTRACT

Does addiction to heroin undermine the voluntariness of heroin addicts' consent to take part in research which involves giving them free and legal heroin? This question has been raised in connection with research into the effectiveness of heroin prescription as a way of treating dependent heroin users. Participants in such research are required to give their informed consent to take part. Louis C. Charland has argued that we should not presume that heroin addicts are competent to do this since heroin addiction by nature involves a loss of ability to resist the desire for heroin. In this article, I argue that Charland is right that we should not presume that heroin addicts are competent to consent, but not for the reason he thinks. In fact, as Charland's critics correctly point out, there is plenty of evidence showing that heroin addicts can resist their desire for heroin. These critics are wrong, however, to conclude from this that we should presume that heroin addicts are competent to give their voluntary consent. There are, I shall argue, other conditions associated with heroin addiction that might constrain heroin addicts' choice in ways likely to undermine the voluntariness of their consent. In order to see this, we need to move beyond the focus on the addicts' desires for heroin and instead consider the wider social and psychological circumstances of heroin addiction, as well as the effects these circumstances may have on the addicts' beliefs about the nature of their options.

INTRODUCTION

Does heroin addiction undermine the voluntariness of heroin addicts' consent to take part in research which involves giving them free heroin? This question has been raised in connection with studies of the effectiveness of prescribing heroin as a way of treating dependent heroin users. The researchers conducting the studies need to obtain the informed consent of the participants. In order for consent to be valid, the person must have voluntarily chosen to perform it.¹ But can consent be given voluntarily if the candidate participants are addicted to heroin? We are assuming, of course, that they are neither intoxi-

cated nor suffering from withdrawal at the time of consent. Consider first the options facing the heroin addict when she is asked to take part in a heroin trial. They appear to be the following: (a₁) Consent to take part in trials and obtain free heroin; (a₂) Decline and obtain heroin from the street; (a₃) Abstain from heroin.² Much of the recent discussion about the voluntariness of heroin addicts' consent has focused on whether or not their consent will be caused by an irresistible desire for heroin. On the one hand, there are those, like Louis C. Charland, who claim that it is in the nature of heroin addiction for

¹ T.L. Beauchamp & J.F. Childress. 2001. *Principles of Biomedical Ethics*. New York, NY: Oxford University Press.

² There is a fourth alternative option, which is to take part in trials, obtain free heroin *and* continue to obtain heroin from the street. Since what is relevant to the question of whether addicts' consent is valid is how they choose between taking part in trials and refusing; for the purpose of this article, we can ignore this alternative.

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Conflict of interest statement: No conflicts declared

individuals addicted to heroin to lose the ability to resist their desire for heroin. The evidence for this is neuroscientific research showing that regular consumption of heroin causes persistent changes in brain structure and function involved in the motivation of behavior, leading heroin addicts to ignore the risks of taking heroin while greatly exaggerating its benefits. In the frequently quoted phrase by Leshner and Koob (two neuroscientists Charland refers to), their brains are ‘hijacked by their drug’.³ Since a loss of ability means heroin addicts cannot refuse offers of free and legal heroin, so the argument goes, we cannot presume they are competent to give voluntary consent to take part in research which involves giving them a choice of free and legal heroin. In fact, we should presume that they lack this competence unless proven otherwise.⁴ On the other hand, there are those like Bennett Foddy and Julian Savulescu, who claim that heroin addicts are competent to give voluntary consent to take part in such research. Heroin addicts have the ability to resist their drug-oriented desires, they argue, and hence can refuse offers of free and legal heroin.⁵ Evidence of this is that many heroin addicts actually quit using heroin without assistance. In fact, according to Foddy and Savulescu, the desire for heroin cannot be distinguished from other strong appetitive desires people have, such as the desire for food, sex or exercise. Since strong appetitive desires do not generally undermine voluntary choice, there is no reason why a strong desire for heroin should do so.

A common ground between the two sides in this debate appears to be the assumption that the voluntariness of heroin addicts’ consent depends on whether or not they are able to resist their desire for heroin.⁶ In this article I first argue that the focus on heroin addicts’ desire is misguided since what matters for whether heroin addicts’ consent is voluntary is not the strength of their desire for heroin, but rather their beliefs about the nature of their options. Second, I argue that Charland is right in that we should not presume that heroin addicts are competent to give their voluntary consent to heroin prescription. However, contrary to what he claims, this has little to do

³ A.I. Leshner & G.F. Koob. *Drugs of Abuse and the Brain. Proc Assoc Am Physicians* 1999; 111(2): 99–108.

⁴ L.C. Charland. *Cynthia’s Dilemma: Consenting to Heroin Prescription. Am J Bioeth* 2002; 2(2): 37–47. It should be kept in mind that Charland does not take this conclusion to imply that research on heroin prescription as a treatment alternative should be banned. If the risks for the participants or society should turn out to be low or non-existent while the positive benefits turn out to be high, strategies that circumvent the ethical problems should be considered, such as using some form of surrogate consent or perhaps setting lower standards for competence: 45.

⁵ B. Foddy & J. Savulescu. *Addiction and Autonomy: Can Addicted People Consent to the Prescription of Their Drug of Choice? Bioethics* 2006; 20(1): 1–15.

⁶ For a similar point, see T. Walker. *Giving Addicts Their Drug of Choice: The Problem of Consent. Bioethics* 2008; 22(6): 314–320.

with the effects of heroin on the addict’s brain. It is because it cannot be ruled out that the wider social and psychological circumstances of severe heroin addiction influence the addicts’ beliefs about their options and hence motivation for action in a way that is likely to undermine the voluntariness of their consent. Chronic heroin addicts tend to lead bad lives. Feelings of powerlessness, hopelessness and despair are common. Since the badness of their lives is part of the condition under which they carry out their choice, we should carefully consider the possibility that it might affect the voluntariness of their consent. In this article, I suggest that one way in which it might do so is by leading to an impairment of their rational will.

1. IRRESISTIBLE DESIRES AND VOLUNTARY CONSENT

What does it mean that a consent is ‘voluntary’, and what are the conditions that can undermine the voluntariness of a consent? Let us begin by distinguishing, very broadly, between three types of options in terms of ‘acceptability’, where the standard for the acceptability of options is an objective standard of well-being.⁷ First, there are options that one strongly dislikes, which one holds to be ‘unacceptable’ in the sense that they bring one’s well-being below a certain threshold. These are options which are thoroughly bad because they involve losses it would be unreasonable to expect anyone to bear. Second, there are options that are not thoroughly bad, that one does not particularly like but which one holds to be ‘acceptable’ in the sense that they bring one’s well-being above a certain threshold. These are options which have ‘sufficient’ value to be choiceworthy. Finally, there are options which bring one’s well-being up to a high level and that one likes so much that one chooses them because of that. Now, according to one plausible view, a person’s choice is voluntary if it is not made because no other acceptable alternative options are available. This view implies the existence of two types of cases in which a person makes a voluntary choice: First, there are cases in which she has at least two acceptable options and chooses

⁷ The view of voluntariness that I rely on throughout this paper is defended by S. Olsaretti in *Freedom, Force and Choice: Against the Rights-Based Definition of Voluntariness. J Polit Philos* 1998; 6(1): 53–78, and in S. Olsaretti. 2004. *Liberty, Desert and the Market*. Cambridge: Cambridge University Press. Although this view comes close, I believe, to the conventional understanding of ‘voluntariness’, it does differ from some familiar definitions in the philosophical literature (see e.g. D. Davidson. 1980. *Freedom to Act. Essays on Actions & Events*. New York: Oxford University Press: 63–81). While space does not permit a discussion of these definitions here (but see Olsaretti. 1998), they all share, in my opinion, an inability to deal adequately with cases of constrained choice (e.g. coercion) and therefore seem unlikely to be of much help in shedding light on the question of addicts’ consent.

one of them because, all things considered, she prefers this option to the other. Second, there are cases in which she has at least one option that she likes so much that she chooses it because of that, whether or not there are any acceptable alternative options. In neither of these cases is her *reason* for making the choice that she has no other acceptable alternative options.⁸ One important implication of this view is that whether a choice is voluntary or not crucially depends on the person's motivation for making the choice, and hence upon her beliefs about her options.⁹ If a person's choice is motivated by an incorrect belief that she has no other acceptable alternative options, her choice will be non-voluntary even if she actually has several acceptable options. For example, someone who believes she is being threatened with a gun to hand over her money and chooses compliance because she fears death *non-voluntarily* chooses to hand over her money even if it turns out that the robbery was in fact a prank. What this shows is that well-informedness may make a crucial difference as to whether or not the conditions for making a voluntary choice apply.¹⁰

Consider now what it could mean that an irresistible desire for heroin undermines the voluntariness of heroin addicts' consent. There seems to be three possible views depending on how the irresistible desire is meant to operate in the addicts' psychology (versions of which all can be found in the addiction literature). The first is that the irresistible desire *by-passes* the addict's choice mechanism altogether by directly causing her consent behavior (i.e. the signing of the consent form) independent of any decision or choice to perform this behaviour.¹¹ A person whose choice mechanism is by-passed in this way is unable to prevent the behaviour from occurring in a way similar to that in which she is unable to prevent her leg from jerking when the doctor triggers her patellar reflex. If this is the way irresistible desires for heroin are meant to undermine voluntary consent, the offer of free and legal heroin must be assumed to simply trigger an automatized 'consent response' in the heroin addict. In other words, the heroin addict is not competent to consent because she cannot make any choice at all. This view seems implausible. Unlike reflexive behaviour,

which cannot be delayed or altered, heroin addicts are, generally, able to delay or alter their drug-oriented behaviour on the basis of deliberation. Evidence of this is that they tend to plan when and how to obtain their drugs, taking into account all sorts of situational contingencies such as availability, risk of arrest, dangers of consumption and so on. In other words, their drug-oriented behaviour tends to be both flexible and adaptable. It is therefore not clear why their consent to take part in research involving the medical provision of heroin should be any less so.

The second possibility is that the irresistible desire *hijacks* the addict's choice-mechanism by removing her ability to refrain from choosing (a_1) even if she feels she has most reason to refrain.¹² Because in this case the desire will be operating through her choice mechanism (since she is choosing to take part in research), her behaviour is not reflexive but intentional. However, her consent must still be assumed to be non-voluntary since she does not give it because she very much likes (a_1), or because all things considered she prefers (a_1) over (a_2) or (a_3). The reason she gives it is that she has no acceptable alternative option.¹³ A difficulty with this view is that it is unclear why the simple fact that the heroin addict has an irresistible desire for heroin should entail that she has no acceptable alternative option. That is, although (a_3) is not an alternative option for a lack of ability, the heroin addict can still obtain heroin from the street as she always has done. In fact, not only does this seem like an option that is available to her, no reason has been given why it cannot be an *acceptable* option from her perspective. But if she considers (a_2) to be acceptable, she can choose (a_1) because all things considered she prefers (a_1) over (a_2). Then her consent will be voluntary.

The third possibility is that the irresistible desire is the result of a fear of withdrawal pain if she refuses to consent. This fear may be thought to create a coercive influence on her decision-making that is sufficiently strong to constitute a threat that she cannot reasonably be expected to hold out against.¹⁴ That is, like the robbery victim who believes she has no other alternative options than to comply with the robber's threat because she fears death, the heroin addict believes she has no other alternative options than to consent to heroin prescription because she fears withdrawal pain. But again, the fear of withdrawal pain – even assuming it is strong enough to constitute a coercive threat – does not entail that (a_2)

⁸ Why cannot a choice between two unacceptable options be voluntary? It seems plausible that such choices must involve some form of coercion since they make the chooser worse off than she would have been if she had not been given the choice. See also Foddy & Savulescu, *op. cit.* note 5.

⁹ See B. Colburn. Debate: The Concept of Voluntariness. *J Polit Philos* 2008; 16(1): 101–111.

¹⁰ S. Olsaretti. Debate: The Concept of Voluntariness – A Reply. *J Polit Philos* 2008; 16(1): 112–121.

¹¹ A.J. Leshner seems to hold a version of this view in A.J. Leshner. Addiction is a Brain Disease, and it Matters. *Science* 1997; 278: 45–47. H. Frankfurt also seems to hold something like this view in H. Frankfurt. Freedom of the Will and the Concept of the Person. *J Philos* 1971; 68(1): 5–20.

¹² G. Watson seems to hold something like this view in G. Watson. Skepticism about Weakness of the Will. *Philos Rev* 1977; 86: 316–339.

¹³ Unlike akratic, or weak-willed behaviour, which generally is believed to be consistent with an ability to refrain, the notion of 'hijacking' implies the removal of this ability.

¹⁴ This kind of view seems to be held by Greenspan in P. Greenspan. Behavioural Control and Freedom of Action. *Philos Rev* 1978; 87(2): 225–240.

cannot be an acceptable alternative option for her. That is, no reason has been given why the heroin addict cannot consider (a_2) to be acceptable. If she does consider it to be an acceptable option, her choosing (a_1) will be voluntary. In fact, it may be added here that there is little evidence to suggest that withdrawal from heroin is bad enough to create a coercive threat. Some compare it to a bad flu.¹⁵ Many heroin addicts even deliberately go through withdrawal, often repeatedly, in order to reduce their tolerance for the drug, thereby decreasing the dose they will need to achieve the high they want.¹⁶

Why believe that an irresistible desire for heroin renders heroin addicts incapable of voluntarily consenting to take part in heroin trials? One reason could be that voluntariness is confused with the philosophical notion of freedom of the will as ability to do otherwise. An irresistible desire for heroin might be thought to undermine the voluntariness of heroin addicts consent because it removes their freedom. Heroin addicts simply cannot refrain from taking heroin. However, even if we assume this view of freedom, it does not follow that someone who lacks the freedom to act in some way cannot act voluntarily. Voluntariness is not the same as freedom in this sense.¹⁷ Consider a person who is offered a well-paid, prestigious job. Suppose she is literally unable to refuse the offer. Given the view of freedom as the ability to do otherwise, she might be said to lack freedom with respect to taking the job. But this lack of freedom does not necessarily make her decision to accept the offer non-voluntary. If her reason for saying yes is the job's prestige and pay, making the choice highly attractive, rather than there being no acceptable alternative options, her choice will be voluntary in the sense assumed here. In other words, if what matters for freedom of will is the ability to do otherwise, what matters for voluntarily acting are the conditions under which the action is carried out, particularly the agent's beliefs about her options and hence motivation for the action. Since irresistible desires can remove freedom without necessarily undermining voluntariness, it might be possible for heroin addicts to consent voluntarily to heroin prescription even if they have an irresistible desire for heroin. It follows that if the question of their competence to give voluntary consent were a matter simply of whether they have an irresistible desire for heroin there is little evidence to suggest that they lack this competence. Nonetheless, in the next section I want to argue that it is not that simple since choices may be non-voluntary, even if they are not caused by irresistible

desires. This means we need to consider the possibility that there might be other conditions associated with heroin addiction that can constrain addicts' choice in ways likely to undermine the voluntariness of their consent.

2. HEROIN ADDICTION AND VULNERABILITY

Those who claim there is no reason why we should not presume heroin addicts are competent to consent justify this by arguing that there is plenty of evidence to suggest that heroin addicts can be persuaded to quit heroin and hence that they have the ability to resist acting upon their desire for heroin. In support of this, they appeal to studies showing that financial concerns, fear of arrest, values regarding parenthood and many other factors which influence decisions in general, often bring a heroin addict's drug-oriented behaviour to a halt.¹⁸ It seems plausible that this evidence shows that heroin addicts generally possess the ability to resist acting upon their desire for heroin. That is, it seems plausible that their desire for heroin, although no doubt intrusive and persistent, is not literally irresistible. Even if this is correct, however, it does not follow that we can simply presume that heroin addicts who consent to take part in heroin trials will do so voluntarily.¹⁹ Just as lacking the ability to refrain from some action does not entail that one's performing of the action must be non-voluntary, possessing the ability to refrain from some action does not entail that one's performing of it must be voluntary. Even a robbery victim threatened with physical harm if she does not hand over her money might have chosen non-compliance if she had believed it was necessary to avoid some larger harm. That does not show that her choice to comply was voluntary. As we have seen, voluntariness crucially depends upon the person's beliefs about the nature of her options and hence motivation for action. If there is evidence that addiction to heroin for many people is associated with conditions that affect their beliefs about their options in ways which might undermine the voluntariness of their consent, the safest assumption is that heroin addicts are not competent to consent unless proven otherwise. I believe this is important because it urges us to move beyond the focus on heroin addicts' desires for heroin and consider the wider social and psychological circumstances of their addictions. Since these

¹⁵ S.J.M. Morse. Hooked on Hype: Addiction and Responsibility. *Law Philos* 2000; 19: 36.

¹⁶ G. Ainslie. A Research-Based Theory of Addictive Motivation. *Law Philos* 2000; 19: 82.

¹⁷ Of course, many philosophers argue that freedom of will is not the same as ability to do otherwise. It is not my aim to defend any particular view of freedom of will here.

¹⁸ Foddy & Savulescu, *op. cit.* note 5. See also N. Levy. Addiction, Autonomy and Ego-Depletion: A Response to Bennett Foddy and Julian Savulescu. *Bioethics* 2006; 20(1): 16–20.

¹⁹ It could be added here that the notion of 'irresistible desires' itself is controversial. Some even deny that it makes sense to speak of desires which are literally irresistible. See e.g., R.F. Baumeister & T.F. Heatherton. Self-Regulation Failure: An Overview. *Psychol Inq* 1996; 7(1): 1–15.

circumstances constitute the conditions under which they make their decisions, they might lead many addicts to form beliefs about their options that affect their motivation in ways that undermine the voluntariness of their consent. But what do we know about heroin addicts' beliefs about their options? The problem is, of course, that heroin addicts are not all alike; their individual circumstances, including social and personal resources, may differ, and accordingly their beliefs about their options as well. Heroin addiction is a multi-determined pattern of behavior and is likely to vary across individuals in terms of severity and causal influences. It is noteworthy, however, that when Charland claims that we should not presume that heroin addicts are competent to consent, his focus is on addicts he characterizes as 'vulnerable in the terminology of research ethics', and describes as 'chronic heroin addicts' with 'a history of repeated treatment failure'.²⁰ This restriction is natural insofar as heroin treatment is generally perceived to suit a minority of heroin users as a second-line treatment for those who do not respond to methadone or buprenorphine treatment delivered under optimal conditions.²¹ The main underlying objective of heroin trials has thus been to determine the therapeutic value of medical heroin prescription to high-risk heroin users for whom such benefits cannot be expected or achieved by existing treatment options.²² There is plenty of evidence of widespread health and social problems in this group of addicts. Charland mentions the example of the Geneva trial where in the experimental group (n = 27), 21 of the subjects had been unemployed for 12 months or more, 4 were infected with HIV, 1 had developed aids, 22 suffered from severe depression, 25 suffered from severe anxiety, 18 had a history of at least one suicide attempt. But high prevalence of health and social problems in the experimental group can also be found in similar trials conducted in Spain, UK, Canada, Germany and the Netherlands.²³ When Foddy and Savulescu claim that many heroin addicts 'function as other citizens in society', that they are 'capable of maintaining professional jobs, caring for children, and driving cars' and appear to take this as evidence that it is safe to presume that heroin addicts are competent to consent, the heroin addicts they have in mind are clearly very different from those Charland describes as 'vulnerable in the terminology of research ethics'.²⁴ However, if the most sensible role of heroin treatment is to be an exceptional 'last resort' option for heroin addicts

who cannot be effectively attracted into or treated in other available therapeutic interventions, the focus should not be on heroin addicts who function as other citizens in society, but on those rightly described by Charland as vulnerable, i.e. chronic heroin addicts who have previously failed in conventional drug-treatment programs and who often have severe health and social problems. So one reason why we should not presume that heroin addicts are competent to consent might have to do with their general vulnerability and the conditions associated with their addictions, conditions that may lead many of them to form beliefs that affect their motivation in ways that undermine the voluntariness of their consent. Let me end the article by considering some of the conditions known to be associated with chronic heroin addiction and suggest how they may lead to beliefs that have such effects.

It is well known that being addicted to heroin can instill a sense of worthlessness and despondency over one's life situation. Due to prolonged addiction problems, heroin addicts face a variety of emotional, social and physiological problems such as job loss, broken relations, deteriorating health, legal problems and many others. Major psychopathological studies of heroin users report rates of co-morbidity that far exceed general population estimates. Joannee Ross et al. report that as many as 80% of people seeking treatment for heroin addiction have at least one other psychiatric disorder, most commonly a mood disorder, anxiety or anti-social personality disorder. Over a quarter of their sample met criteria for current major depression, representing a prevalence many times higher than that of the general Australian population.²⁵ In fact, on the whole, dysphoric mood states seem to be the rule rather than the exception among heroin addicts seeking any kind of treatment.²⁶ There is controversy as to whether such states should be considered a cause or a consequence of heroin addiction, but for present purposes, what is important is that these states tend to be commonly found in heroin addicts seeking treatment. In addition to high rates of co-morbidity, it is well-known that many chronic heroin addicts lead marginalized lives in impoverished environments often associated with criminal activity, anxiety and high levels of risk. Can we rule out that conditions such as these have implications for the voluntariness of their consent to take part in research involving the medical provision of heroin? Of course, it may be objected that conditions of psychiatric illness and social distress are not part of *the nature* of heroin addiction, that many heroin

²⁰ Charland, *op. cit.* note 4, p. 38.

²¹ N. Lintzeris. Prescription of Heroin for the Management of Heroin Dependence: Current Status. *CSN Drugs* 2009; 23(6): 463–476.

²² B. Fischer et al. Heroin-Assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics. *J Urban Health* 2007; 84(4): 552–562.

²³ For a brief summary, see Fischer, *op. cit.* note 22.

²⁴ See Foddy & Savulescu, *op. cit.* note 5, p. 4.

²⁵ J. Ross et al. The Characteristics of Heroin Users Entering Treatment: Findings From The Australian Treatment Outcome Study. *Drug and Alcohol Review* 2005; 24: 411–418.

²⁶ I. Maremmani et al. The Mental Status of 1090 Heroin Addicts at Entry into Treatment: Should Depression be Considered a 'Dual Diagnosis'? *Ann Gen Psych* 2007; 6(31): 1–6.

addicts – presumably many of those who never seek treatment, but quit without assistance – do not suffer from such conditions. That may be true. But once again, it is important to bear in mind that the question about heroin addicts' consent is not about the nature of heroin addiction viewed in isolation from the people addicted to heroin and their social and psychological circumstances. The target group of heroin trials is chronic heroin addicts who do not succeed in conventional drug treatment programs and who often have severe health and social problems. The question is whether heroin addicts in this group are competent to consent to take part in research that involves giving them free and legal heroin. If it cannot be ruled out that their consent is made in response to a situation of constrained choice, the safest assumption is that they lack this competence until proven otherwise. But is there any reason to think that their consent might be made in response to a situation of constrained choice? I want to suggest one reason, which has to do with the general badness of their lives and the effects it might have on their beliefs about their options and motivation in light of those options. This badness stems from conditions associated with chronic heroin addiction that give rise to feelings of powerlessness, hopelessness and despair. What I want to suggest is that we should carefully consider the possibility that such conditions might create situations of constrained choice for many chronic heroin addicts by shaping the meanings they give to their options and hence their motivation for action. More specifically, we should consider the possibility that they create beliefs that continuing to obtain heroin from the street is unacceptable because it involves personal harm, while abstaining from heroin is not an option. If taking part in research appears to these addicts to be the only acceptable option, the voluntariness of their consent could be undermined. To see how such a situation could arise, consider first the option of obtaining heroin from the street. Many chronic heroin addicts reach a point in their addiction 'careers' in which their current lifestyles do not appear to them to be sustainable any longer. Presumably the costs of maintaining such a lifestyle, which is organized around procuring and securing illicit heroin and often involves criminal activity and high levels of risk, will over time begin to exceed the benefits. Evidence of this is that many chronic heroin addicts eventually seek help for their addiction. A reasonable assumption might be that they do so because they come to consider a life revolving around obtaining illicit heroin to involve personal harm and hence to be unacceptable in the sense of no longer bringing their well-being above a certain threshold. Consider next the option of abstaining from heroin. Of course, if heroin addicts were motivated by an irresistible desire for heroin, abstaining would have been a non-option because of a lack of ability to do so. But while there does seem to be strong evidence for saying

that heroin addicts generally possess the ability to resist their desire for heroin, this does not show that abstaining is an acceptable alternative option for most chronic heroin addicts. For an action to be an acceptable option, it is not sufficient that one has the ability or power to perform it. One must also *believe* that one has that ability or power. There are many studies showing that mood disorders such as depression and anxiety lower belief in one's capabilities, or perceived 'self-efficacy'.²⁷ Since there is a strong correlation between mood disorders and chronic heroin addiction, a reasonable assumption could be that many chronic heroin addicts harbour a low sense of self-efficacy and lack of confidence in their capabilities to abstain from heroin.²⁸ Chronic heroin addiction is associated with hopelessness about the future and a sense of powerlessness to influence the direction of one's life – reinforced by a history of failed efforts to abstain. It may be added that maintaining abstinence is a formidable task for many chronic heroin addicts, often requiring fundamental lifestyle changes such as restructuring social and recreational activities, developing occupational competencies and so on. Now, a lack of belief in one's own ability clearly undermines one's will. Thus, according to a standard view, intentions involve plans of action and such plans, in order to be rational, require the belief that one has an acceptable chance of changing the world in ways one believes are for the better. Given this view, it would not be rational to form intentions one believes one is not going to carry out.²⁹ The implication is that heroin addicts with a very low belief in their capacity to abstain from heroin are likely to find it extremely difficult to form intentions to abstain. That is, since they believe they are going to fail to abstain if they try, they are likely to lack the will to abstain. Consequently, their commitment to personal change may be low. Since it is not the case that believing one has reasons not to make an effort to exercise an ability (since one thinks it is futile) entails that one does not possess *the ability*, the problem here is not a loss of ability. The problem is rather an impairment of rational will due to a lack of belief in self-efficacy. It cannot be ruled out, I think, that such impairments of the will may lead many chronic heroin addicts to believe falsely that abstinence is a non-option.

If this is correct, everything depends on the option of taking part in research. Are chronic heroin addicts going to consider this option to have a high value, not just as an

²⁷ A. Bandura. 1997. *Self-Efficacy. The Exercise of Control*. New York: W.H. Freeman and Company: 343–349.

²⁸ In fact, according to Gossop et al. one factor that consistently emerged as a significant predictor of treatment outcome was perceived self-efficacy to refrain from drug use. See M. Gossop et al. Factors Predicting Outcome Among Opiate Addicts After Treatment. *Br J Clin Psychol* 1990; 29: 209–216.

²⁹ M. Bratman. 1987. *Intention, Plans, and Practical Reason*. Harvard University Press.

acceptable way to escape the need to obtain heroin from the street or to obtain free and legal heroin, but as something they consider will bring their *well-being up to a high level*? In fact, there appears to be little reason to think so. Evidence of this is that many heroin addicts actually refuse to take part in such research.³⁰ One reason could be that they find the costs associated with, e.g. keeping regular appointments with healthcare professionals, too high. Another might be a belief that a heroin prescription in itself does not solve many of their problems. Whatever the reason, chronic heroin addicts who *do* consent must weigh these costs less than the benefits associated with obtaining free and legal heroin. Presumably, they consider the value of obtaining free and legal heroin to be high enough to make taking part in research acceptable, even if they do not consider the combined value of obtaining free and legal heroin *and* taking part in research to be very high. To sum up, if the reasoning so far is correct, it cannot be ruled out that many chronic heroin addicts consider obtaining heroin from the street as unacceptable while abstaining from heroin is not an option, which leaves them with only one option, which is taking part in research involving the medical provision of heroin. Since there is evidence to suggest that they might choose this option, not because they find it highly attractive, but because they do not have any acceptable alternative options, it cannot be ruled out that their consent is non-voluntary. What constrains their choice is not their desire for heroin, but the wider social and psychological circumstances of their heroin addiction and the beliefs about their options that these circumstances create.

3. CONCLUSION

I have argued that we should not presume that heroin addicts are competent to consent to heroin prescription. However, unlike Charland's argument that reaches the same conclusion, the argument I have suggested does not rely on any controversial view of the nature of addiction,

³⁰ In heroin trials in Switzerland, only a third of subjects decided to take part when given the choice. See T.V. Perneger et al. A Randomised trial of Heroin Maintenance Programme for Addicts who Fail in Conventional drug Treatment. *Br Med J* 1998; 317: 13–18.

but on empirical evidence about the social and psychological circumstances typical of chronic heroin addiction. Another important difference is that my argument does not imply that no heroin addicts are competent to consent. It only rules out that we should presume that most heroin addicts are – especially those heroin addicts who might be particularly vulnerable to offers of free and legal heroin due to the badness of their lives. Thus, the argument allows both that there could be heroin addicts who are competent to consent, as well as that it may be possible to promote opportunities to give competent consent for some of those who lack this competence by strengthening their perceived self-efficacy and making them more well-informed about their options, thereby providing them with more acceptable options.³¹ The paradox is that the heroin addicts who are most likely to have the competence to consent (or to achieve this competence as a result of therapy) are precisely those who are likely to respond to abstinence-based treatment, who have a will to quit heroin and hence who do not appear to be in the target group for treatment that involves offers of free and legal heroin. For the latter, who will tend to be chronic heroin addicts living in social distress with a history of repeated treatment failure and poor mental and physical health, Charland is right that the safest assumption is that they lack the competence to consent until proven otherwise.

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³¹ It has been claimed that if Charland's argument were accepted, it would raise similar doubts about the competence of heroin addicts to consent voluntarily to any treatment that involved being maintained on an agonist, such as methadone or a partial agonist like buprenorphine. See A. Carter & W. Hall. Informed Consent to Opioid Agonist Maintenance Treatment: Recommended Ethical Guidelines. *Int J Drug Pol* 2008; 19: 79–89. Whether or not this is correct, the present argument does not have this implication. Unlike the heroin addicts who consent to heroin prescription because their will to abstain from heroin is impaired, the heroin addicts who consent to treatment involving methadone clearly demonstrate a will to abstain from heroin. They may therefore have acceptable alternative options such as seeking treatment without methadone. They may also consider treatment involving methadone as the best way to achieve their goal of abstinence, that is, as an option of high value. In both cases, their consent will be voluntary.