

Substance Abuse Counselor Ethics, Confidentiality, and Boundaries (Updated)

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Introduction

Ethics is essential to the safe and effective delivery of care to individuals seeking addiction treatment. Therefore, specific codes of ethics, as well as state and federal laws, have been developed to guide addiction professionals in their delivery of professional care to individuals seeking their services. This course details the guidelines of ethics, confidentiality, and boundaries for substance abuse counselors from several resources specific to alcohol and drug counselors. This course also reviews the most essential and universal principles of health care ethics, while highlighting how to effectively resolve the ethical dilemmas that may arise while delivering care to individuals in need.

Section 1: Ethics

Case 1

Alex is a 24-year-old female client with a history of drug abuse and anxiety. Alex's drug abuse began in her late teens and has continued up until recently. Initially, Alex began using drugs such as ketamine, cocaine and cannabis in social situations. However, Alex reports her drug abuse quickly escalated to an "almost everyday occurrence." Alex also reports she continued to use drugs to help her anxiety. Alex attributes her anxiety to the "traumas" she experienced during childhood. Alex's mother passed away when she was 10 years old and subsequently Alex grew up in a single parent home. Alex reports she was often left alone as a child and did not get along well with her father, who possesses a history of alcohol abuse. Alex recalls her anxiety began shortly after her mother's death. She felt like she could not relate well to her father and was often terrified by his "drunken tirades." Alex's father eventually obtained treatment for his alcohol abuse, however, Alex's anxiety continued after her father's sobriety. Eventually, in her late teens Alex began using drugs in college when she "hung out with friends" to help with her anxiety. Alex reports at that time she entered into a relationship with a male individual who lived in her dorm. As the relationship progressed she continued to use drugs on a consistent basis. Alex's drug use continued through college and intensified as her relationships with men continued. After college, as her relationships became increasingly serious, Alex began using drugs on a "semi-daily basis" until her drug use escalated to an "every day thing." Alex's drug use continued until her recent relationship ended. Upon the termination of her most recent relationship, which Alex has described as "pretty much toxic," Alex began seeking help for her drug abuse. She entered substance abuse counseling and has been sober for several months. Alex attributes her sobriety to her determination, will for a healthier lifestyle and her counselor. As time progresses, Alex feels quite close to her counselor and begins to develop romantic feelings for him. After counseling sessions, Alex often initiates conversation with her counselor regarding personal topics and attempts to subtly ask him out on dates.

Alex's counselor does not take Alex up on her invitations, although he does not make any attempt to quell Alex's advancements. Alex continues to flirt with her counselor for the next few weeks. During that time, Alex's counselor begins to develop a personal connection with Alex and seemingly appears to flirt back with her. As the flirtations continue, Alex begins to develop anxiety about her relationship with her counselor. Over the next few days, Alex's anxiety increases and so does her desire to use drugs. At the same time, Alex's counselor begins to become conflicted about his personal feelings for Alex. He is not sure if he should continue to meet with her or end the professional relationship between them in order to continue a personal relationship. At their next session, Alex's anxiety begins to intensify beyond her control and she expresses her interest in using drugs. Alex's counselor reaches an impasse and is not sure where his professional relationship with Alex ends and his personal relationship begins.

Case 2

Jane is a 42-year-old alcoholic and single mother of two children, ages 12 and 9. Recently Jane has entered counseling for her alcohol addiction. She is trying to maintain her sobriety for the sake of her health and children. Jane has battled alcoholism since her early 20s; however, her struggle with alcohol intensified after her divorce approximately 8 years ago. Jane has remained single since her divorce and does not often see or interact with her ex-husband. Along the same lines, her children do not have a relationship with their father. Jane has maintained a job as an accountant for the past 15 years. After the recent death of her parents, Jane has expressed that it has become harder for her to balance her career with being a single parent. Jane feels like she has no personal time for herself and can never "truly unwind." As a result, she is finding it harder to refrain from alcohol. Over the past several weeks, she reports drinking up to "5 - 6 gin and tonics" per evening. She also reports that she often sends her children to bed with no dinner and locks them in their rooms for long periods of time so she can "drink and relax." Jane also admits that she has not been very patient with her children recently and has resorted "striking them when they misbehave." Furthermore, Jane reports she often leaves her children alone for long periods of time on the weekends to "go out for a drink." Jane fears she is losing control of her life and her ability to control her drinking. Jane is not sure what she will do next but firmly believes her children need to be by her side for her to succeed.

Upon hearing the aforementioned reports from Jane, Jane's addiction professional becomes concerned for Jane's well-being. Moreover, the addiction professional becomes concerned for the well-being of Jane's children. Jane's addiction professional is not confident in Jane's ability to care for her children and feels Jane's children may be in danger. It appears Jane can no longer maintain her sobriety and effectively care for her children. It also appears that Jane does not have much support to help her maintain her professional, personal and family responsibilities. Jane's addiction professional believes Jane needs additional treatment for her alcoholism. At the same time, Jane's addiction professional believes Jane's children also need help. At the conclusion of their latest meeting, where Jane admits to further neglect of her children, Jane's addiction professional feels action is necessary. However, Jane's addiction professional feels torn. On one hand, Jane's addiction professional feels Jane's children need help before they are put in serious danger. On the other hand, Jane's addiction professional believes

that any action taken towards Jane and her children may have severe consequences for Jane's health and battle with alcoholism. Jane's addiction professional is left struggling with the aforementioned internal debate and is unsure about what to do next.

Case 3

Frank is a 29-year-old male client with a history of drug and alcohol abuse. Frank has entered counseling to achieve sobriety. Frank reports his battle with drugs and alcohol began in college. While attending college, Frank would often go to parties and/or bars and use drugs or drink excessively. Frank admits he often would "black-out" and wake up in random places and in "strange" women's beds after a night out drinking. After college Frank continued to binge drink and use drugs. Frank also admits his "black-outs" continued and he would often "pick up" women while he was out "partying." Frank has tested positive for several sexually transmitted diseases (STDs); however, he has continued to engage in unprotected intercourse under the influence of drugs and alcohol. Frank reports he often "dates" multiple women at one time and combines binge alcohol drinking, drugs such as cocaine and sex to numb the depression he feels over his past actions. Frank is not sure if he can stop his previously mentioned actions because they have been "an intricate part of his life for so long". Additionally, Frank reports he does enjoy himself when he is drinking and doing drugs even if it brings him depression later on. With that said, Frank understands he needs to stop his unhealthy lifestyle because his actions are putting his health, and the health of others, in jeopardy.

Several weeks pass and Frank makes positive progress with his drug and alcohol addiction, although he reports he is still having trouble refraining from unprotected sex with multiple partners. As time progresses, Frank continues to tell his addiction professional stories about his past drinking episodes and drug abuse. Frank's addiction professional listens carefully to Frank's reports and picks up several details which peak interest. Several days later, via social media outlets, Frank's addiction professional discovers that a close friend is romantically linked to Frank. Although Frank's addiction professional is not certain of the details regarding the relationship between the close friend and Frank, the addiction professional is concerned for the health of both parties. Stuck in the middle of loyalty to a friend and professional obligations to Frank, the addiction professional is not sure how to proceed with the professional information obtained through counseling sessions with Frank and the observations made via various social media outlets.

The scenarios outlined in the previous case studies represent the types of ethical dilemmas and challenges addiction professionals may face while delivering care to individuals seeking their services. Unfortunately, those types of scenarios can be quite common and complex to resolve. Therefore, it is essential for addiction professionals to understand how to effectively manage and resolve the various types of ethical dilemmas and challenges that may arise. With that said, the question is, how can addiction professionals effectively manage and resolve the ethical dilemmas and challenges put forth while delivering care to individuals seeking their services? The simple, straightforward answer to the aforementioned question is as follows: addiction professionals can effectively manage and resolve the

ethical dilemmas and challenges put forth while delivering care to individuals seeking their services by, first and foremost, understanding their ethical obligations and responsibilities to their clients.

Addiction professionals have many responsibilities to their clients. Some of the most important responsibilities relate to ethics. Ethics can refer to the moral principles which guide an individual's behavior and/or actions¹. At the basic level, ethics and the principles related to ethics help individuals distinguish right from wrong. On the broader scale, ethics can help forge an individual's character, personality, decision making process and how he or she views the world. In essence, ethics and the principles related to ethics are a major determining factor in what makes a person an individual and how individuals interact with the greater world around them.

Due to the individual nature of ethics, every person possesses the potential to have distinct and different ethical principles. In other words, each individual is unique and therefore has the potential to maintain a unique set of ethical principles. Nevertheless, individuals have to coexist and work together side by side. Cooperation is essential for the betterment of mankind and it is absolutely necessary in the workplace. Individuals have to work together as a team to accomplish goals and to achieve success, especially in health care settings. Team work is essential to the safe and effective administration of health care, regardless of what form it takes. Moreover, it has been maintained that without effective team work among health care professionals, there can be no effective health care. Therefore, it is paramount that individuals work together in a cohesive manner under a unifying set of ethical principles.

To establish the much needed cohesion among health care professionals, as well as the necessary shared set of ethical principles, health care professionals take oaths and/or make professional agreements to uphold specific ethical standards. An oath can refer to a promise or testimony regarding one's future actions or behavior. Health care professionals from different disciplines take different oaths or make different professional agreements. For example, medical doctors take the Hippocratic Oath, while nurses take a variation of the Hippocratic oath referred to as the Nightingale Pledge. Regardless of the respective discipline of the health care professional, historically a health care professional's oath is taken to bind the individual to a specific set of ethical principles. No matter where the individual health care professional is from or what their personal ethical principles are, health care professionals agree to follow a new unifying set of ethical principles that will govern their behaviors throughout their professional careers. When health care professionals take oaths they swear, from that moment on, to put the collectively agreed upon principles of health care ethics at the core of their own ethical principles and to use them as a guide for the administration of health care and/or during counseling.

As previously mentioned, health care professionals, including addiction professionals, do indeed take different oaths or make different professional agreements depending on their disciplines. With that said, there is a common link among health care related oaths and professional agreements. This common link can be found in the four cornerstones of health care ethics which support the foundation of the health care system and its related fields. The four cornerstones of health care ethics are as follows: autonomy, justice, beneficence and nonmaleficence.

Autonomy

Each of the aforementioned principles have specific meanings when applied to health care and health care related fields. For example, the principle of autonomy can refer to the acceptance or acknowledgement that individuals possess the capacity to think, act and form decisions about themselves, their own life and their personal health care; free from external control, influence, force and/or coercion^{1,2}. Autonomy is believed to be one of the basic human rights of all men and women, and therefore it is one of the most valued ethical principles across the planet. Thus, it is no surprise that autonomy is one of the most important cornerstones for health care ethics. That being said, how does autonomy relate to individuals seeking substance abuse counselors and individual addiction professionals? Essentially, the principle of autonomy grants patients and clients the sole right to make decisions about their own personal, health care, health and overall well-being, without any outside control, force and/or influence. The importance of the previous concept cannot be understated, because its acknowledgement and practice underscores the very essence of health care and substance abuse counseling.

The effectiveness of substance abuse counseling often depends on the relationship between a client and an addiction professional. In order for the relationship to be conducive to treatment, a trust must exist between the individual seeking counseling and the individual providing the counseling. A client must be able to fully trust his or her addiction professional in order to adequately and effectively undergo counseling. Clients must also believe that his or her addiction professional has his or her best interest at hand. Furthermore, in order for substance abuse counseling to exist as a practice and/or system, the trust between clients and addiction professionals must be stable and unwavering. The reason being is simple - if clients do not trust or believe their addiction professionals have their best interest at hand, they will eventually stop seeking counseling, which would inevitably put the entire substance abuse counseling system in jeopardy of collapse. Without a substance abuse counseling system in place, thousands of potential individuals in need of counseling would be unable to receive the help they may require to improve or better their lives. Fortunately, the inclusion of autonomy as a principle of health care and substance abuse counseling ensures a trust can be maintained between those seeking counseling and those providing counseling.

The principle of autonomy works to establish trust in the substance abuse counseling system by recognizing the individual's ability to make his or her own decisions regarding personal health and overall well-being. In other words, under many circumstances, the final decisions on treatment, action or further counseling is at the discretion of the client, not the addiction professional. A client, typically, cannot necessarily be forced into treatment or counseling against his or her will. It is up to the client to make decisions about his or her care, not the addiction professional. Beyond those concepts, according to the principle of autonomy, an addiction professional must respect the decision of the client and should not, in any way shape or form, lead, dictate, misinform, coerce, force and/or intimidate the client into making any decision regarding his or her individual care. Additionally, an addiction professional should not conduct experiments with clients, unless consent is obtained from the client, and/or push his or her own personal agenda at the expense of the client's health and overall well-being. Addiction professionals must allow clients to make their own decisions and must do what is best for the client.

Therefore, with the principle of autonomy firmly in place, clients can proceed with their counseling with the freedom of knowing that they will be making their own health-related decisions and with the reassuring understanding that their addiction professional will be acting with their best interest at hand. There are some exceptions and/or applicable laws which may dictate an individual's health care or related counseling; however, for the most part, autonomy grants individuals complete control over their health and related decisions, allowing for the much needed trust between clients and addiction professionals required for adequate care.

As previously mentioned, the principle of autonomy is essential to the relationship between clients and addiction professionals, although occasionally it is simply not adhered to or overlooked. At times, it may be difficult for an addiction professional to accept the decisions made by their clients. For example, a client may refuse to quit smoking cigarettes even though it has been well established that nicotine can be dangerous to an individual's health and overall well-being. In situations like the previous example, addiction professionals may find themselves forcing or leading a client into making a decision about his or her addictions and/or health. When addiction professionals force or lead a client into making a decision, they are in essence, overlooking the principle of autonomy and, ultimately, not respecting the individual's right to make his or her own decision about his or her health. Even though it is widely accepted that cigarettes and nicotine can be detrimental to an individual's health, an addiction professional cannot make, force or coerce a client into quitting smoking. The decisions must be made solely by the individual client. The previous notion extends to all aspects of counseling. An addiction professional cannot make his or her client follow any course of treatment or therapy. The clients must be afforded the opportunity to formulate their own opinions and decisions. When addiction professionals find themselves forcing or leading a client into making a health-related decision they should cease and remember the principle of autonomy. With that said, addiction professionals can provide clients with accurate, unbiased information and education to assist them in the decision making process.

An addiction professional possesses specific training and knowledge that the average person may not have. Therefore, through counseling, the sharing of knowledge from an addiction professional to a client may be beneficial to the client's decision making process. Providing education to clients may expand their minds as well as their perspective, allowing them to make informed decisions to improve their well-being. For example, a young adult client may continue to use nicotine containing products because he or she may not understand the detrimental effects of nicotine on the human body. By providing the young adult client with information regarding the negative effects of nicotine, an addiction professional can educate the client and perhaps the client may then conclude that nicotine is harmful and quit smoking. An addiction professional can help clients understand the consequences of their actions through the sharing of valuable information; however, an addiction professional cannot make a client do anything he or she does not want to do. When providing health care information and education to clients, it is necessary for the addiction professional to include both the potential positive and negative aspects of potential recommendations. A complete picture must be presented to clients in order for them to make an informed decision about their health and overall well-being. Presenting one side of a potential health care related situation or outcome, or providing incomplete information, may lead a

client in one direction over another. To fully achieve respect for patient autonomy, all information must be provided to a client in a complete, balanced and timely manner to afford the client with an opportunity to process the available options so that the client may arrive at an independent, enlightened health care decision.

Unfortunately, as previously mentioned, the principle of autonomy is not always upheld. As a result, protective measures and safeguards have been put into place within the greater system of health care to ensure the principle of autonomy is respected. The safeguards to ensure individual autonomy come in the form of state and federal laws. One of these such laws is the Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPAA. HIPAA was passed by the U. S. government to establish national standards and protocols to protect the individual's personal health care information³. HIPAA sets limits and conditions on the uses and disclosures of individuals' personal health care information, while establishing that all individuals' health care information be properly secured and maintained³. It also gives rights to individuals regarding their health care information, including the right to request copies of their own medical records³. In short, HIPAA dictates how health care professionals can and should share, protect, examine, review, and transmit an individual's personal health care information, while identifying the patient or client as the sole recipient of his or her own personal health care information, unless deemed otherwise by the individual³.

When HIPAA was signed into Federal law, it effectively put the patient at the center of his or her own personal health care by directing all channels of patient health care information directly towards the patient. This channeling of patient health care information goes a long way to maintain the respect for patient autonomy. By establishing the patient as the sole recipient of his or her own personal health care information, HIPAA helps the patient remain autonomous. Essentially, patients do not have to share their health care information with anyone they do not want to, including family members, friends, colleagues and employers. Patients have the right to include or exclude individuals from their personal life when it comes to their own health care. The previous concepts allow the patient the space and clarity he or she may require to arrive at conclusions regarding his or her own health care. In other words, HIPAA provides patients with the opportunity to formulate decisions about their health care on their own terms.

HIPAA also secures the respect of patient autonomy by assuring that all health care patient information is given directly to the patient. Under HIPAA laws, a health care professional cannot give out any information about a patient's health care to anyone, unless the patient or legal proceedings allow it³. Furthermore, HIPAA not only dictates how information is transmitted between health care professionals and patients, it also dictates how information is transmitted among and between health care professionals. Patients' health care information should be transmitted among and between health care professionals on a need to know basis³. Essentially, if health care professionals do not need access to a given patient's health care information to do their job, then they should not be granted access to said health care information. Furthermore, health care professionals should only be granted access to a patient's health care information pertinent to their role and responsibilities. The following example will highlight the previous concepts. A 36-year-old female is seeking counseling from Addiction Professional 1. Addiction Professional 2 has an office near Addiction Professional 1. One day Addiction Professional 2

observes the 36-year-old female client leaving Addiction Professional 1's office. Upon observing the client, Addiction Professional 2 recognizes the client as a former acquaintance. Addiction Professional 2 becomes curious about the client and would like to know more about her current state. Eventually, Addiction Professional 2 approaches Addiction Professional 1, and proceeds to ask Addiction Professional 1 various health-related questions about the 36-year-old female client. Addiction Professional 1 becomes slightly uncomfortable as a result of Addiction Professional 2's questions. However, Addiction Professional 1 does not disclose any health-related information about the client in question. Addiction Professional 2 is annoyed by the lack of information, although soon realizes that any transmission of health-related information regarding the 36-year-old female client may be considered a HIPAA violation.

In the previous example, Addiction Professional 2 wanted Addiction Professional 1 to share health-related information about a client. The client was not seeking counseling from Addiction Professional 2, nor related to Addiction Professional 2 in any professional manner. As a result, under current HIPAA laws, Addiction Professional 2 has no right to any health-related information regarding the client. In other words, the 36-year-old female is not a client of Addiction Professional 2, and therefore, Addiction Professional 2 does not need to know any of her health-related information. If Addiction Professional 1 shared the client's health-related information with Addiction Professional 2, it may be viewed as a HIPAA violation. In addition to the previous requirements, addiction professionals must follow HIPAA restrictions on patient identifiers when transmitting requisite client information among colleagues. HIPAA restrictions were put in place to prohibit nonessential personnel from obtaining individuals' health care information. HIPAA restrictions regarding the transmission of individuals' health care information among and between health care professionals retain respect for patient autonomy by limiting the leakage of patients' health care information to individuals that may use it to influence the patient in any manner. The restrictions also reinforce the flow of patients' health care information to the individual patient.

Another important safeguard to individual autonomy is the concept of informed consent. Informed consent can refer to the process health care professionals must go through to inform patients about their potential health care options in order for patients to select the best health care option for them^{2,4}. In other words, informed consent refers to the process of outlining the possible benefits and risks of a health care intervention, e.g. treatment, test, surgery, procedure, so the patient can understand, acknowledge and choose whether or not to accept or reject any health care related intervention offered to him or her by a health care professional. Informed consent can also refer to the process of a health care professional receiving consent from a patient regarding the administration of a health care intervention^{2,4}. Informed consent ensures respect for patient autonomy by ensuring the accurate, complete, unbiased distribution of information regarding a health care intervention to those receiving health care. Informed consent also dictates that any information regarding health care be directed to the patient before the intervention is carried out on said patient. That last piece of information regarding the timing of health care information is essential to the concept of informed consent's ability to maintain respect for patient autonomy.

Health care information regarding a potential patient intervention must be provided to a patient before the intervention occurs to allow the patient an opportunity to process the benefits and risks of the intervention and to conclude whether or not he or she wants to receive the intervention. The goal of the principle of autonomy is to allow the patient/client with an opportunity to formulate his or her own decisions regarding his or her health care. As previously highlighted, providing accurate, complete, unbiased health care information to patients on the benefits and risks of a health care intervention can aid patients in the decision making process. The requirement that health care information be presented to patients before interventions are administered also maintains respect for patient autonomy by preventing health care professionals from administering health care intervention without the acknowledgement of the patient.

Before an intervention is administered, a patient must acknowledge, typically by signing a document, that he or she has received information regarding an intervention and that he or she accepts the intervention with an understanding of the benefits and risks of the intervention. A health care professional cannot administer an intervention to a patient at his or her own discretion. The health care intervention must be acknowledged and accepted by the patient. Permission to administer an intervention must be granted to the health care professional by the patient, subsequently preserving respect for patient autonomy. The act of a health care professional obtaining a patient signed informed consent document goes a long way to protect both the patient's rights and the health care professional.

The patient's signed informed consent document provides evidence that a health care professional reviewed the benefits and risks of a health care intervention as well as obtained acceptance and permission from the patient to administer said intervention. If a health care professional performs a health care intervention and cannot provide evidence of informed consent, legal consequences may apply^{2,4}. With that established, there are emergency situations where informed consent may not be required for a health care professional to administer life-saving interventions. There may also be legal situations where a health care professional may have to seek alternate routes to obtain informed consent. Nevertheless, it is in the best interest of the health care professional to obtain informed consent from a patient when applicable.

The principle of autonomy is a key component of health care and effective substance abuse counseling. It helps establish the necessary trust between clients and addiction professionals as well as the notion that addiction professionals have the best interest of the individual client at hand. Moreover, the principle of autonomy recognizes the patient/client as an individual with the ability to make informed decisions about the direction of his or her own personal health care and overall well-being. Addiction professionals should maintain the principle of autonomy at all times.

Justice

The next important cornerstone of health care ethics is justice. As with the principle of autonomy, the principle of justice has a specific meaning when it relates to health care and related fields. Justice, when used in the context of health care, can refer to the fair and legal allocation of health care resources to

patients/clients^{1,2}. Essentially, what the previous concept means is that patients/clients in similar situations should have access to the same health care options or the same level of health care. One patient cannot be favored over another patient and/or one patient cannot be neglected for any reason, while another patient receives extra attention or health care. In other words, one patient/client cannot receive health care at the detriment of another patient/client. Every patient, once admitted into a health care system, should have the opportunity to receive access to the same health care resources.

Health care professionals can achieve and maintain justice by administering health care in an unbiased, fair manner. Once a patient is admitted into a health care setting, health care professionals should treat patients equally and fairly. Health care should be administered to patients based on need. Race, gender and/or socioeconomic status should not dictate how health care is administered to patients. Also, patients' personalities and/or personal backgrounds should not be a determining factor in the administration or allocation of health care resources. Additionally, personal relationships between health care professionals and patients should not affect the delivery of health care. A patient should not receive a higher level of health care due to a personal relationship with an individual health care professional; nor should health care be withheld based on a personal relationship.

Justice, as it relates to health care, dictates the impartial allocation of available health care resources to patients in need. Similar patients in similar situations have the same right to available health care resources. A fair-minded approach to the administration of health care can ensure the aforementioned concepts are obtained. With that said, what may be considered to be a health care resource? Almost anything that can be used to treat, provide therapy and/or improve the health, overall well-being and quality of life of a patient/client, within reason and legal standards, may be considered a health care resource. Basically, anything from a hospital bed, to an individual medication, to a health care professional's time may be considered a health care resource. With that said, unfortunately, in the current health care climate, resources can often be in short supply.

Over the past few years, patient populations have increased in size and number, resulting in stretches of time when health care demand far exceeds health care resource supply. Unfortunately, health care is not immune to the fundamental concepts of supply and demand. If demand exceeds supply, as with any other venture, problems can arise. The only difference when it comes to health care when compared to other ventures is that a lot more, in the way of individuals' health, overall well-being and quality of life, is on the line. When health care resources are limited, the need for the principle of justice is even more important. When resources are dwindling and patient populations are increasing, health care professionals must keep the principle of justice in mind to ensure the allocation of resources is completed in a fair, unbiased manner.

Bearing the previous concepts in mind, what does the principle of justice mean for the individual addiction professional? Simply put, it means that an addiction professional should treat all of his or her clients equally. An addiction professional's time should be evenly distributed among all clients in a manner that is fair and unbiased. An addiction professional should not divert time to one client at the expense of another client. Additionally, an addiction professional should not give preference of scheduling to a client based on their personal relationship with the client or any other specific reason

outside of the scope of justice. Every client of an addiction professional should have equal opportunities when it comes to the very valuable resource of an addiction professional's time. There will be exceptions, such as emergencies, but for the most part, addiction professionals should allocate their resources based on need and equality.

As previously mentioned, in the current health care climate, there may be times when the availability of health care resources are in flux. For example, there may be times when addiction professionals have everything they need to manage their clients effectively and there may be times when addiction professionals lack the necessary health care resources to manage their ever growing client populations. Whatever the case may be, addiction professionals must achieve and maintain the principle of justice at all times. The allocation of whatever health care resources are available to individuals must be done in a fair, unbiased manner in order to maintain the integrity of the addiction professional-client relationship as well as the integrity of the health care system as a whole.

Beneficence and Nonmaleficence

The final two cornerstones of health care are beneficence and nonmaleficence. Beneficence and nonmaleficence also have specific meanings when they are applied to health care and related fields. Beneficence can refer to the act of doing what is best for the patient, while nonmaleficence can refer to the ideal of inflicting no harm to patients - do no harm to patients/clients^{1,2}. Beneficence and nonmaleficence typically go hand and hand and are often referred to as the most important principles of health care - the reason being, is that both beneficence and nonmaleficence lie at the very heart of the ideals of health care and help establish the very essence of health care. In other words, the principles of beneficence and nonmaleficence work to maintain the system of health care as a working entity designed to better the health of all those in need of care.

The system of health care was established to serve humanity in order to improve the health and quality of life of all those who may enter into the health care system. Furthermore, individuals seek health care to improve their state of well-being. Whether they are in pain, injured, sick or in need of counseling, individuals enter into the care of another individual to better their situation and quality of life. Typically, individuals do not enter the care of another individual to worsen their situation and/or quality of life. If individuals consistently entered the care of another individual only to find their health, overall well-being, and quality of life routinely diminished, they would stop seeking care from that individual. The same can be said for the system of health care. If patients requiring health care were continually admitted into a system that did not promote and/or consider their health, overall well-being, and quality of life, they would refuse to enter into that system - thus, negating the basic need for the health care system as it is currently know.

Patients seeking care from health care professionals supports the entire system of health care, as well as its ideals of improving health and quality of life. In turn, health care professionals administering care to patients which improves their health, overall well-being, and quality of life strengthens and perpetuates the system by attracting new patients/clients. In addition, it also helps the system of health care

maintain its ideals and the very essence of what makes health care a form of care. If the ideals and essence of health care were jeopardized and/or wiped out in any way the system could not continue on, and many individuals would not be able to receive the help they may require. In order for the health care system to thrive, there must be an understanding between the individuals seeking health care and the individuals providing health care that clearly stipulates and illuminates the core principles and ideals of health care. The necessary understanding between patients and health care professionals can be found in the principles of beneficence and nonmaleficence.

As previously mentioned, the principle of beneficence can refer to the act of doing what is best for the patient^{1,2}. The principle of beneficence may also be understood as follows. Beneficence, as it relates to health care, can refer to the act of doing what is best for the patient, with consideration for the patient's pain, physical and mental suffering, risk of disability, risk of diminished health, overall well-being and quality of life, as well as risk of death^{1,2}. Additionally, beneficence can refer to the act of promoting patients' health^{1,2}. Essentially, the principle of beneficence dictates that a health care professional must act and administer health care and/or counseling in a manner which is best for the patient/client, while considering the patient and the risks of the health care administered to the patient, e.g. promoting health care interventions, which are best for the patient^{1,2}.

As outlined above, it is critical for health care professionals to always act in the best interest of the patient. Health care professionals should not put their interests or personal agendas first while administering health care and/or engaging in counseling. The best interest of the patient must come first. Acting in the best interest of the patient is the very reason health care professionals are employed to care for patients. It forms the basis for health care related professions and individual health care professionals' duties. It also goes a long way to promote beneficence. If health care professionals act in the best interest of the patient, they are, in essence, doing what is best for the patient. Also, by acting in the best interest of the patient, health care professionals may be in a better position to consider the patient and his or her concerns about health and well-being. Finally, acting in the best interest of the patient will enable health care professionals to consistently consider the benefits and risks of potential health care interventions before they are administered to a patient. In doing so, health care professionals can allow themselves an opportunity to understand how the potential intervention will affect the patient and the patient's health, overall well-being and quality of life. Therefore, acting in the best interest of the patient can help health care professionals achieve and maintain the principle of beneficence.

To build on the concepts of beneficence, the concepts of nonmaleficence must also be considered. The principle of nonmaleficence can refer to the ideal of inflicting no harm to patients - do no harm to patients/clients^{1,2}. In essence, the principle of nonmaleficence takes the ideals behind beneficence to the next level. Beneficence dictates that health care professionals must do what is best for patients, while considering patients and promoting their health, overall well-being and quality of life. The ethical principle of nonmaleficence takes the concepts behind beneficence and goes even further. Nonmaleficence guides health care professionals to the next step in moral, ethical behavior. It provides an organic progression for health care professionals to follow in their practice. Not only must health care professionals do what is best for the individual patient, they must also do no harm to patients. The

relationship between beneficence and nonmaleficence cannot be understated. They are the left and right hands which support the notion of health care and guide health care professionals in their actions. Simply put, without the principles of beneficence and nonmaleficence, there could be no health care in its truest sense. With the aforementioned concepts in mind, how do the principles of beneficence and nonmaleficence relate to addiction professionals? The answer to the previous question is as follows: addiction professionals must not intentionally bring harm onto a patient/client.

Not every patient is ideal. Some patients can be extremely stressful to manage or counsel. Additionally, some patients may be ill-tempered, difficult and/or simply noncompliant with any related health care or counseling methods. With that in mind, however challenging a patient/client may be, in no way, shape or form should an addiction professional intentionally bring harm onto a patient/client. Whether it is physical, emotional or mental, no harm can be brought onto a client by an addiction professional. Typically, patients/clients are not their best selves when they are seeking health care and/or counseling. The challenging behavior of clients may be a result of their pain, discomfort or illness. A patient/client may not be making an intentional decision to be challenging. He or she may simply have no choice due to his or her situation. Furthermore, for a patient in extreme pain or suffering from the complications of a disease or health related condition, being pleasant and personable may not be a high priority. Whatever the case may be, challenging behavior from a patient may be a sign of deeper rooted issues connected to health related concerns or a reflection of the internal pain from which they may be suffering. Challenging or abrasive client behavior should not be met with reciprocated abrasive behavior from an addiction professional. Such behavior may prove to have harmful effects on a patient's health, overall well-being and quality of life. It may also put the addiction professional in direct conflict with the principles of beneficence and nonmaleficence.

Due to the potential conflicts with the principles of beneficence and nonmaleficence, as with the other cornerstones, safeguards have been put into place within the greater system of health care to ensure beneficence and nonmaleficence are respected and fully realized. The safeguards to ensure the principles of beneficence and nonmaleficence are met may come in the form of organizational policies and procedures. Organizational policies and procedures are designed and developed with the best interest of the patient in mind. They serve as answers to questions which may arise on how to best administer health care to patients. They provide safety regulations, emergency protocols and professional standards. In essence, organizational policies and procedures serve as a guide to help health care professionals inflict the least amount of harm to patients, while achieving a beneficial outcome. With that said, in order for organizational policies and procedures to protect the principles of beneficence and nonmaleficence, addiction professionals must adhere to and follow their organization's policies and procedures. An addiction professional should have an understanding of their specific organization's or facility's policies and procedures in order for them to effectively maintain the principles of beneficence and nonmaleficence.

The principles of beneficence and nonmaleficence are absolutely necessary to substance abuse counseling and the system of health care. A system which was developed to prevent harm cannot stand if it is continually causing harm. Addiction professionals must act in the best interest of the patient/client and must not do harm to patients/clients. After all, patients seek health care and

specifically, substance abuse counseling to improve their situations and reduce harm, and not to receive harm. Addiction professionals must honor the previous fundamental understanding by preventing and/or limiting the amount of harm done to patients, while promoting the health of the individual patient and respecting the patient's own personal health care decisions.

Section 1: Summary

Addiction professionals may face various types of ethical dilemmas and challenges while delivering care to individuals seeking their services. The first step for addiction professionals towards managing the ethical dilemmas and challenges that may arise is to gather an understanding of the ethical obligations and responsibilities they have to their clients. The key ethical obligations and responsibilities addiction professionals have to their clients can be observed in the four cornerstones of health care ethics, which include: autonomy, justice, beneficence and nonmaleficence. Each of the aforementioned principles have specific meanings when applied to health care and health care related fields. For example, the principle of autonomy can refer to the acceptance or acknowledgement that individuals possesses the capacity to think, act and form decisions about themselves and their own life; free from external control, influence, force and/or coercion, while the principle of justice can refer to the fair and legal allocation of health care resources to patients/clients^{1,2}. The remaining cornerstones of health care ethics may be the most important to the integrity of the health care system as well as the very essence of health care ideals. With that said, beneficence can refer to the act of doing what is best for the patient, while nonmaleficence can refer to the ideal of inflicting no harm to patients - do no harm to patients/clients^{1,2}. Addiction professionals should strive to maintain the aforementioned four principles at all times to best serve their clients and manage any ethical dilemma and/or challenge that may arise.

Section 1: Personal Reflection Question

What are the four cornerstones of health care ethics and how may they apply to substance abuse counseling?

Section 2: Codes of Ethics

It has been well established that ethics is important to health care. Ethical principles help guide the safe and effective administration of health care as well as ensure that every individual has an opportunity to have a voice regarding his or her own personal health. Due to the importance of ethics in health care, professional organizations, such as the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) have developed codes of ethics to help guide addiction professionals in their delivery of professional care to individuals seeking their services. The NAADAC's code of ethics builds on the four cornerstones of health care: autonomy, justice, beneficence and nonmaleficence, and expands their ideals to provide addiction professionals with further insight into their professional responsibilities and

obligations to their clients. The NAADAC's code of ethics is broken down into 9 major sections or principles. The remainder of this section will highlight the 9 major principles of the NAADAC's code of ethics. Each of the 9 principles is highlighted and broken down into further informational segments which outline how each principle may impact various points of interest such as: addiction professionals' behavior, client relationships, diversity, confidentiality and boundaries. The information presented below was derived from the NAADAC's code of ethics².

Principle I: The Counseling Relationship

- Addiction professionals should understand and accept their responsibility to ensure the safety and welfare of their client, and to act for the good of each client while exercising respect, sensitivity, and compassion. Providers shall treat each client with dignity, honor, and respect, and act in the best interest of each client.
- Addiction professionals should understand the right of each client to be fully informed about treatment, and shall provide clients with information in clear and understandable language regarding the purposes, risks, limitations, and costs of treatment services, reasonable alternatives, their right to refuse services, and their right to withdraw consent within time frames delineated in the consent. Providers have an obligation to review with their client - in writing and verbally - the rights and responsibilities of both Providers and clients. Providers shall have clients attest to their understanding of the parameters covered by the Informed Consent.
- Addiction professionals should clarify the nature of relationships with each party and the limits of confidentiality at the outset of services when agreeing to provide services to a person at the request or direction of a third party.
- Addiction professionals shall respect the diversity of clients and seek training and supervision in areas in which they are at risk of imposing their values onto clients. Furthermore, addiction professionals shall not practice, condone, facilitate, or collaborate with any form of discrimination against any client.
- Addiction professionals who act on behalf of a client who has been judged legally incompetent or with a representative who has been legally authorized to act on behalf of a client, shall act with the client's best interests in mind, and shall inform the designated guardian or representative of any circumstances which may influence the relationship. Providers recognize the need to balance the ethical rights of clients to make choices about their treatment, their capacity to give consent to receive treatment-related services, and parental/familial/representative legal rights and responsibilities to protect the client and make decisions on their behalf.
- Addiction professionals who work with clients who have been mandated to counseling and related services, shall discuss legal and ethical limitations to confidentiality. Furthermore, if the client refuses services, the addiction professional shall discuss with the client the potential consequences of refusing the mandated services, while respecting client autonomy.
- Addiction professionals shall obtain a signed Release of Information from a potential or actual client if the client is working with another behavioral health professional to help establish a collaborative professional relationship.

- Addiction professionals shall consider the inherent risks and benefits associated with moving the boundaries of a counseling relationship beyond the standard parameters. Consultation and supervision shall be sought and documented.
- Addiction professionals shall make every effort to avoid multiple relationships with a client. When a dual relationship is unavoidable, the professional shall take extra care so that professional judgment is not impaired and there is no risk of client exploitation. Such relationships include, but are not limited to, members of the addiction professional's immediate or extended family, business associates of the professional, or individuals who have a close personal relationship with the professional or the professional's family. When extending these boundaries, addiction professionals should take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that their judgment is not impaired and no harm occurs. Consultation and supervision shall be documented.
- Addiction professionals should recognize that there are inherent risks and benefits to accepting as a client someone with whom they have a prior relationship. This includes anyone with whom the addiction professional had a casual, distant, or past relationship. Addiction professional to engaging in a counseling relationship with a person from a previous relationship, the addiction professional shall seek consultation or supervision. The burden is on the addiction professional to ensure that their judgment is not impaired and that exploitation is not occurring.
- Addiction professionals considering initiating contact with or a relationship with a previous client shall seek documented consultation or supervision prior to its initiation.
- Addiction professionals shall clarify who "the client" is, when accepting and working with more than one person as "the client." In group counseling, addiction professionals shall take reasonable precautions to protect the members from harm.
- Addiction professionals shall truthfully represent facts to all clients and third-party payers regarding services rendered, and the costs of those services.
- Addiction professionals shall communicate information in ways that are developmentally and culturally appropriate. The addiction professional should offer clear understandable language when discussing issues related to informed consent.
- Addiction professionals shall create treatment plans in collaboration with their client. Treatment plans shall be reviewed and revised on an ongoing and intentional basis to ensure their viability and validity.
- Addiction professionals shall provide their client with the highest quality of care as well as appropriately store documentation.
- Addiction professionals should create, maintain, protect, and store documentation required per federal and state laws and rules, and organizational policies.
- Addiction professionals have an obligation to speak out regarding barriers and obstacles that impede access to and/or growth and development of clients. When advocating for a specific client, addiction professionals should obtain written consent prior to engaging in advocacy efforts.

- Addiction professionals should recognize that each client is entitled to the full extent of physical, social, psychological, spiritual, and emotional care required to meet their needs.
- Addiction professionals should recognize their influential positions with respect to clients, trainees, and research participants and shall not exploit the trust and dependency of any client, trainee, or research participant. Addiction professionals should not engage in any activity that violates or diminishes the civil or legal rights of any client. Addiction professionals should not use coercive treatment methods with any client, including threats, negative labels, or attempts to provoke shame or humiliation. Addiction professionals should not impose their personal religious or political values on any client.
- Addiction professionals shall not engage in any form of sexual or romantic relationship with any current or former client, nor accept as a client anyone with whom they have engaged in a romantic, sexual, social, or familial relationship. This prohibition includes in-person and electronic interactions and/or relationships. Addiction Professionals are prohibited from engaging in counseling relationships with friends or family members with whom they have an inability to remain objective.
- Addiction professionals should terminate services with clients when services are no longer required, no longer serve the client's needs, or the Provider is unable to remain objective. Counselors provide pre-termination counseling and offer appropriate referrals as needed. Providers may refer a client, with supervision or consultation, when in danger of harm by the client or by another person with whom the client has a relationship.
- Addiction professionals should make necessary coverage arrangements to accommodate interruptions such as vacations, illness, or unexpected situation.
- Addiction professionals should not abandon any client in treatment. Providers who anticipate termination or interruption of services to clients shall notify each client promptly and seek transfer, referral, or continuation of services in relation to each client's needs and preferences.
- Addiction professionals should ensure that all fees charged for services are fair, reasonable, and commensurate with the services provided and with due regard for clients' ability to pay.
- Addiction professionals should not refer clients to their private practice unless the policies, at the organization at the source of the referral, allow for self-referrals. When self-referrals are not an option, clients shall be informed of other appropriate referral resources.
- Addiction professionals should not offer or accept any commissions, rebates, kickbacks, bonuses, or any form of remuneration for referral of a client for professional services, nor engage in fee splitting.
- Addiction professionals should not use relationships with clients to promote personal gain or profit of any type of commercial enterprise.
- Addiction professionals should not withhold records they possess that are needed for any client's treatment solely because payment has not been received for past services.

- Addiction professionals shall not withhold reports to referral agencies regarding client treatment progress or completion solely because payment has not yet been received in full for services, particularly when those reports are to courts or probation officers who require such information for legal purposes. Reports may note that payment has not yet been made, or only partially made, for services rendered.
- Addiction professionals should clearly disclose and explain to each client, prior to the onset of services, (1) all costs and fees related to the provision of professional services, including any charges for cancelled or missed appointments, (2) the use of collection agencies or legal measures for nonpayment, and (3) the procedure for obtaining payment from the client if payment is denied by a third party payer.
- Addiction professionals should provide the same level of professional skills and service to each client without regard to the compensation provided by a client or third party payer, and whether a client is paying full fee, a reduced fee, or has their fees waived.
- Addiction professionals should charge each client only for services actually provided to a client regardless of any oral or written contract a client has made with the addiction professional or agency.
- Addiction professionals should maintain accurate and timely clinical and financial records for each client.
- Addiction professionals should give reasonable and written notice to clients of impending suspension of services for nonpayment.
- Addiction professionals should give reasonable and written notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse—when such action is taken, addiction professionals shall not reveal clinical information.
- Addiction professionals can engage in bartering for professional services if: (1) the client requests it, (2) the relationship is not exploitative, (3) the professional relationship is not distorted, (4) federal and state laws and rules allow for bartering, and (5) a clear written contract is established with agreement on value of item(s) bartered for and number of sessions, prior to the onset of services. Providers consider the cultural implications of bartering and discuss relevant concerns with clients. Agreements shall be delineated in a written contract. Providers shall seek supervision or consultation and document.
- Addiction professionals should recognize that clients may wish to show appreciation for services by offering gifts. Addiction professionals shall take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.
- Addiction professionals should not engage in uninvited solicitation of potential clients who are vulnerable to undue influence, manipulation, or coercion due to their circumstances.
- Addiction professionals are prohibited from engaging in a personal or romantic virtual e-relationship with current clients.

Principle II: Confidentiality and Privileged Communication

- Addiction professionals should understand that confidentiality and anonymity are foundational to addiction treatment and embrace the duty of protecting the identity and privacy of each client as a primary obligation.
- Addiction professionals should create and maintain appropriate documentation. Providers shall ensure that records and documentation kept in any medium (i.e., cloud, laptop, flash drive, external hard drive, tablet, computer, paper, etc.) are secure.
- Addiction professionals should notify client, during informed consent, about procedures specific to client access of records. Addiction professionals shall provide a client reasonable access to documentation regarding the client upon his/her written request. Addiction professionals shall protect the confidentiality of any others contained in the records. Addiction professionals shall limit the access of clients to their records – and provide a summary of the records – when there is evidence that full access could cause harm to the client. A treatment summary shall include dates of service, diagnoses, treatment plan, and progress in treatment. Addiction professionals should seek supervision or consultation prior to providing a client with documentation, and shall document the rationale for releasing or limiting access to records. Addiction professionals should provide assistance and consultation to the client regarding the interpretation of counseling records.
- Addiction professionals should encourage ongoing discussions with clients regarding how, when, and with whom information is to be shared.
- Addiction professionals shall not disclose confidential information regarding the identity of any client, nor information that could potentially reveal the identity of a client, without written consent and authorization by the client. In situations where the disclosure is mandated or permitted by state and federal law, verbal authorization shall not be sufficient except for emergencies.
- Addiction professionals and the organizations they work for should ensure that confidentiality and privacy of clients is protected by addiction professionals, employees, supervisees, students, office personnel, other staff and volunteers.
- Addiction professionals, during informed consent, shall disclose the legal and ethical boundaries of confidentiality and disclose the legal exceptions to confidentiality.
- Addiction professionals may reveal client identity or confidential information without client consent when a client presents a clear and imminent danger to themselves or to other persons, and to emergency personnel who are directly involved in reducing the danger or threat. Addiction professionals should seek supervision or consultation when unsure about the validity of an exception.
- Addiction professionals ordered to release confidential privileged information by a court shall obtain written, informed consent from the client, take steps to prohibit the disclosure, or have it limited as narrowly as possible because of potential harm to the client or counseling relationship.
- Addiction professionals should release only essential information when circumstances require the disclosure of confidential information.

- Addiction professionals should inform the client when the addiction professional is a participant in a multidisciplinary care team providing coordinated services to the client. The client shall be informed of the team's member credentials and duties, information being shared, and the purposes of sharing client information.
- Addiction professionals should discuss confidential client information in locations where they are reasonably certain they can protect client privacy.
- Addiction professionals should obtain client authorization prior to disclosing any information to third party payers (i.e., Medicaid, Medicare, insurance payers, private payers).
 - Addiction professionals should use encryption and precautions that ensure that information being transmitted electronically or other medium remains confidential.
- Addiction professionals should protect the confidentiality of deceased clients by upholding legal mandates and documented preferences of the client.
- Addiction professionals, who provide group, family, or couples therapy, shall describe the roles and responsibilities of all parties, limits of confidentiality, and the inability to guarantee that confidentiality shall be maintained by all parties.
- Addiction professionals should protect the confidentiality of any information received regarding counseling minor clients or adult clients who lack the capacity to provide voluntary informed consent, regardless of the medium, in accordance with federal and state laws, and organization policies and procedures. Parents, guardians, and appropriate third parties are informed regarding the role of the counselor, and the boundaries of confidentiality of the counseling relationship.
- Addiction professionals should obtain informed consent and written permissions and releases before videotaping, audio recording, or permitting third party observation of any client interaction or group therapy session.
- Addiction professionals should obtain informed consent and written release of information prior to recording an electronic therapy session. Prior to obtaining informed consent for recording e-therapy, the addiction professional should seek supervision or consultation, and document recommendations. Addiction professionals shall disclose to client in informed consent how e-records shall be stored, maintained, and disposed of and in what time frame.
- Addiction professionals who receive confidential information about any client (past, present or potential) shall not disclose that information without obtaining written permission from the client (past, present or potential) allowing for such release.
- Addiction professionals who are part of integrative care teams, shall not release confidential client information to external care team members without obtaining written permission from the client allowing such release.
- Addiction professionals shall store, safeguard, and dispose of client records in accordance with state and federal laws, accepted professional standards, and in ways which protect the confidentiality of clients.

Principle III: Professional Responsibilities and Workplace Standards

- Addiction professionals should conduct themselves with integrity.
- Addiction professionals should not engage in, endorse or condone discrimination against prospective or current clients and their families, students, employees, volunteers, supervisees, or research participants based on their race, ethnicity, age, disability, religion, spirituality, gender, gender identity, sexual orientation, marital or partnership status, language preference, socioeconomic status, immigration status, active duty or veteran status, or any other basis.
- Addiction professionals should provide services that are nondiscriminatory and nonjudgmental. Addiction professionals should not exploit others in their professional relationships. Addiction professionals should maintain appropriate professional and personal boundaries.
- Addiction professionals should not participate in, condone, or be associated with any form of dishonesty, fraud, or deceit.
- Addiction professionals shall not engage in any criminal activity.
- Addiction professionals shall not engage in or condone any form of harassment, including sexual harassment.
- Addiction professionals should claim and present only those educational degrees and specialized certifications that they have earned from the appropriate institutions or organizations. Addiction professionals should not imply Master's level competence until their Master's degree is awarded. Addiction professionals shall not imply doctoral-level competence until their doctoral title or degree is awarded. The accreditations of a specific institution of higher learning or degree program shall be accurately represented.
- Addiction professionals should claim and promote only those licenses and certifications that are current and in good standing.
- Addiction professionals should ensure that their credentials and affiliations are identified accurately.
- Addiction professionals should not misrepresent professional qualifications, education, experience, memberships or affiliations.
- Addiction professionals should provide services within their scope of practice and competency, and shall offer services that are science-based, evidence-based, and outcome-driven. Addiction professionals should engage in counseling practices that are grounded in rigorous research methodologies. Addiction professionals should maintain adequate knowledge of and adhere to applicable professional standards of practice.
- Addiction professionals should practice within the boundaries of their competence.
- Addiction professionals should seek and develop proficiency through relevant education, training, skills, and supervised experience prior to independently delivering specialty services.

- Addiction professionals should recognize that the highest levels of educational achievement are necessary to provide the level of service clients deserve. Addiction professionals should embrace the need for formal and specialized education as a vital component of professional development, competency, and integrity. Providers pursue knowledge of new developments within the addiction and behavioral health professions and increase competency through formal education, training, and supervised experience.
- Addiction professionals should pursue and engage in continuing education and professional development opportunities in order to maintain and enhance knowledge of research-based scientific developments within the profession.
- Addiction professionals should use techniques, procedures, and modalities that have a scientific and empirical foundation. Addiction professionals should utilize counseling techniques and procedures that are grounded in theory, evidence-based, outcome-driven and/or a research-supported promising practice. Addiction professionals should not use techniques, procedures, or modalities that have substantial evidence suggesting harm, even when these services are requested.
- Addiction professionals should discuss and document potential risks, benefits and ethical concerns prior to using developing or innovative techniques, procedures, or modalities with a client.
- Addiction professionals should develop multicultural counseling competency by gaining knowledge specific to multiculturalism, increasing awareness of cultural identifications of clients, evolving cultural humility, displaying a disposition favorable to difference, and increasing skills pertinent to being a culturally-sensitive addiction professional.
- Addiction professionals should work to educate medical professionals about substance use disorders, the need for primary treatment of these disorders, and the need to limit the use of mood altering chemicals for persons in recovery.
- Addiction professionals should recognize the need for the use of mood altering chemicals in limited medical situations, and will work to educate medical professionals to limit, monitor, and closely supervise the administration of such chemicals when their use is necessary.
- Addiction professionals should collaborate with other health care professionals in providing a supportive environment for any client who receives prescribed medication.
- Addiction professionals should be aware of the need for collegiality and cooperation in the helping professions.
- Addiction professionals should develop respectful and collaborative relationships with other professionals who are working with a specific client.
- Addiction professionals should be advocates for their clients in those settings where the client is unable to advocate for themselves.
- Addiction professionals should recognize the effect of impairment on professional performance and shall seek appropriate professional assistance for any personal problems or conflicts that may impair work performance or clinical judgment.

- Addiction professionals should offer and provide assistance and consultation as needed to peers, coworkers, and supervisors who are demonstrating professional impairment, and intervene to prevent harm to clients.
- Addiction professionals should create a written plan, policy or Professional Will for addressing situations involving the Provider's incapacitation, termination of practice, retirement, or death.
- Addiction professionals should give appropriate credit to the authors or creators of all materials used in their course of their work. Providers shall not plagiarize another person's work.

Principle IV: Working In a Culturally Diverse World

- Addiction professionals shall be knowledgeable and aware of cultural, individual, societal, and role differences amongst the clients they serve.
- Addiction professionals shall recognize and be sensitive to the diverse cultural meanings associated with confidentiality and privacy.
- Addiction professionals practicing cultural humility shall be open to the values, norms, and cultural heritage of their clients and shall not impose his or her values/beliefs on the client.
- Addiction professionals should respect the roles of family members, social supports, and community structures, hierarchies, values and beliefs within the client's culture.
- Addiction professionals should use methodologies, skills, and practices that are evidence-based and outcome-driven for the populations being serviced.
- Addiction professionals shall recognize that conventional counseling styles may not meet the needs of all clients.

Principle V: Assessment, Evaluation and Interpretation

- Addiction professionals shall use assessments appropriately within the counseling process.
- Addiction professionals should utilize only those assessment instruments whose validity and reliability have been established for the population tested, and for which they have received adequate training in administration and interpretation.
- Addiction professionals should explain to clients the nature and purposes of each assessment and the intended use of results, prior to administration of the assessment.
- Addiction professionals should provide an appropriate environment free from distractions for the administration of assessments.
- Addiction professionals shall provide proper diagnosis of mental health and substance use disorders, within their scope and licensure.

- Addiction professionals shall not misuse assessment results and interpretations.
- Addiction professionals shall maintain the integrity and security of tests and assessment data, thereby addressing legal and contractual obligations.

Principle VI: E-Therapy, E-Supervision, and Social Media

- Addiction professionals who choose to engage in the use of technology for e-therapy, distance counseling, and e-supervision shall pursue specialized knowledge and competency regarding the technical, ethical, and legal considerations specific to technology, social media, and distance counseling.
- Addiction professionals who engage in the use of electronic platforms for the delivery of services shall take reasonable steps to verify the client’s/supervisee’s identity prior to engaging in the e-therapy relationship and throughout the therapeutic relationship.
- Addiction professionals utilizing technology, social media, and distance counseling within their practice recognize that they are subject to state and federal laws and regulations governing the counselor’s practicing location.
- Addiction professionals should assess and document the client’s/supervisee’s ability to benefit from and engage in e-therapy services.
- Addiction professionals shall take reasonable steps to determine whether the client/supervisee physically, intellectually, emotionally, linguistically and functionally capable of using e-therapy platforms and whether e-therapy/e-supervision is appropriate for the needs of the client/supervisee.
- Addiction professionals should maintain electronic records in accordance with relevant state and federal laws and statutes.
- Addiction professionals shall not accept clients’ “friend” requests on social networking sites or email (from Facebook, My Space, etc.), and shall immediately delete all personal and email accounts to which they have granted client access and create new accounts.

Principle VII: Supervision and Consultation

- Addiction professionals who teach and provide clinical supervision accept the responsibility of enhancing professional development of students and supervisees by providing accurate and current information, timely feedback and evaluations, and constructive consultation.
- Addiction professionals should complete training specific to clinical supervision prior to offering or providing clinical supervision to students or other professionals.
- Addiction professionals and clinical supervisors shall inform supervisees of policies and procedures to which supervisors shall adhere.

- Addiction professionals and clinical supervisors shall intentionally develop respectful and relevant professional relationships and maintain appropriate boundaries with clinicians, students, interns, and supervisees, in all venues.
- Addiction professionals and clinical supervisors shall not disclose confidential information in teaching or supervision without the expressed written consent of a client, and only when appropriate steps have been taken to protect client's identity and confidentiality.
- Addiction professionals and clinical supervisors shall monitor the services provided by supervisees.
- Addiction professionals and clinical supervisors should ensure supervisees, interns and students, shall disclose to clients their status as students and supervisees, and shall provide an explanation as to how their status affects the limits of confidentiality.
- Addiction professionals and educators and site supervisors shall ensure that program content and instruction are based on the most current knowledge and information available in the profession.
- Addiction professionals, educators and site supervisors shall ensure that students' performances are evaluated in a fair and respectful manner and on the basis of clearly stated criteria.
- Addiction professionals, educators and site supervisors shall avoid dual relationships and/or nonacademic relationships with students, interns, and supervisees.
- Addiction professionals clinical Supervisors shall not actively supervise relatives, romantic or sexual partners, nor personal friends, nor develop romantic, sexual, or personal relationships with students or supervisees.

Principle VIII: Resolving Ethical Concerns

- Addiction professionals shall adhere to and uphold the NAADAC Code of Ethics, and shall be knowledgeable regarding established policies and procedures for handling concerns related to unethical behavior, at both the state and national levels. Additionally, addiction professionals should strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek supervision and/or consultation when necessary.
- Addiction professionals should understand and endorse the NAADAC Code of Ethics and other applicable ethics codes from professional organizations or certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.
- Addiction professionals should utilize and document, when appropriate, an ethical decision-making model when faced with an ethical dilemma. A viable ethical decision-making model shall include but is not limited to: (a) supervision and/or consultation regarding the concern; (b) consideration of relevant ethical standards, principles, and laws; (c) generation of potential courses of action; (d) deliberation of risks and benefits of each potential course of action; (e) selection of an objective decision based on the circumstances and welfare of all involved; and (f) reflection, and re-direction if necessary, after implementing the decision.

- Addiction professionals shall seek and document supervision and/or consultation in the event that ethical responsibilities conflict with agency policies and procedures, state and/or federal laws, regulations, and/or other governing legal authority.
- Addiction professionals shall report unethical conduct or unprofessional modes of practice - leading to harm - which they become aware of to the appropriate certifying or licensing authorities, state or federal regulatory bodies, and/or NAADAC.
- Addiction professionals shall seek consultation and direction from supervisors, consultants or the NAADAC Ethics Committee when uncertain about whether a particular situation or course of action may be in violation of the NAADAC Code of Ethics.
- Addiction professionals shall not initiate, participate in, or encourage the filing of an ethics or grievance complaint as a means of retaliation against another person.

Principle IX: Research and Publication

- Addiction professionals should support the efforts of researchers by participating in research whenever possible.
- Addiction professionals when conducting research should plan, design, conduct, and report research in a manner that is consistent with relevant ethical principles, federal and state laws, internal review board expectations, institutional regulations, and scientific standards governing research.
- Addiction professionals when conducting research should seek supervision and/or consultation and observe necessary safeguards to protect the rights of research participants, especially when the research plan, design and implementation deviates from standard or acceptable practices.
- Addiction professionals when conducting research are responsible for their participants' welfare.
- Addiction professionals when conducting research shall commit to the highest standards of scholarship, and shall present accurate information, disclose potential conflicts of interest, and make every effort to prevent the distortion or misuse of their clinical and research findings.
- Addiction professionals when conducting research shall provide appropriate explanations regarding the research and obtain applicable consents from a guardian or legally authorized representative prior to working with a research participant who is not capable of giving informed consent.
- Addiction professionals when conducting research shall report research findings accurately and without distortion, manipulation, or misrepresentation of data.
- Addiction professionals who author books, journal articles, or other materials which are published or distributed shall not plagiarize or fail to cite persons for whom credit for original ideas or work is due.
- Addiction professionals who review material submitted for publication, research, or other scholarly purposes shall respect the confidentiality and proprietary rights of those who submitted it.

Section 2: Summary

It has been well established that ethics is important to health care. Ethical principles help guide the safe and effective administration of health care as well as ensure that every individual has an opportunity to have a voice regarding his or her own personal health. Due to the importance of ethics in health care, professional organizations, such as the NAADAC, have developed codes of ethics to help guide addiction professionals in their delivery of professional care to individuals seeking their services. The NAADAC's code of ethics builds on the four cornerstones of health care ethics: autonomy, justice, beneficence and nonmaleficence, and expands their ideals to provide addiction professionals with further insight into their professional responsibilities and obligations to their clients. It is essential that addiction professionals understand and uphold the ethical principles put forth by the NAADAC's code of ethics to effectively deliver care to those in need.

Section 2: Personal Reflection Question

How can addiction professionals use the NAADAC's code of ethics to guide their delivery of professional care to individuals seeking their services?

Section 3: State Codes of Ethics

In addition to the NAADAC's code of ethics, individual states may have their own specific codes of ethics for addiction professionals. Individual state codes of ethics are typically designed to optimize addiction professionals' understanding of how to safely and effectively deliver professional care to individuals seeking their services. State codes of ethics may vary - therefore, it is important for an addiction professional to be aware of the codes of ethics set forth by his or her state of licensure. Addiction professionals should also be aware that individual states may have further codes of ethics relating to specialty certifications, endorsements and/or credentials. Addiction professionals should also be aware of further state codes of ethics relating to any specialty certifications, endorsements and/or credentials they may hold. To provide examples of individual state codes of ethics, this section will highlight Iowa state codes of ethics as well as California state codes of ethics regarding addiction professionals. Iowa state codes of ethics can be found in Figure 1 and Figure 2, while California state codes of ethics can be found in Figure 3 and Figure 4. Much like the NAADAC's code of ethics, each of the previously mentioned state's codes of ethics is broken down into sections or principles to outline specific ethical points of interest such as: addiction professionals' behavior, client relationships, diversity, confidentiality and boundaries. The remainder of this section will consist of the aforementioned figures highlighting Iowa and California state codes of ethics.

Figure 1: Iowa State Code of Ethics For All IBC Certified Professionals⁵

This Code of Ethics is adopted to aid in the delivery of the highest quality of professional care to persons seeking services. It is hoped that these standards will assist the certified professional to determine the propriety of his or her conduct in relationships with clients, colleagues, members of allied professions, and the public.

Principle I. Responsibility to clients

IBC certified professionals respect the rights of those persons seeking their assistance and make reasonable efforts to ensure that their services are used appropriately.

A. IBC certified professionals do not discriminate against or refuse professional service to anyone on the basis of race, gender, religion, national origin or sexual orientation.

1. IBC certified professionals avoid bringing personal or professional issues into the counseling relationship. Through an awareness of the impact of stereotyping and discrimination, the certified professional guards the individual rights and personal dignity of clients.

2. IBC certified professionals are knowledgeable about disabling conditions, demonstrate empathy and personal emotional comfort in interactions with clients with disabilities, and make available physical, sensory, and cognitive accommodations that allow clients with disabilities to receive services.

B. IBC certified professionals do not use their professional relationships with clients to further their own interests.

C. IBC certified professionals respect the right of clients to make decisions and help them to understand the consequences of these decisions.

D. IBC certified professionals continue therapeutic relationships only as long as it is reasonably clear that clients are benefiting from the relationship.

E. IBC certified professionals assist persons in obtaining other therapeutic services if the counselor is unable or unwilling to provide professional help.

F. IBC certified professionals do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment.

G. IBC certified professionals obtain written, informed consent from clients before videotaping, audio recording, or permitting third-party observation.

H. IBC certified professionals respect the integrity and protect the welfare of the client. The certified professional, in the presence of professional conflict, is concerned primarily with the welfare of the client.

I. IBC certified professionals ensure the presence of an appropriate setting for clinical work to protect the client from harm and the certified professional and professional from censure.

J. IBC certified professionals do not continue to practice while having a physical or mental disability which renders the certified professional unable to practice the occupation or profession with reasonable skill or which may endanger the health and safety of the persons under the certified professional's care.

Principle II: Dual relationships

A. IBC certified professionals are aware of their influential position with respect to clients, and they avoid exploiting the trust and dependency of such persons. IBC certified professionals, therefore, make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, IBC certified professionals take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with clients and/or their family members.

1. Soliciting and/or engaging in sexual conduct with clients is prohibited; this includes the five years following the termination of services.

2. IBC certified professionals do not accept as clients anyone with whom they have engaged in sexual conduct.

3. IBC certified professionals are aware of their professionalism and healthy boundaries with clients when it comes to social networking for at least a period of one year following the termination of services.

- a. IBC certified professionals do not “friend” their own clients, past or present, or clients of an agency for which they work, on Facebook or other social media sites.
 - b. IBC certified professionals use professional and ethical judgment when including photos and/or comments on social media sites.
 - c. IBC certified professionals do not provide their personal contact information to clients, i.e. home/personal cell phone number, personal email, Skype, Twitter, etc. nor engage in communication with clients through these mediums except in cases of agency/professional business
- B. IBC certified professionals are aware of their influential position with respect to students, employees, and supervisees, and they avoid exploiting the trust and dependency of such persons. IBC certified professionals, therefore, make every effort to avoid dual relationships that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, IBC certified professionals take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with students, employees or supervisees.

Principle III: Confidentiality

IBC certified professionals embrace, as primary obligation, the duty of protecting the privacy of clients and do not disclose confidential information acquired in teaching, practice or investigation without appropriately executed consent.

- A. IBC certified professionals make appropriate provisions for the maintenance of confidentiality and the ultimate disposition of confidential records. IBC certified professionals ensure that data obtained, including any form of electronic communication, are secured by the available security methodology. Data shall be limited to information that is necessary to and appropriate to the services being provided and be accessible only to appropriate personnel.
- B. IBC certified professionals adhere to all federal, state, and local laws regarding confidentiality and the certified professional’s responsibility to report clinical information in specific circumstances to the appropriate authorities.
- C. IBC certified professionals discuss the information obtained in clinical, consulting, or observational relationships only in the appropriate settings for professional purposes that are in the client’s best interest. Written and oral reports present only data germane and pursuant to the purpose of evaluation, diagnosis, progress, and compliance. Every effort is made to avoid undue invasion of privacy.
- D. IBC certified professionals reveal information received in confidence only when there is a clear and imminent danger to the client or other persons, and then only to appropriate workers, public authorities, and threatened parties.

Principle IV: Professional competence and integrity

IBC certified professionals maintain high standards of professional competence and integrity.

- A. IBC certified professionals seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.
- B. IBC certified professionals, as teachers, supervisors, and researchers, are dedicated to high standards of scholarship and present accurate information.
- C. IBC certified professionals do not engage in sexual or other harassment or exploitation of clients, students, trainees, supervisees, employees, colleagues, research subjects, or actual or potential witnesses or complainants in investigations and ethical proceedings.
- D. IBC certified professionals do not diagnose, treat, or advise on problems outside the recognized boundaries of their competence.

E. IBC certified professionals do not engage in conduct which does not meet the generally accepted standards of practice for their profession including, but not limited to, incompetence, negligence or malpractice.

Principle V: Responsibility to students, employees, and supervisees

IBC certified professionals do not exploit the trust and dependency of students, employees, and supervisees.

A. IBC certified professionals do not permit students, employees, or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience and competence.

B. IBC certified professionals who supervise others accept the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations, and constructive consultation.

Principle VI: Responsibility to the profession

IBC certified professionals respect the rights and responsibilities of professional colleagues.

A. IBC certified professionals treat colleagues with respect, courtesy, and fairness and afford the same professional courtesy to other professionals.

1. IBC certified professionals do not offer professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.

2. IBC certified professionals cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.

3. IBC certified professionals report the unethical conduct or practice of others in the profession to the appropriate certifying authority.

4. IBC certified professionals do not knowingly file a false report against another professional concerning an ethics violation.

B. As employees or members of organizations, IBC certified professionals refuse to participate in an employer's practices which are inconsistent with the ethical standards enumerated in this Code.

C. IBC certified professionals assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

D. IBC certified professionals who are the authors of books or other materials that are published or distributed cite persons to whom credit for original ideas is due.

Principle VII: Financial arrangements

IBC certified professionals make financial arrangements for services with clients and third-party payers that are reasonably understandable and conform to accepted professional practices.

A. IBC certified professionals do not offer, give or receive commissions, rebates or other forms of remuneration for the referral of clients.

B. IBC certified professionals do not charge excessive fees for services.

C. IBC certified professionals disclose their fees to clients at the beginning of services.

D. IBC certified professionals do not enter into personal financial arrangements.

E. IBC certified professionals represent facts truthfully to clients and third-party payers, regarding services rendered.

F. IBC certified professionals do not accept a private fee or any other gift or gratuity for professional work.

Principle VIII: Advertising

IBC certified professionals engage in appropriate informational activities, including those that enable lay persons to choose professional services on an informed basis.

A. IBC certified professionals accurately represent their competence, education, training, and experience.

B. IBC certified professionals do not use a firm name, letterhead, publication, term, title designation or document which states or implies an ability, relationship or qualification which the certified professional does not have.

C. IBC certified professionals do not use any professional identification (such as a business card, office sign, letterhead, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive. A statement is false, fraudulent, misleading, or deceptive if it:

1. contains a material misrepresentation of fact;
2. fails to state any material fact necessary to make the statement, in light of all circumstances, not misleading; or
3. is intended to or is likely to create an unjustified expectation.

Principle IX: Legal and Moral Standards

IBC certified professionals uphold the law and have high morals in both professional and personal conduct.

Grounds for discipline under this principle include, but are not limited to, the following:

1. Conviction of any felony or misdemeanor, excluding minor traffic offenses, whether or not the case is pending an appeal. A plea or verdict of guilty or a conviction following an Alford Plea, or any other plea which is treated by the court as a plea of guilty and all the proceedings in which the sentence was deferred or suspended, or the conviction expunged shall be deemed a conviction within the meaning of this section.
2. Permitting, aiding, abetting, assisting, hiring or conspiring with an individual to violate or circumvent any of the laws relating to licensure or certification under any licensing or certification act.
3. Fraud-related conduct under this principle includes, but is not limited to, the following:
 - a. Publishing or causing to be published any advertisement that is false, fraudulent, deceptive or misleading.
 - b. Engaging in fraud, misrepresentation, deception or concealment of material fact in:
 1. Applying for or assisting in securing certification or certification renewal.
 2. Taking any examination provided for #1 above including fraudulently procured credentials.
 - c. Making misleading, deceptive, untrue or fraudulent representation in the practice or the conduct of the profession or practicing fraud or deceit, either alone or as a conspirator.
 - d. Failing to cooperate with an investigation by interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representatives; by use of threats or harassment against, or inducement to any patient, client or witness to prevent them from providing evidence in a disciplinary proceeding or any person to prevent or attempt to prevent a disciplinary proceeding or other legal action from being filed, prosecuted or completed. Failing to cooperate with a board investigation in any material respect.
 - e. Committing a fraudulent insurance act.
 - f. Signing or issuing, in the certified professional's capacity, a document or statement that the certified professional knows, or ought to know, contains a false or misleading statement.
 - g. Using a firm name, letterhead, publication, term, title designation or document which states or implies an ability, relationship or qualification which the certified professional does not have.
 - h. Practicing the profession under a false name or name other than the name under which the

certification is held.

i. Impersonating any certified professional or representing oneself as a certified professional for which one has no current certification.

j. Charging a client or a third party payer for a service not performed, or submitting an account or charge for services that is false or misleading.

This does not apply to charging for an un-kept appointment by a client.

k. Charging a fee that is excessive in relation to the service or product for which it is charged.

l. Offering, giving or promising anything of value or benefit to any federal, state, or local employee or official for the purpose of influencing that employee or official to circumvent federal, state, or local law, regulation or ordinance governing the certified professional or their profession.

4. Engaging in sexual conduct, as defined in the Iowa Code, with a client during a period of time in which a professional relationship exists and for five years after that period of time.

Figure 2: Iowa State Code of Ethics for Prevention Specialists⁶

Principle 1: Non-discrimination

A prevention specialist shall not discriminate against service recipients or colleagues based on race, religion, national origin, sex, age, sexual orientation, sexual identity, economic condition or physical, medical or mental disability. A prevention specialist should broaden his or her understanding and acceptance of cultural and individual differences, and in so doing render services and provide information sensitive to those differences.

Prevention specialists shall be knowledgeable about disabling conditions, demonstrate empathy and personal emotional comfort in interactions with participants with disabilities, and make available physical, sensory, and cognitive accommodations that allow individuals with disabilities to receive services. Prevention specialists should comply with all local, state and Federal laws regarding the accommodation of individuals with disabilities.

Principle 2: Competency

Prevention specialists shall master their prevention specialty's body of knowledge and skill competencies, strive continually to improve personal proficiency and quality of service delivery, and discharge professional responsibility to the best of their ability. Competence includes a synthesis of education and experience combined with an understanding of the cultures within which prevention application occurs. The maintenance of competence requires continual learning and professional improvement throughout one's career.

Incompetence includes but is not limited to a substantial lack of knowledge or ability to discharge professional obligations within the scope of the prevention profession, or a substantial deviation from the standards of skill ordinarily possessed and applied by professional peers acting in the same or similar circumstances.

A. Professionals should be diligent in discharging responsibilities. Diligence imposes the responsibility to render services carefully and promptly, to be thorough, and to observe applicable technical and ethical standards.

B. Due care requires a professional to plan and supervise adequately and evaluate to the extent possible any professional activity for which he or she is responsible.

C. A prevention specialist should recognize limitations and boundaries of competencies and not use techniques or offer services outside of his or her competencies. Each professional is responsible for assessing the adequacy of his or her own competence for the responsibility to be assumed. When asked

to perform such services, a prevention specialist shall, to the best of their ability, refer to an appropriately qualified professional. When no such professional exists, a prevention specialist shall clearly notify the requesting person/organization of the gap in services available.

D. Ideally prevention specialists should be supervised by competent senior prevention specialists. When this is not possible, prevention specialists should seek peer supervision or mentoring from other competent prevention specialists.

E. When a prevention specialist has knowledge of unethical conduct or practice on the part of an agency or prevention specialist, he or she has an ethical responsibility to report the conduct or practices to funding, regulatory or other appropriate bodies.

F. A prevention specialist should recognize the effect of impairment on professional performance and should be willing to seek appropriate professional assistance for any form of substance misuse, psychological impairment, emotional distress, or any other physical related adversity that interferes with their professional functioning.

G. Prevention specialists do not permit students, employees, or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience and competence.

H. Prevention specialists who supervise others accept the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations, and constructive consultation.

Principle 3: Integrity

To maintain and broaden public confidence, prevention specialists should perform all responsibilities with the highest sense of integrity. Personal gain and advantage should not subordinate service and the public trust. Integrity can accommodate the inadvertent error and the honest difference of opinion. It *cannot* accommodate deceit or subordination of principle.

A. All information should be presented fairly and accurately. Each professional should document and assign credit to all contributing sources used in published material or public statements.

B. Prevention specialists should not misrepresent either directly or by implication professional qualifications or affiliations.

C. Where there is evidence of impairment in a colleague or a service recipient, a prevention specialist should be supportive of assistance or treatment.

D. Prevention specialists should not be associated directly or indirectly with any service, products, individuals, and organizations in a way that is misleading.

E. Prevention specialists should demonstrate integrity through dutiful cooperation in the ethics process of their certifying authority.

F. Prevention specialists shall not engage in conduct which does not meet the generally accepted standards of practice for the prevention profession including, but not limited to, incompetence, negligence or malpractice.

1. Falsifying, amending or making incorrect essential entries or failing to make essential entries of services provided.

2. Acting in such a manner as to present a danger to public health or safety, or to any participant including, but not limited to, impaired behavior, incompetence, negligence or malpractice, such as: a. Failing to comply with a term, condition or limitation on a certification or license.

b. Suspension, revocation, probation or other restrictions on any professional certification or licensure imposed by any state or jurisdiction, unless such action has been satisfied and/or reversed.

c. Administering to oneself any controlled substance not prescribed by a doctor, or aiding and abetting another person in the use of any controlled substance not prescribed to that person.

d. Using any drug or alcoholic beverage to the extent or in such manner as to be dangerous or injurious

to self or others, or to the extent that such use impairs the ability of such person to safely provide professional services.

e. Using drugs while providing professional services.

G. Prevention specialists make financial arrangements for services with service recipients and third-party payers that are reasonably understandable and conform to accepted professional practices.

Principle 4: Nature of Services

Practices shall do no harm to service recipients. Services provided by prevention specialists shall be respectful and non-exploitive.

A. Services should be provided in a way which preserves the protective factors inherent in each culture and individual.

B. Prevention specialists should use formal and informal structures to receive and incorporate input from service recipients in the development, implementation and evaluation of prevention services.

C. Where there is suspicion of abuse of children or vulnerable adults, the prevention specialist shall report the evidence to the appropriate agency and follow up to ensure that appropriate action has been taken.

D. Prevention specialists should adhere to the same principles of professionalism outlined in the Prevention Code of Ethics online as they would offline. With this in mind, the following are additional guidelines regarding the use of technology:

1. Prevention specialists are discouraged from interacting with current or past direct program participants on personal social networking sites. It is recommended that prevention specialists establish a professional social networking site for this purpose. a. Prevention specialists should not affiliate with their own direct program recipients on personal social media sites.

b. Prevention specialists use professional and ethical judgment when including photos and/or comments online or in prevention materials.

c. Prevention specialists should not provide their personal contact information to direct program recipients, i.e. home/personal cell phone number, personal email, social media accounts, etc. nor engage in communication with direct program participants through these mediums except in cases of agency/professional business

2. It is the responsibility of the prevention specialist to ensure, to the best of his or her ability, that professional networks used for sharing confidential information are secure and that only verified and registered users have access to the information.

3. Prevention specialists should be aware that any information they post on a social networking site may be disseminated (whether intended or not) to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity. When posting content online, they should always remember that they are representing the prevention field, their organization and their community, and so should always act professionally and take caution not to post information that is ambiguous or that could be misconstrued or taken out of context. It is recommended that employees not identify themselves as connected to their agency on their personal website.

4. Employees should be aware that employers may reserve the right to edit, modify, delete, or review Internet communications and that writers assume all risks related to the security, privacy and confidentiality of their posts. When moderating any website, the prevention specialist should delete inaccurate information or other's posts that violate the privacy and confidentiality of participants or that are of an unprofessional nature.

5. Prevention specialists should refer, as appropriate, to an employer's social media or social networking policy for direction on the proper use of social media and social networking in relation to their employment.

E. Prevention Specialists must be aware of their influential position with respect to employees,

supervisees, and direct program recipients, and they avoid exploiting the trust and dependency of such persons. Prevention specialists, therefore, make every effort to avoid dual relationships with prevention participants that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, Prevention Specialists take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with direct prevention recipients, their family members, employees or supervisees.

Principle 5: Confidentiality

Confidential information acquired during service delivery shall be safe guarded from disclosure, including – but not limited to – verbal disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases. Prevention specialists are responsible for knowing the confidentiality regulations relevant to their prevention specialty.

Prevention specialists make appropriate provisions for the maintenance of confidentiality and the ultimate disposition of confidential records. Prevention specialists ensure that data obtained including program evaluation data and any form of electronic communication, are secured by the available security methodology. Data shall be limited to information that is necessary to and appropriate to the services being provided and be accessible only to appropriate personnel. Data presented publically shall be distributed only in ways that protects the confidentiality of individual participants.

Principle 6: Ethical Obligations for Community and Society

According to their consciences, prevention specialists should be proactive on public policy and legislative issues. The public welfare and the individual’s right to services and personal wellness should guide the efforts of prevention specialists to educate the general public and policy makers. Prevention specialists should adopt a personal and professional stance that promotes health.

Prevention Specialists should be aware of their local and national regulations regarding lobbying and advocacy, and act within the laws and funding guidelines.

Figure 3: California State Code of Ethics for CAADE Professionals⁷

California Association for Alcohol/Drug Educators (CAADE)

The CAADE Code of Ethics applies to the following individuals: Certified AOD counselors holding a Certified Addictions Treatment Counselor (CATC) credential at any and all tier levels (I, II, III, IV, V and N); Certified Addictions Treatment Counselor Interns (CATC-I); individuals registered to obtain certification by the California Association for Alcohol/Drug Educators (Registrant); individuals holding a CAADE Prevention Specialist (CPS) Credential; individuals holding a Certified Clinical Supervisor (CCS) Credential; and, individuals holding a Certified Addiction Treatment Educator (CATE) Certificate. All credentialed individuals hereinafter referred to as CAADE Professional.

Principle 1: Non-Discrimination

The CAADE Professional shall not discriminate against clients or professionals based on race, religion, age, gender, disability, national ancestry, sexual orientation or economic condition.

A. The CAADE Professional shall be knowledgeable about disabling conditions, demonstrate empathy in interactions with clients with disabilities, and make available physical, sensory, and cognitive accommodations that allow clients with disabilities to receive services.

Principle 2: Responsibility

The CAADE Professional shall espouse objectivity and integrity, and maintain the highest standards in the services the CAADE Professional offers.

A. The CAADE Professional shall maintain respect for institutional policies and management functions of the agencies and institutions within which the services are being performed, but may take appropriate initiative toward improving such policies when it will better serve the interest of the client.

B. The CAADE Professional shall not verbally, physically, or sexually harass, threaten, or abuse another staff member.

C. The CAADE Professional who is aware of unethical conduct or unprofessional modes of practice shall report such inappropriate behavior to the appropriate authority.

D. An applicant who sits for the CATC examination shall be responsible for assuring that he/she has met all the requirements for certification except passage of that examination, and that he/she has appropriately documented his/her compliance.

E. The CAADE Professional acknowledges and promotes the client's' right to autonomous decision-making and recognizes their role to assist clients in their efforts to identify, clarify, and pursue their goals. The CAADE Professional may limit client's' autonomous decision making if, in the CAADE Professional's assessment, the client's actions or potential actions appear to pose a serious and imminent risk to themselves or others.

F. The CAADE Professional shall recognize the ethical responsibility of self-care as being paramount to the delivery of effective service. The CAADE Professional recognizes that any impairment that renders the CAADE Professional ineffective will necessitate that the CAADE Professional seek needed assistance up to and including separation from employment until such time the CAADE Professional can effectively engage in client care. The CAADE Professional shall support employee assistance programs in this respect.

Principle 3: Competence

The CAADE Professional shall recognize that the profession is founded on national standards of competency which promote the best interests of society, of the client, of the CAADE Professional and of the profession. The CAADE Professional shall recognize the need for ongoing education and clinical supervision as a component of professional competency.

A. The CAADE Professional shall recognize professional boundaries and limitations of the CATC's, Registrant's, and/or CPS' competencies and only offer/provide services or use techniques within the scope of his/her registration or certification as an AOD counselor.

Principle 3.5: Supervision

Any experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has a personal relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

Principle 4: Legal and Ethical Standards

The CAADE Professional shall abide by and uphold the ethical standards contained in this Code of Conduct.

A. The CAADE Professional shall be fully cognizant and abide by all state and federal laws and laws governing the practice of addiction counseling, including but not limited to regulations protecting participant's, patient's, or resident's rights to confidentiality in accordance with the Code of Federal Regulations, Title 42, Part 2, Sections 2.1 et seq., and the Counselor Certification Regulations in the

California Code of Regulations, Title 9, Sections 13000 et seq.

B. The CAADE Professional shall not claim either directly, or by implication, professional qualifications/affiliations that The CAADE Professional does not possess.

C. The CAADE Professional will not use, possess, or be under the influence of alcohol or illicit drugs on program premises or while attending or conducting program services.

D. The CAADE Professional shall cooperate with investigations into alleged violations of this Code of Conduct, whether initiated by the California Department of Health Care Services (DHCS), or the California Association of Alcohol/Drug Educators, and shall supply information requested during any investigation unless disclosure of the information would violate the confidentiality requirements of the Code of Federal Regulations, Title 42, Part 2, Sections 2.1 et seq. The CAADE Professional, authorizes CAADE to release all information CAADE, its Board, or its agents possess, and hereby releases CAADE, its Board, or its agents from any liability.

Principle 5: Publication Credit

The CAADE Professional shall assign credit to all who have contributed to the published material and for the work upon which the publication is based.

A. The CAADE Professional who publishes books or articles and/or makes professional presentations will assure that all sources of information and contributions are properly cited.

Principle 6: Client Welfare

The CAADE Professional shall hold the welfare of the client paramount when making any decisions or recommendations concerning referral, treatment procedures or termination of treatment.

Principle 7: Confidentiality

The CAADE Professional working in the best interest of the client shall embrace, as a primary obligation, the duty of protecting client's rights under confidentiality and shall not disclose confidential information acquired in teaching, practice, or investigation without appropriately executed consent.

Principle 8: Client Relationships

It is the responsibility of The CAADE Professional to safeguard the integrity of the counseling relationship and to ensure that the client has reasonable access to effective treatment. The CAADE Professional shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship.

Principle 9: Interprofessional Relationships

The CAADE Professional shall treat colleagues with respect, courtesy, fairness, and good faith and shall afford the same to other professionals.

A. The CAADE Professional shall refrain from offering professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.

B. The CAADE Professional shall cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.

C. The CAADE Professional shall not in any way exploit relationships with supervisees, employees, students, research participants, volunteers, or clients.

D. The CAADE Professional shall seek resolution of workplace or professional issues in an appropriately assertive, understanding, and sensitive manner, utilizing established protocols when such exist.

Principle 10: Financial Arrangements

- A. The CAADE Professional shall inform the client of all financial policies at the time of Informed Consent and for the duration of the working relationship.
- B. The CAADE Professional shall consider the ability of a client to meet the financial cost in establishing rates for professional services (sliding fee scale).
- C. The CAADE Professional shall not engage in fee splitting. The CAADE Professional shall not send or receive any commission or rebate or any other form of remuneration for referral of clients for professional services.
- D. The CAADE Professional, in the practice of counseling, shall not at any time use one's relationship with clients for personal gain or for the profit of an agency or any commercial enterprise of any kind.

Figure 4: California State Code of Ethics for Alcohol/Drug Counselors Holding A CCAPP Endorsement⁸**Principle 1: Non-discrimination**

The alcoholism and drug abuse counselor/registrant must not discriminate against clients or professionals based on race, religion, age, sex, handicaps, national ancestry, sexual orientation or economic condition.

Principle 2: Responsibility

The alcoholism and drug abuse counselor/registrant must espouse objectivity and integrity, and maintain the highest standards in the services the counselor offers.

- a. The alcoholism and drug counselor/registrant, as a teacher, must recognize the counselor's primary obligation to help others acquire knowledge and skill in dealing with the disease of chemical dependency.
- b. The alcoholism and drug abuse counselor/registrant, as a practitioner, must accept the professional challenge and responsibility deriving from the counselor's work.
- c. The alcoholism and drug counselor, who supervises others, accepts the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations and constructive consultation.

Principle 3: Competence

The alcoholism and drug abuse counselor/registrants must recognize that the profession is founded on national standards of competence which promote the best interests of society, of the client, of the counselor and of the profession as a whole. The counselor must recognize the need for ongoing education as a component of professional competency.

- a. The alcoholism and drug abuse counselor/registrant must prevent the practice of alcoholism and drug abuse counseling by unqualified and unauthorized persons.
- b. The alcoholism and drug abuse counselor/registrant who is aware of unethical conduct or of unprofessional modes of practice must report such violations to the appropriate certifying authority.
- c. The alcoholism and drug abuse counselor/registrant must recognize boundaries and limitations of counselor's competencies and not offer services or use techniques outside of these professional competencies.
- d. The alcoholism and drug abuse counselor/registrant must recognize the effect of professional impairment on professional performance and must be willing to seek appropriate treatment for oneself or for a colleague. The counselor must support peer assistance programs in this respect.

Principle 4: Legal Standards and Moral Standards

The alcoholism and drug abuse counselor/registrant must uphold the legal and accepted moral codes, which pertain to professional conduct.

- a. The alcoholism and drug abuse counselor/registrant must not claim directly or by implication, professional qualifications/affiliations that the counselor does not possess.
- b. The alcoholism and drug abuse counselor/registrant must not use the affiliation with CCAPP Credentialing for purposes that are not consistent with the stated purposes of the organization.
- c. The alcoholism and drug abuse counselor/registrant must not associate with or permit the counselor's name to be used in connection with any services or products in a way that is incorrect or misleading.
- d. The alcoholism and drug abuse counselor/registrant associated with the development or promotion of books or other products offered for commercial sale must be responsible for ensuring that such books or products are presented in a professional and factual way.
- e. The alcoholism and drug abuse counselor/registrant must not attempt to secure certification or registration (or certification renewal) by fraud, deceit, or misrepresentation on any application or other documents submitted to the certifying organization whether engaged in by an applicant for certification or registration or in support of any application for certification or registration. Any altered documents as identified by staff in the application or renewal process will be denied immediately and reapplication may be required. The CCAPP Credentialing Board Chair may deny the application or reapplication as a result of such fraudulent activity. The alcoholism and drug abuse counselors holding a specialty credential should not claim directly or by implication, professional qualifications/affiliations that the counselor does not possess.
- f. The alcoholism and drug abuse counselor/registrant must not violate, attempt to violate or conspire to violate any regulation or law adopted by the California Department of Health Care Services or

Principle 5: Public Statements

The alcoholism and drug abuse counselor/registrant must respect the limits of present knowledge in public statements concerning alcoholism and other forms of drug addiction.

- a. The alcoholism and drug abuse counselor/registrant who represents the field of alcoholism counseling to clients, other professionals, or to the general public must report fairly and accurately the appropriate information.
- b. The alcoholism and drug abuse counselor/registrant must acknowledge and document materials and techniques used.
- c. The alcoholism and drug abuse counselor/registrant who conducts training in alcoholism or drug abuse counseling skills or techniques must indicate to the audience the requisite training/qualifications required to properly perform these skills and techniques.

Principle 6: Publication Credit

The alcoholism and drug abuse counselor/registrant must assign credit to all who have contributed to the published material and for the work upon which the publication is based.

- a. The alcoholism and drug abuse counselor/registrants must recognize joint authorship, major contributions of a professional character, made by several persons to a common project. The author who has made the principle contribution to a publication must be identified as a first listed.
- b. The alcoholism and drug abuse counselor/registrant must acknowledge in footnotes or an introductory statement minor contributions of a professional character, extensive clerical or similar assistance and other minor contributions.
- c. The alcoholism and drug abuse counselor/registrant must acknowledge, through specific citations, unpublished, as well as published material, that has directly influenced the research or writing.
- d. The alcoholism and drug abuse counselor/registrant who compiles and edits for publication the

contributions of others must list oneself as editor, along with the names of those who have contributed.

Principle 7: Client Welfare

The alcoholism and drug abuse counselor/registrant must respect the integrity and protect the welfare of the person or group with whom the counselor is working.

- a. The alcoholism and drug abuse counselor/registrant must define for self and others the nature and direction of loyalties and responsibilities and keep all parties concerned informed of these commitments.
- b. The alcoholism and drug abuse counselor/registrant, in the presence of professional conflict, must be concerned primarily with the welfare of the client.
- c. The alcoholism and drug abuse counselor/registrant must terminate a counseling or consulting relationship when it is reasonably clear that the client is not benefiting from it.
- d. The alcoholism and drug abuse counselor/registrant, in referral cases, must assume the responsibility for the client's welfare either by termination by mutual agreement and/or by the client becoming engaged with another professional. In situations when a client refuses treatment, referral or recommendations, the alcohol and drug abuse counselor must carefully consider the welfare of the client by weighing the benefits of continued treatment or termination and must act in the best interest of the client.
- e. The alcoholism and drug abuse counselor/registrant who asks a client to reveal personal information from other professionals or allows information to be divulged must inform the client of the nature of such transactions. The information released or obtained with informed consent must be used for expressed purposes only.
- f. The alcoholism and drug abuse counselor/registrant must not use a client in a demonstration role in a workshop setting where such participation would potentially harm the client.
- g. The alcoholism and drug abuse counselor/registrant must ensure the presence of an appropriate setting for clinical work to protect the client from harm and the counselor and the profession from censure.
- h. The alcoholism and drug abuse counselor/registrant must collaborate with other health care professional(s) in providing a supportive environment for the client who is receiving prescribed medications.

Principle 8: Confidentiality

The alcoholism and drug abuse counselor/registrant must embrace, as a primary obligation, the duty of protecting the privacy of clients and must not disclose confidential information acquired, in teaching, practice or investigation. The alcoholism and drug abuse counselors holding a specialty credential should define for self and others the nature and direction of loyalties and responsibilities and keep all parties concerned informed of these commitments. The alcoholism and drug abuse counselors holding a specialty endorsement, in the presence of professional conflict should be concerned primarily with the welfare of the client.

- a. The alcoholism and drug abuse counselor/registrant must inform the client and obtain agreement in areas likely to affect the client's participation including the recording of an interview, the use of interview material for training purposes, and observation of an interview by another person.
- b. The alcoholism and drug abuse counselor/registrant must make provisions for the maintenance of confidentiality and the ultimate disposition of confidential records.
- c. The alcoholism and drug abuse counselor/registrant must reveal information received in confidence only when there is clear and imminent danger to the client or to other persons, and then only to appropriate professional workers or public authorities.
- d. The alcoholism and drug abuse counselor/registrant must discuss the information obtained in clinical

or consulting relationships only in appropriate settings, and only for professional purposes clearly concerned with the case. Written and oral reports must present only data germane to the purpose of the evaluation and every effort must be made to avoid undue invasion of privacy.

e. The alcoholism and drug abuse counselor/registrant must use clinical and other material in classroom teaching and writing only when the identity of the persons involved is adequately disguised.

Principle 9: Client Relationships

The alcoholism and drug abuse counselor/registrant must inform the prospective client of the important aspects of the potential relationship.

a. The alcoholism and drug abuse counselor/registrant must inform the client and obtain the client's agreement in areas likely to affect the client's participation including the recording of an interview, the use of interview material for training purposes, and/or observation of an interview by another person.

b. The alcoholism and drug abuse counselor/registrant must inform the designated guardian or responsible person of the circumstances, which may influence the relationship when the client is a minor or incompetent.

c. Dual Relationships:

i. The alcoholism and drug abuse counselor/registrant must seek to nurture and support the development of a relationship with clients as equals rather than to take advantage of individuals who are vulnerable and exploitable.

ii. The alcoholism and drug abuse counselor/registrant must not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.

iii. Because all relationship begins with a power differential, the alcoholism and drug abuse counselor/registrant must not exploit relationships with current or former clients for personal gain, including social or business relationships.

iv. Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an alcohol and other drug abuse counselors.

v. The alcoholism and drug abuse counselor/registrant must not accept gifts from clients, other treatment organizations or the providers of materials or services used in practice.

Principle 10: Inter-professional Relationships

The alcoholism and drug abuse counselor/registrant must treat colleagues with respect, courtesy and fairness, and must afford the same professional courtesy to other professionals.

a. The alcoholism and drug abuse counselor/registrant must not offer professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.

b. The alcoholism and drug abuse counselor/registrant must cooperate with duly constituted professional ethics committees, staff requests and promptly supply necessary information unless constrained by the demands of confidentiality. Failure to cooperate with the committee or staff may result in immediate suspension until such time cooperation is given. Additionally, the alcoholism and drug abuse counselor/registrant may not use threatening gestures, behaviors or other forms of coercion with the committee, colleagues, members, staff or other individuals.

c. The alcoholism and drug abuse counselor/registrant must not in any way exploit relationships with supervisees, employees, students, research participants or volunteers. The alcoholism and drug abuse counselors holding a specialty endorsement should inform the prospective client of the important

aspects of the potential relationship

Principle 11: Remuneration

The alcoholism and drug abuse counselor/registrant must establish financial arrangements in professional practice and in accordance with the professional standards that safeguard the best interests of the client, of the counselor and of the profession.

- a. The alcoholism and drug abuse counselor/registrant must inform the client of all financial policies. In circumstances where an agency dictates explicit provisions with its staff for private consultations, clients must be made fully aware of these policies.
- b. The alcoholism and drug abuse counselor/registrant must not send or receive any commission or rebate or any other form of remuneration for referral of clients for professional services. The counselor must not engage in fee splitting.
- c. The alcoholism and drug abuse counselor/registrant in clinical or counseling practice must not use one's relationship with clients to promote personal gain or the profit of an agency or commercial enterprise of any kind.
- d. The alcoholism and drug abuse counselor/registrant must not accept a private fee or any other gift or gratuity for professional work with a person who is entitled to such services through an institution or agency. The policy of a particular agency may make explicit provisions for private work with its client by members of its staff, and in such instances, the client must be fully apprised of all policies affecting the client.

Principle 12: Societal Obligations

The alcoholism and drug abuse counselor/registrant must advocate changes in public policy and legislation to afford opportunity and choice for all persons whose lives are impaired by alcoholism and other forms of drug addiction. The counselors must inform the public through active civic and professional participation in community affairs of the effects of alcoholism and drug addiction and must act to guarantee that all persons, especially the needy and disadvantaged, have access to the necessary resources and services. The alcoholism and drug abuse counselor/registrant must adopt a personal and professional stance, which promotes the wellbeing of all human beings.

The CCAPP is comprised of certified counselors who, as responsible health care professionals, believe in the dignity and worth of human beings. In practice of their profession, they assert that the ethical principles of autonomy, beneficence, and justice must guide their professional conduct. As professionals dedicated to the treatment of alcohol and drug dependent clients and their families, they believe that they can effectively treat its individual and families manifestations. CCAPP certified counselors dedicate themselves to promote the best interest of their society, of their clients, of their profession, and of their colleagues.

The undersigned hereby understands and agrees to comply with the code of ethics as outlined in this document. The undersigned also agrees to abide by the California Department of Health Care Services Code of Conduct outlined in Chapter 8; Subchapter 3, Section 13060. The undersigned also understands and consents to the release of information pertaining to any ethical violation(s) and/or sanctions as part of the process of becoming a CCAPP member, registrant, or a certificate. The information may be disclosed to the California Department of Health Care Services and to the California state-approved certification bodies. I agree to cooperate with complaint investigations and supply information requested during complaint investigations unless such disclosure of information would violate the confidentiality requirements of Subpart 2, Title 42, Code of Federal Regulations.

Section 3: Summary

Individual states may have their own specific codes of ethics to help guide addiction professionals' delivery of care to clients. Individual state codes of ethics are typically designed to optimize addiction professionals' understanding of how to safely and effectively deliver professional care to individuals seeking their services. State codes of ethics may vary. Therefore, it is important for an addiction professional to be aware of the codes of ethics set forth by his or her state of licensure. Addiction professionals should also be aware that individual states may have further codes of ethics relating to specialty certifications, endorsements and/or credentials. Addiction professionals should also be aware of further state codes of ethics relating to any specialty certifications, endorsements and/or credentials they may hold.

Section 3: Personal Reflection Question

Why is it important for addiction professionals to obtain information regarding applicable state codes of ethics?

Section 4: Title 42 of the Code of Federal Regulations, Part 2

Codes of ethics help guide addiction professionals in their daily delivery of care to individuals in need. However, federal laws and regulations are required to ensure addiction professionals adhere to the various codes of ethics, as well as to protect and safeguard individual patient/client rights. That being said, one of the most important patient/client rights relates to confidentiality. Confidentiality is one of the core duties of health care practice and requires health care professionals to keep patient's personal health information private and secure.

To protect patient/client confidentiality federal laws, regulations and acts have been established by the U.S. government and related organizations. One such federal act which protects confidentiality is HIPAA. As outlined in Section 1, HIPAA was passed by the U. S. government to establish national standards and protocols to protect an individual's personal health care information³. HIPAA sets limits and conditions on the uses and disclosures of an individual's personal health care information, while establishing that all patient health care information be properly secured and maintained³. In other words, HIPAA mandates that health care professionals respect patients' confidentiality and keep patients' health information private. HIPAA applies to the health care system as a whole and goes a long way to protect patient health information, although HIPAA does allow for the transmission of health care information among health care professionals on a need to know basis - meaning if a patient's health care information is relevant to the treatment of that patient, then a health care professional may be allowed access to such information. For example, if a health care professional is treating a patient with multiple conditions and/or diseases, the health care professional may need information regarding all of the patient's conditions/diseases to adequately treat the patient. In essence, the health care professional may require a full patient history to safely and effectively manage the patient's overall health. At first glance, having access to a patient's history may not appear problematic; however, if the patient's history includes substance abuse and/or treatment for addictions, the potential for problems or issues to arise may develop.

Unfortunately, in today's society, there is a stigma around addiction and addiction treatment. Often, individuals suffering from addiction or who possess a history of addiction treatment are chastised, discriminated against, and all too often face legal ramifications. The stigma associated with addiction, as well as the legal and societal consequences that come along with it, often prevent individuals from seeking care or treatment for their addictions.

To address the aforementioned issue, the federal government enacted Title 42 of the Code of Federal Regulations, Part 2, otherwise referred to as 42 CFR Part 2. The goal of enacting 42 CFR Part 2 was to encourage individuals to seek substance abuse treatment by removing the potential fear of privacy violations and subsequent legal and social ramifications that could follow. To accomplish the previous goal, 42 CFR Part 2 heightened the restrictions, even beyond those of HIPAA, on an individual's protected health information related to addiction treatment. Title 42 CFR Part 2 protects the confidentiality of records containing the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with the performance of any federally assisted program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research⁹. Title 42 CFR Part 2 was first promulgated in 1975 and since that time, 42 CFR Part 2 has achieved the goals of those who initiated it, while safeguarding patient's confidentiality. Amendments and changes have been made to 42 CFR Part 2 over the years to increase its overall effectiveness within the greater health care system. Title 42 CFR Part 2 can be found within Figure 5. Due to the importance of 42 CFR Part 2, addiction professionals should be very familiar with its particular principles and stipulations.

Figure 5: 42 CFR Part 2¹⁰

Subpart A—Introduction

§2.1 Statutory authority for confidentiality of substance use disorder patient records.

Title 42, United States Code, Section 290dd-2(g) authorizes the Secretary to prescribe regulations. Such regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this statute, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

§2.2 Purpose and effect.

(a) *Purpose.* Pursuant to 42 U.S.C. 290dd-2(g), the regulations in this part impose restrictions upon the disclosure and use of substance use disorder patient records which are maintained in connection with the performance of any part 2 program. The regulations in this part include the following subparts:

(1) Subpart B of this part: General Provisions, including definitions, applicability, and general restrictions;

(2) Subpart C of this part: Disclosures with Patient Consent, including disclosures which require patient consent and the consent form requirements;

(3) Subpart D of this part: Disclosures without Patient Consent, including disclosures which do not

require patient consent or an authorizing court order; and

(4) Subpart E of this part: Court Orders Authorizing Disclosure and Use, including disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders.

(b) *Effect.* (1) The regulations in this part prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) The regulations in this part are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable by reason of the availability of their patient record than an individual with a substance use disorder who does not seek treatment.

(3) Because there is a criminal penalty for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers v. United States*, 327 U.S. 614, 621-22, 66 S. Ct. 705, 707-08 (1946)).

§2.3 Criminal penalty for violation.

Under 42 U.S.C. 290dd-2(f), any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined in accordance with Title 18 of the U.S. Code.

§2.4 Reports of violations.

(a) The report of any violation of the regulations in this part may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of the regulations in this part by an opioid treatment program may be directed to the United States Attorney for the judicial district in which the violation occurs as well as to the Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight.

Subpart B—General Provisions

§2.11 Definitions.

For purposes of the regulations in this part:

Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for withdrawal management or maintenance treatment for the purpose of avoiding an individual's concurrent enrollment in more than one treatment program.

Diagnosis means any reference to an individual's substance use disorder or to a condition which is identified as having been caused by that substance use disorder which is made for the purpose of treatment or referral for treatment.

Disclose means to communicate any information identifying a patient as being or having been diagnosed with a substance use disorder, having or having had a substance use disorder, or being or having been referred for treatment of a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person.

Federally assisted—see §2.12(b).

Informant means an individual:

(1) Who is a patient or employee of a part 2 program or who becomes a patient or employee of a part 2 program at the request of a law enforcement agency or official; and

(2) Who at the request of a law enforcement agency or official observes one or more patients or employees of the part 2 program for the purpose of reporting the information obtained to the law enforcement agency or official.

Maintenance treatment means long-term pharmacotherapy for individuals with substance use disorders that reduces the pathological pursuit of reward and/or relief and supports remission of substance use disorder-related symptoms.

Member program means a withdrawal management or maintenance treatment program which reports patient identifying information to a central registry and which is in the same state as that central registry or is in a state that participates in data sharing with the central registry of the program in question.

Minor, as used in the regulations in this part, means an individual who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, the age of 18 years.

Part 2 program means a federally assisted program (federally assisted as defined in §2.12(b) and program as defined in this section). See §2.12(e)(1) for examples.

Part 2 program director means:

(1) In the case of a part 2 program that is an individual, that individual.

(2) In the case of a part 2 program that is an entity, the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer of the part 2 program.

Patient means any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a part 2 program. *Patient* includes any individual who, after arrest on a criminal charge, is identified as an individual with a substance use disorder in order to

determine that individual's eligibility to participate in a part 2 program. This definition includes both current and former patients.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient, as defined in this section, can be determined with reasonable accuracy either directly or by reference to other information. The term does not include a number assigned to a patient by a part 2 program, for internal use only by the part 2 program, if that number does not consist of or contain numbers (such as a social security, or driver's license number) that could be used to identify a patient with reasonable accuracy from sources external to the part 2 program.

Person means an individual, partnership, corporation, federal, state or local government agency, or any other legal entity, (also referred to as "individual or entity").

Program means:

(1) An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or

(2) An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or

(3) Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.

Qualified service organization means an individual or entity who:

(1) Provides services to a part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(2) Has entered into a written agreement with a part 2 program under which that individual or entity:

(i) Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the part 2 program, it is fully bound by the regulations in this part; and

(ii) If necessary, will resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by the regulations in this part.

Records means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts). For the purpose of the regulations in this part,

records include both paper and electronic records.

Substance use disorder means a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal. For the purposes of the regulations in this part, this definition does not include tobacco or caffeine use.

Third-party payer means an individual or entity who pays and/or agrees to pay for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of the patient's family or on the basis of the patient's eligibility for federal, state, or local governmental benefits.

Treating provider relationship means that, regardless of whether there has been an actual in-person encounter:

- (1) A patient is, agrees to, or is legally required to be diagnosed, evaluated, and/or treated, or agrees to accept consultation, for any condition by an individual or entity, and;
- (2) The individual or entity undertakes or agrees to undertake diagnosis, evaluation, and/or treatment of the patient, or consultation with the patient, for any condition.

Treatment means the care of a patient suffering from a substance use disorder, a condition which is identified as having been caused by the substance use disorder, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means any federal, state, or local law enforcement agency or official who enrolls in or becomes an employee of a part 2 program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

Withdrawal management means the use of pharmacotherapies to treat or attenuate the problematic signs and symptoms arising when heavy and/or prolonged substance use is reduced or discontinued.

§2.12 Applicability.

(a) *General—(1) Restrictions on disclosure.* The restrictions on disclosure in the regulations in this part apply to any information, whether or not recorded, which:

(i) Would identify a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person; and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date;

for the purpose of treating a substance use disorder, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290dd-2(c)) applies to any information, whether or not recorded, which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date; for the purpose of treating a substance use disorder, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* A program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (2) of this section relating to the Department of Veterans Affairs and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Participating provider in the Medicare program;

(ii) Authorization to conduct maintenance treatment or withdrawal management; or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of substance use disorders;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of federal financial assistance in any form, including financial assistance which does not directly pay for the substance use disorder diagnosis, treatment, or referral for treatment; or

(ii) Conducted by a state or local government unit which, through general or special revenue sharing or other forms of assistance, receives federal funds which could be (but are not necessarily) spent for the substance use disorder program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions—* (1) *Department of Veterans Affairs.* These regulations do not apply to information on substance use disorder patients maintained in connection with the Department of Veterans Affairs' provision of hospital care, nursing home care, domiciliary care, and medical services under Title 38, U.S.C. Those records are governed by 38 U.S.C. 7332 and regulations issued under that authority by the Secretary of Veterans Affairs.

(2) *Armed Forces.* The regulations in this part apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Department of Veterans Affairs furnishing health care to veterans.

(3) *Communication within a part 2 program or between a part 2 program and an entity having direct administrative control over that part 2 program.* The restrictions on disclosure in the regulations in this part do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of patients with substance use disorders if the communications are:

(i) Within a part 2 program; or

(ii) Between a part 2 program and an entity that has direct administrative control over the program.

(4) *Qualified service organizations.* The restrictions on disclosure in the regulations in this part do not apply to communications between a part 2 program and a qualified service organization of information needed by the qualified service organization to provide services to the program.

(5) *Crimes on part 2 program premises or against part 2 program personnel.* The restrictions on disclosure and use in the regulations in this part do not apply to communications from part 2 program personnel to law enforcement agencies or officials which:

(i) Are directly related to a patient's commission of a crime on the premises of the part 2 program or against part 2 program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* The restrictions on disclosure and use in the regulations in this part do not apply to the reporting under state law of incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, the restrictions continue to apply to the original substance use disorder patient records maintained by the part 2 program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information— (1) Restriction on use of information.* The restriction on the use of any information subject to the regulations in this part to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a part 2 program, regardless of the status of the person obtaining the information or whether the information was obtained in accordance with the regulations

in this part. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see §2.17) or through patient access (see §2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—(i) Third-party payers, administrative entities, and others.* The restrictions on disclosure in the regulations in this part apply to:

(A) Third-party payers with regard to records disclosed to them by part 2 programs or under §2.31(a)(4)(iii)(A);

(B) Entities having direct administrative control over part 2 programs with regard to information that is subject to the regulations in this part communicated to them by the part 2 program under paragraph (c)(3) of this section; and

(C) Individuals or entities who receive patient records directly from a part 2 program or other lawful holder of patient identifying information and who are notified of the prohibition on re-disclosure in accordance with §2.32.

(ii) [Reserved]

(e) *Explanation of applicability—(1) Coverage.* These regulations cover any information (including information on referral and intake) about patients receiving diagnosis, treatment, or referral for treatment for a substance use disorder created by a part 2 program. Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide substance use disorder diagnosis, treatment, or referral for treatment. However, the regulations in this part would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of substance use disorder diagnosis, treatment, or referral for treatment and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.

(2) *Federal assistance to program required.* If a patient's substance use disorder diagnosis, treatment, or referral for treatment is not provided by a part 2 program, that patient's record is not covered by the regulations in this part. Thus, it is possible for an individual patient to benefit from federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in paragraph (b) of this section. For example, if a federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by the regulations in this part unless the program itself received federal assistance as defined by paragraph (b) of this section.

(3) *Information to which restrictions are applicable.* Whether a restriction applies to use or disclosure affects the type of information which may be disclosed. The restrictions on disclosure apply to any information which would identify a patient as having or having had a substance use disorder. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the part 2 program for the purpose of diagnosis, treatment, or referral for

treatment of patients with substance use disorders. (Note that restrictions on use and disclosure apply to recipients of information under paragraph (d) of this section.)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as having or having had a substance use disorder which is initially prepared by a part 2 provider in connection with the treatment or referral for treatment of a patient with a substance use disorder. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by the regulations in this part. The following are not covered by the regulations in this part:

(i) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement agencies or officials; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved does not have a substance use disorder (*e.g.*, involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

§2.13 Confidentiality restrictions and safeguards.

(a) *General.* The patient records subject to the regulations in this part may be disclosed or used only as permitted by the regulations in this part and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any federal, state, or local authority. Any disclosure made under the regulations in this part must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in the regulations in this part apply whether or not the part 2 program or other lawful holder of the patient identifying information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement agency or official or other government official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by the regulations in this part.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a health care facility or component of a health care facility which is publicly identified as a place where only substance use disorder diagnosis, treatment, or referral for treatment is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of this part or if an authorizing court order is entered in accordance with subpart E of this part. The regulations permit acknowledgement of the presence of an identified patient in a health care facility or part of a health care facility if the health care facility is not publicly identified as only a substance use disorder diagnosis, treatment, or referral for treatment facility, and if the acknowledgement does not reveal that the patient has a substance use disorder.

(2) Any answer to a request for a disclosure of patient records which is not permissible under the regulations in this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a substance use disorder. An inquiring party may be provided a copy of the regulations in this part and advised that they restrict the disclosure of substance use disorder patient records, but may not be told affirmatively that the regulations restrict

the disclosure of the records of an identified patient.

(d) *List of disclosures.* Upon request, patients who have consented to disclose their patient identifying information using a general designation pursuant to §2.31(a)(4)(iii)(B)(3) must be provided a list of entities to which their information has been disclosed pursuant to the general designation.

(1) Under this paragraph (d), patient requests:

(i) Must be made in writing; and

(ii) Are limited to disclosures made within the past two years;

(2) Under this paragraph (d), the entity named on the consent form that discloses information pursuant to a patient's general designation (the entity that serves as an intermediary, as described in §2.31(a)(4)(iii)(B)) must:

(i) Respond in 30 or fewer days of receipt of the written request; and

(ii) Provide, for each disclosure, the name(s) of the entity(-ies) to which the disclosure was made, the date of the disclosure, and a brief description of the patient identifying information disclosed.

(3) The part 2 program is not responsible for compliance with this paragraph (d); the entity that serves as an intermediary, as described in §2.31(a)(4)(iii)(B), is responsible for compliance with the list of disclosures requirement.

§2.14 Minor patients.

(a) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable state law to apply for and obtain substance use disorder treatment, any written consent for disclosure authorized under subpart C of this part may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a part 2 program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a state or local law requiring the program to furnish the service irrespective of ability to pay.

(b) *State law requiring parental consent to treatment.* (1) Where state law requires consent of a parent, guardian, or other individual for a minor to obtain treatment for a substance use disorder, any written consent for disclosure authorized under subpart C of this part must be given by both the minor and their parent, guardian, or other individual authorized under state law to act in the minor's behalf.

(2) Where state law requires parental consent to treatment, the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of this part;

or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the part 2 program director under paragraph (c) of this section.

(c) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a substantial threat to the life or physical well-being of the minor applicant or any other individual may be disclosed to the parent, guardian, or other individual authorized under state law to act in the minor's behalf if the part 2 program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of this part to their parent, guardian, or other individual authorized under state law to act in the minor's behalf; and

(2) The minor applicant's situation poses a substantial threat to the life or physical well-being of the minor applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf.

§2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors—(1) Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage their own affairs, any consent which is required under the regulations in this part may be given by the guardian or other individual authorized under state law to act in the patient's behalf.

(2) *No adjudication of incompetency.* In the case of a patient, other than a minor or one who has been adjudicated incompetent, that for any period suffers from a medical condition that prevents knowing or effective action on their own behalf, the part 2 program director may exercise the right of the patient to consent to a disclosure under subpart C of this part for the sole purpose of obtaining payment for services from a third-party payer.

(b) *Deceased patients—(1) Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as having a substance use disorder is subject to the regulations in this part. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable state law. If there is no such applicable state law appointment, the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 251, Jan. 3, 2018]

§2.16 Security for records.

(a) The part 2 program or other lawful holder of patient identifying information must have in place

formal policies and procedures to reasonably protect against unauthorized uses and disclosures of patient identifying information and to protect against reasonably anticipated threats or hazards to the security of patient identifying information. These formal policies and procedures must address:

(1) Paper records, including:

(i) Transferring and removing such records;

(ii) Destroying such records, including sanitizing the hard copy media associated with the paper printouts, to render the patient identifying information non-retrievable;

(iii) Maintaining such records in a secure room, locked file cabinet, safe, or other similar container, or storage facility when not in use;

(iv) Using and accessing workstations, secure rooms, locked file cabinets, safes, or other similar containers, and storage facilities that use or store such information; and

(v) Rendering patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (*e.g.*, removing direct identifiers).

(2) Electronic records, including:

(i) Creating, receiving, maintaining, and transmitting such records;

(ii) Destroying such records, including sanitizing the electronic media on which such records are stored, to render the patient identifying information non-retrievable;

(iii) Using and accessing electronic records or other electronic media containing patient identifying information; and

(iv) Rendering the patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (*e.g.*, removing direct identifiers).

(b) [Reserved]

§2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under §2.67, no part 2 program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a part 2 program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

§2.18 Restrictions on the use of identification cards.

No person may require any patient to carry in their immediate possession while away from the part 2 program premises any card or other object which would identify the patient as having a substance use disorder. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a part 2 program.

§2.19 Disposition of records by discontinued programs.

(a) *General.* If a part 2 program discontinues operations or is taken over or acquired by another program, it must remove patient identifying information from its records or destroy its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under §2.16, unless:

(1) The patient who is the subject of the records gives written consent (meeting the requirements of §2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the part 2 program.

(b) *Special procedure where retention period required by law.* If paragraph (a)(2) of this section applies:

(1) Records, which are paper, must be:

(i) Sealed in envelopes or other containers labeled as follows: “Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]”;

(A) All hard copy media from which the paper records were produced, such as printer and facsimile ribbons, drums, etc., must be sanitized to render the data non-retrievable; and

(B) [Reserved]

(ii) Held under the restrictions of the regulations in this part by a responsible person who must, as soon as practicable after the end of the required retention period specified on the label, destroy the records and sanitize any associated hard copy media to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under §2.16.

(2) Records, which are electronic, must be:

(i) Transferred to a portable electronic device with implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or

key and implemented access controls for the confidential process or key; or

(ii) Transferred, along with a backup copy, to separate electronic media, so that both the records and the backup copy have implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or key and implemented access controls for the confidential process or key; and

(iii) Within one year of the discontinuation or acquisition of the program, all electronic media on which the patient records or patient identifying information resided prior to being transferred to the device specified in (i) above or the original and backup electronic media specified in (ii) above, including email and other electronic communications, must be sanitized to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under §2.16; and

(iv) The portable electronic device or the original and backup electronic media must be:

(A) Sealed in a container along with any equipment needed to read or access the information, and labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date];" and

(B) Held under the restrictions of the regulations in this part by a responsible person who must store the container in a manner that will protect the information (*e.g.*, climate controlled environment); and

(v) The responsible person must be included on the access control list and be provided a means for decrypting the data. The responsible person must store the decryption tools on a device or at a location separate from the data they are used to encrypt or decrypt; and

(vi) As soon as practicable after the end of the required retention period specified on the label, the portable electronic device or the original and backup electronic media must be sanitized to render the patient identifying information non-retrievable consistent with the policies established under §2.16.

§2.20 Relationship to state laws.

The statute authorizing the regulations in this part (42 U.S.C. 290dd-2) does not preempt the field of law which they cover to the exclusion of all state laws in that field. If a disclosure permitted under the regulations in this part is prohibited under state law, neither the regulations in this part nor the authorizing statute may be construed to authorize any violation of that state law. However, no state law may either authorize or compel any disclosure prohibited by the regulations in this part.

§2.21 Relationship to federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by the regulations in this part and by administrative action taken under section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR part 1316); or

section 301(d) of the Public Health Service Act (42 U.S.C. 241(d) and the implementing regulations at 42 CFR part 2a). These research privilege statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under subpart E of this part of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes.

§2.22 Notice to patients of federal confidentiality requirements.

(a) *Notice required.* At the time of admission to a part 2 program or, in the case that a patient does not have capacity upon admission to understand his or her medical status, as soon thereafter as the patient attains such capacity, each part 2 program shall:

(1) Communicate to the patient that federal law and regulations protect the confidentiality of substance use disorder patient records; and

(2) Give to the patient a summary in writing of the federal law and regulations.

(b) *Required elements of written summary.* The written summary of the federal law and regulations must include:

(1) A general description of the limited circumstances under which a part 2 program may acknowledge that an individual is present or disclose outside the part 2 program information identifying a patient as having or having had a substance use disorder;

(2) A statement that violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to appropriate authorities consistent with §2.4, along with contact information;

(3) A statement that information related to a patient's commission of a crime on the premises of the part 2 program or against personnel of the part 2 program is not protected;

(4) A statement that reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected; and

(5) A citation to the federal law and regulations.

(c) *Program options.* The part 2 program must devise a notice to comply with the requirement to provide the patient with a summary in writing of the federal law and regulations. In this written summary, the part 2 program also may include information concerning state law and any of the part 2 program's policies that are not inconsistent with state and federal law on the subject of confidentiality

of substance use disorder patient records.

§2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a part 2 program from giving a patient access to their own records, including the opportunity to inspect and copy any records that the part 2 program maintains about the patient. The part 2 program is not required to obtain a patient's written consent or other authorization under the regulations in this part in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of this information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under §2.12(d)(1).

Subpart C—Disclosures With Patient Consent

§2.31 Consent requirements.

(a) *Required elements for written consent.* A written consent to a disclosure under the regulations in this part may be paper or electronic and must include:

(1) The name of the patient.

(2) The specific name(s) or general designation(s) of the part 2 program(s), entity(ies), or individual(s) permitted to make the disclosure.

(3) How much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed.

(4)(i) The name(s) of the individual(s) to whom a disclosure is to be made; or

(ii) *Entities with a treating provider relationship with the patient.* If the recipient entity has a treating provider relationship with the patient whose information is being disclosed, such as a hospital, a health care clinic, or a private practice, the name of that entity; or

(iii) *Entities without a treating provider relationship with the patient.*

(A) If the recipient entity does not have a treating provider relationship with the patient whose information is being disclosed and is a third-party payer, the name of the entity; or

(B) If the recipient entity does not have a treating provider relationship with the patient whose information is being disclosed and is not covered by paragraph (a)(4)(iii)(A) of this section, such as an entity that facilitates the exchange of health information or a research institution, the name(s) of the entity(-ies); and

(1) The name(s) of an individual participant(s); or

(2) The name(s) of an entity participant(s) that has a treating provider relationship with the patient whose information is being disclosed; or

(3) A general designation of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed.

(i) When using a general designation, a statement must be included on the consent form that the patient (or other individual authorized to sign in lieu of the patient), confirms their understanding that, upon their request and consistent with this part, they must be provided a list of entities to which their information has been disclosed pursuant to the general designation (*see* §2.13(d)).

(ii) [Reserved]

(5) The purpose of the disclosure. In accordance with §2.13(a), the disclosure must be limited to that information which is necessary to carry out the stated purpose.

(6) A statement that the consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer

(7) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided.

(8) The signature of the patient and, when required for a patient who is a minor, the signature of an individual authorized to give consent under §2.14; or, when required for a patient who is incompetent or deceased, the signature of an individual authorized to sign under §2.15. Electronic signatures are permitted to the extent that they are not prohibited by any applicable law.

(9) The date on which the consent is signed.

(b) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through reasonable diligence could be known, by the individual or entity holding

the records to be materially false.

§2.32 Prohibition on re-disclosure.

(a) *Notice to accompany disclosure.* Each disclosure made with the patient's written consent must be accompanied by one of the following written statements:

(1) This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65; or

(2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

(b) [Reserved]

[83 FR 251, Jan. 3, 2018]

§2.33 Disclosures permitted with written consent.

(a) If a patient consents to a disclosure of their records under §2.31, a part 2 program may disclose those records in accordance with that consent to any person or category of persons identified or generally designated in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§2.34 and 2.35, respectively.

(b) If a patient consents to a disclosure of their records under §2.31 for payment and/or health care operations activities, a lawful holder who receives such records under the terms of the written consent may further disclose those records as may be necessary for its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder. Disclosures to contractors, subcontractors, and legal representatives to carry out other purposes such as substance use disorder patient diagnosis, treatment, or referral for treatment are not permitted under this section. In accordance with §2.13(a), disclosures under this section must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

(c) Lawful holders who wish to disclose patient identifying information pursuant to paragraph (b) of this section must have in place a written contract or comparable legal instrument with the contractor or voluntary legal representative, which provides that the contractor, subcontractor, or voluntary legal representative is fully bound by the provisions of part 2 upon receipt of the patient identifying information. In making any such disclosures, the lawful holder must furnish such recipients with the notice required under §2.32; require such recipients to implement appropriate safeguards to prevent unauthorized uses and disclosures; and require such recipients to report any unauthorized uses, disclosures, or breaches of patient identifying information to the lawful holder. The lawful holder may

only disclose information to the contractor or subcontractor or voluntary legal representative that is necessary for the contractor or subcontractor or voluntary legal representative to perform its duties under the contract or comparable legal instrument. Contracts may not permit a contractor or subcontractor or voluntary legal representative to re-disclose information to a third party unless that third party is a contract agent of the contractor or subcontractor, helping them provide services described in the contract, and only as long as the agent only further discloses the information back to the contractor or lawful holder from which the information originated.

[83 FR 251, Jan. 3, 2018]

§2.34 Disclosures to prevent multiple enrollments.

(a) *Restrictions on disclosure.* A part 2 program, as defined in §2.11, may disclose patient records to a central registry or to any withdrawal management or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

- (i) The patient is accepted for treatment;
- (ii) The type or dosage of the drug is changed; or
- (iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

- (i) Patient identifying information;
- (ii) Type and dosage of the drug; and
- (iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of §2.31, except that:

(i) The consent must list the name and address of each central registry and each known withdrawal management or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any withdrawal management or maintenance treatment program established within 200 miles of the program, but does not need to individually name all programs.

(b) *Use of information limited to prevention of multiple enrollments.* A central registry and any withdrawal management or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under subpart E of

this part.

(c) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose:

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollments.

(d) *Permitted disclosure by a withdrawal management or maintenance treatment program to prevent a multiple enrollment.* A withdrawal management or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollments.

§2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A part 2 program may disclose information about a patient to those individuals within the criminal justice system who have made participation in the part 2 program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (*e.g.*, a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or post-trial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of §2.31 (except paragraph (a)(6) of this section which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the part 2 program, the patient, and the individual(s) within the criminal justice system who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a

specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on re-disclosure and use.* An individual within the criminal justice system who receives patient information under this section may re-disclose and use it only to carry out that individual's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 251, Jan. 3, 2018]

Subpart D—Disclosures Without Patient Consent

§2.51 Medical emergencies.

(a) *General rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained.

(b) *Special rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the part 2 program shall document, in writing, the disclosure in the patient's records, including:

- (1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;
- (2) The name of the individual making the disclosure;
- (3) The date and time of the disclosure; and
- (4) The nature of the emergency (or error, if the report was to FDA).

§2.52 Research.

(a) Notwithstanding other provisions of this part, including paragraph (b)(2) of this section, patient identifying information may be disclosed by the part 2 program or other lawful holder of part 2 data, for the purpose of conducting scientific research if the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer or their designee makes a determination that the recipient of the patient identifying information:

- (1) If a HIPAA-covered entity or business associate, has obtained and documented authorization from the patient, or a waiver or alteration of authorization, consistent with the HIPAA Privacy Rule at 45

CFR 164.508 or 164.512(i), as applicable; or

(2) If subject to the HHS regulations regarding the protection of human subjects (45 CFR part 46), either provides documentation that the researcher is in compliance with the requirements of the HHS regulations, including the requirements related to informed consent or a waiver of consent (45 CFR 46.111 and 46.116) or that the research qualifies for exemption under the HHS regulations (45 CFR 46.101(b) and any successor regulations; or

(3) If both a HIPAA covered entity or business associate and subject to the HHS regulations regarding the protection of human subjects, has met the requirements of paragraphs (a)(1) and (2) of this section; and

(4) If neither a HIPAA covered entity or business associate or subject to the HHS regulations regarding the protection of human subjects, this section does not apply.

(b) Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section:

(1) Is fully bound by the regulations in this part and, if necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by the regulations in this part.

(2) Must not re-disclose patient identifying information except back to the individual or entity from whom that patient identifying information was obtained or as permitted under paragraph (c) of this section.

(3) May include part 2 data in research reports only in aggregate form in which patient identifying information has been rendered non-identifiable such that the information cannot be re-identified and serve as an unauthorized means to identify a patient, directly or indirectly, as having or having had a substance use disorder.

(4) Must maintain and destroy patient identifying information in accordance with the security policies and procedures established under §2.16.

(5) Must retain records in compliance with applicable federal, state, and local record retention laws.

(c) *Data linkages*—(1) *Researchers*. Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section that requests linkages to data sets from a data repository(-ies) holding patient identifying information must:

(i) Have the request reviewed and approved by an Institutional Review Board (IRB) registered with the Department of Health and Human Services, Office for Human Research Protections in accordance with 45 CFR part 46 to ensure that patient privacy is considered and the need for identifiable data is justified. Upon request, the researcher may be required to provide evidence of the IRB approval of the research project that contains the data linkage component.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not

provided to law enforcement agencies or officials.

(2) *Data repositories.* For purposes of this section, a data repository is fully bound by the provisions of part 2 upon receipt of the patient identifying data and must:

(i) After providing the researcher with the linked data, destroy or delete the linked data from its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under §2.16 Security for records.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not provided to law enforcement agencies or officials.

(2) Except as provided in paragraph (c) of this section, a researcher may not redisclose patient identifying information for data linkages purposes.

§2.53 Audit and evaluation.

(a) *Records not copied or removed.* If patient records are not downloaded, copied or removed from the premises of a part 2 program or other lawful holder, or forwarded electronically to another electronic system or device, patient identifying information, as defined in §2.11, may be disclosed in the course of a review of records on the premises of a part 2 program or other lawful holder to any individual or entity who agrees in writing to comply with the limitations on re-disclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to a part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder;

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a utilization or quality control review, or such individual's or entity's or quality improvement organization's contractors, subcontractors, or legal representatives.

(2) Is determined by the part 2 program or other lawful holder to be qualified to conduct an audit or evaluation of the part 2 program or other lawful holder.

(b) *Copying, removing, downloading, or forwarding patient records.* Records containing patient identifying information, as defined in §2.11, may be copied or removed from the premises of a part 2 program or other lawful holder or downloaded or forwarded to another electronic system or device from the part 2 program's or other lawful holder's electronic records by any individual or entity who:

(1) Agrees in writing to:

(i) Maintain and destroy the patient identifying information in a manner consistent with the

policies and procedures established under §2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to the part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder; or

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a utilization or quality control review, or such individual's or entity's or quality improvement organization's contractors, subcontractors, or legal representatives.

(c) Medicare, Medicaid, Children's Health Insurance Program (CHIP), or related audit or evaluation. (1) Patient identifying information, as defined in §2.11, may be disclosed under paragraph (c) of this section to any individual or entity for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation, including an audit or evaluation necessary to meet the requirements for a Centers for Medicare & Medicaid Services (CMS)-regulated accountable care organization (CMS-regulated ACO) or similar CMS-regulated organization (including a CMS-regulated Qualified Entity (QE)), if the individual or entity agrees in writing to comply with the following:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under §2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section.

(2) A Medicare, Medicaid, or CHIP audit or evaluation under this section includes a civil or administrative investigation of a part 2 program by any federal, state, or local government agency with oversight responsibilities for Medicare, Medicaid, or CHIP and includes administrative enforcement, against the part 2 program by the government agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(3) An audit or evaluation necessary to meet the requirements for a CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must be conducted in accordance with the following:

(i) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must:

(A) Have in place administrative and/or clinical systems; and

(B) Have in place a leadership and management structure, including a governing body and chief executive officer with responsibility for oversight of the organization's management and for ensuring compliance with and adherence to the terms and conditions of the Participation Agreement or similar documentation with CMS; and

(ii) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must have a signed Participation Agreement or similar documentation with CMS, which provides that the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE):

(A) Is subject to periodic evaluations by CMS or its agents, or is required by CMS to evaluate participants in the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) relative to CMS-defined or approved quality and/or cost measures;

(B) Must designate an executive who has the authority to legally bind the organization to ensure compliance with 42 U.S.C. 290dd-2 and this part and the terms and conditions of the Participation Agreement in order to receive patient identifying information from CMS or its agents;

(C) Agrees to comply with all applicable provisions of 42 U.S.C. 290dd-2 and this part;

(D) Must ensure that any audit or evaluation involving patient identifying information occurs in a confidential and controlled setting approved by the designated executive;

(E) Must ensure that any communications or reports or other documents resulting from an audit or evaluation under this section do not allow for the direct or indirect identification (*e.g.*, through the use of codes) of a patient as having or having had a substance use disorder; and

(F) Must establish policies and procedures to protect the confidentiality of the patient identifying information consistent with this part, the terms and conditions of the Participation Agreement, and the requirements set forth in paragraph (c)(1) of this section.

(4) Program, as defined in §2.11, includes an employee of, or provider of medical services under the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(2) of this section.

(5) If a disclosure to an individual or entity is authorized under this section for a Medicare, Medicaid, or CHIP audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(2) of this section, the individual or entity may further disclose the patient identifying information that is received for such purposes to its contractor(s), subcontractor(s), or legal representative(s), to carry out the audit or evaluation, and a quality improvement organization which obtains such information under paragraph (a) or (b) of this section may disclose the information to that individual or entity (or, to such individual's or entity's contractors, subcontractors, or legal representatives, but only for the purposes of this section).

(6) The provisions of this paragraph do not authorize the part 2 program, the federal, state, or local government agency, or any other individual or entity to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the

audit or evaluation as specified in paragraph (c) of this section.

(d) Limitations on disclosure and use. Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the part 2 program or other lawful holder from which it was obtained and may be used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under §2.66.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 252, Jan. 3, 2018]

Subpart E—Court Orders Authorizing Disclosure and Use

§2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290dd-2 and the regulations in this part. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under the regulations in this part.

(b) *Examples.* (1) A person holding records subject to the regulations in this part receives a subpoena for those records. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under the regulations in this part.

(2) An authorizing court order is entered under the regulations in this part, but the person holding the records does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person holding the records must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of the regulations in this part.

§2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under the regulations in this part may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under §2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§2.63 Confidential communications.

(a) A court order under the regulations in this part may authorize disclosure of confidential communications made by a patient to a part 2 program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime allegedly committed by the patient, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

§2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which the applicant asserts that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given written consent (meeting the requirements of the regulations in this part) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be provided:

(1) Adequate notice in a manner which does not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in §2.64(d).

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of the regulations in this part. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to investigate or prosecute a patient in connection with a criminal proceeding may be applied for by the person holding the records or by any law enforcement or prosecutorial officials who are responsible for conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under §2.66 is sought in addition to an order under this section, the person holding the records must be provided:

(1) Adequate notice (in a manner which will not disclose patient identifying information to other persons) of an application by a law enforcement agency or official;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in §2.65(d); and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a law enforcement agency or official.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of

conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the part 2 program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a law enforcement agency or official, that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within federal, state, or local government has in fact been represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of the extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment of only that public interest and need found by the court.

§2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a part 2 program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to investigate or prosecute a part 2 program or the person holding the records (or employees or agents of that part 2 program or person holding the records) in connection with a criminal or administrative matter may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a

part 2 program or the person holding the records (or agents or employees of the part 2 program or person holding the records) in which the applicant asserts that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has provided written consent (meeting the requirements of §2.31) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the part 2 program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with §2.66(c).

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of §2.64.

(d) *Limitations on disclosure and use of patient identifying information.* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient in connection with a criminal matter, or be used as the basis for an application for an order under §2.65.

§2.67 Orders authorizing the use of undercover agents and informants to investigate employees or agents of a part 2 program in connection with a criminal matter.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a part 2 program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the part 2 program are engaged in criminal misconduct.

(b) *Notice.* The part 2 program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with §2.67(c)), unless the application asserts that:

(1) The part 2 program director is involved in the suspected criminal activities to be investigated by the undercover agent or informant; or

(2) The part 2 program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents of the program who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good

cause exists. To make this determination the court must find all of the following:

(1) There is reason to believe that an employee or agent of the part 2 program is engaged in criminal activity;

(2) Other ways of obtaining evidence of the suspected criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the part 2 program outweigh the potential injury to patients of the part 2 program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a part 2 program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to investigate or prosecute employees or agents of the part 2 program in connection with the suspected criminal activity; and

(4) Include any other measures which are appropriate to limit any potential disruption of the part 2 program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed in a part 2 program under this section may be used to investigate or prosecute any patient in connection with a criminal matter or as the basis for an application for an order under §2.65.

42 CFR Part 2: The Final Rule

As previously mentioned, over the years there have been amendments, changes and acts made to 42 CFR Part 2 in order to update its relevance and improve upon its overall effectiveness within the greater system of health care. One of the changes or acts made to 42 CFR Part 2 is referred to as the final rule. The remainder of this section will highlight information relevant to the final rule which took effect on February 2, 2018.

Final Rule Summary^{9,10}

- The final rule makes changes to the Substance Abuse and Mental Health Services Administration's (SAMHSA) regulations governing the Confidentiality of Substance Use Disorder Patient Records. These

changes are intended to better align the regulations with advances in the U.S. health care delivery system while retaining important privacy protections for individuals seeking treatment for substance use disorders. The final rule addresses the prohibition on re-disclosure notice by including an option for an abbreviated notice. This final rule also addresses the circumstances under which lawful holders and their legal representatives, contractors, and subcontractors may use and disclose patient identifying information for purposes of payment, health care operations, and audits and evaluations. Finally, the final rule is making minor technical corrections to ensure accuracy and clarity in SAMHSA's regulations.

Final Rule Compliance dates^{9,10}

- The compliance date for all provisions of the final rule, except for § 2.33(c), is February 2, 2018. Contracts between lawful holders and contractors, subcontractors, and legal representatives must comply with § 2.33(c) within two years of the effective date of the final rule.

Final Rule Revisions to 42 CFR Part 2^{9,10}

- **Prohibition on Re-Disclosure Notice (§ 2.32)** - 42 CFR Part 2 requires that a notice prohibiting re-disclosure accompany disclosures of 42 CFR Part 2P information. Under the final rule, SAMHSA has adopted an abbreviated notice that is 80 characters long to fit in standard free-text space within health care electronic systems. The abbreviated notice in the final rule reads “Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records.”
- **Disclosures Permitted with Written Consent (§ 2.33(b))** - 42 CFR Part 2 requires written patient consent prior to the disclosure of any 42 CFR Part 2 information, with few exceptions. Under the final rule, if a patient consents to a disclosure of his or her 42 CFR Part 2 information for payment and/or health care operations activities, the lawful holder who receives such information may now further disclose those records to its contractors as necessary to carry out payment and/or health care operations purposes on behalf of such lawful holder but may not do so for treatment purposes. In the previous context, treatment means diagnosis, treatment or referral for treatment, care coordination or case management.

Examples of permissible activities under § 2.33(b) that SAMHSA considers to be payment and health care operations activities include:

- Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing and related health care data processing
- Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services)
- Patient safety activities
- Activities pertaining to:

- The training of student trainees and health care professionals;
 - The assessment of practitioner competencies
 - The assessment of provider and/or health plan performance
 - Training of non-health care professionals
 - Accreditation, certification, licensing, or credentialing activities
 - Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care
 - Third-party liability coverage
 - Activities related to addressing fraud, waste and abuse
 - Conducting or arranging for medical review, legal services, and auditing functions
 - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies
 - Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations
 - Customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers
 - Resolution of internal grievances
 - The sale, transfer, merger, consolidation, or dissolution of an organization
 - Determinations of eligibility or coverage (e.g. coordination of benefit services or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims
 - Risk adjusting amounts due based on enrollee health status and demographic characteristics
 - Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges
- **Contract Provisions for Disclosures (§ 2.33(c))** - The final rule requires a lawful holder who engages a contractor to carry out payment and or health care operations activities to have in place a written contract or comparable legal instrument specifically requiring the contractor to comply with 42 CFR Part 2. The lawful holders must require recipients of the 42 CFR Part 2 information to implement appropriate safeguards to prevent unauthorized uses and disclosures and to report any unauthorized uses, disclosures or breaches of 42 CFR Part 2 information to the lawful holder.

- **Audit and evaluation (§ 2.53)** - Under the final rule, a lawful holder may now disclose 42 CFR Part 2 information to its contractors if the disclosure is for “a Medicare, Medicaid or CHIP audit or evaluation, including a civil investigation or administrative remedy.”

Final Rule Practical Points of Interest For Addiction Professionals^{9,10}

- The final rule revises 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records regulations.
- The final rule aims to provide for greater flexibility in disclosing patient identifying information within the health care system, while continuing to address the need to protect the confidentiality of substance use disorder patient records.
- Addiction professionals should review and revise organizational policies and procedures to ensure they are in line with the final rule.
- Addiction professionals should review and revise patient consent forms to allow for the disclosure of 42 CFR Part 2 information for payment and/or health care operations to contractors to ensure the “purpose” section of the consent form is consistent with the purpose of the disclosure.
- Addiction professionals should review and revise agreements as needed between lawful holders and contractors, if the contractor will be receiving and disclosing 42 CFR Part 2 information for payment and health care operations, to ensure the contractor is required to comply with 42 CFR Part 2.
- Addiction professionals should be aware that confidentiality restrictions and safeguards add a requirement that, upon request, patients who have included a general designation in the “To Whom” section of their consent form must be provided a list of entities to which their information has been disclosed pursuant to the general designation.
- Addiction professionals should be aware that SAMHSA clarifies the prohibition on re-disclosure only applies to information that would identify, directly or indirectly, an individual as having been diagnosed, treated, or referred for treatment for a substance use disorder, such as indicated through standard medical codes, descriptive language, or both, and allows other health-related information shared by the 42 CFR Part 2 program to be re-disclosed, if permissible under other applicable laws.
- Addiction professionals should be aware that patients can revoke consent to one or more parties named in a multi-party consent form while leaving the rest of the consent in effect.
- Addiction professionals should be aware that 42 CFR Part 2 allows the use of a single consent form authorizing the disclosure of 42 CFR Part 2 patient information to different recipients for different purposes.
- Addiction professionals should be aware that 42 CFR Part 2 permits the disclosure of information under certain circumstances without consent during a medical emergency or in other limited situations.

- Addiction professionals should be aware that when a disclosure is made in connection with a medical emergency, the 42 CFR Part 2 program must document in the patient's record the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Section 4: Summary

Federal laws and regulations are required to protect and safeguard individual patient/client rights. One of the most important patient/client rights is confidentiality. Confidentiality is one of the core duties of health care practice and requires health care professionals to keep patient's personal health information private and secure. To protect patient/client confidentiality federal laws, regulations and acts have been established by the U.S. government and related organizations. One such federal act which protects confidentiality is HIPAA. Another such act or group of regulations that protects confidentiality is 42 CFR Part 2.

The goal of enacting 42 CFR Part 2 was to encourage individuals to seek substance abuse treatment by removing the potential fear of privacy violations and subsequent legal and social ramifications that may follow. To accomplish the previous goal, 42 CFR Part 2 heightened the restrictions, even beyond those of HIPAA, on individuals' protected health information related to addiction treatment. 42 CFR Part 2 protects the confidentiality of the records containing the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with the performance of any federally assisted program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research⁹. Over the years there have been amendments, changes and acts made to 42 CFR Part 2 in order to update its relevance and improve upon its overall effectiveness within the greater system of health care. One of the changes or acts made to 42 CFR Part 2 is referred to as the final rule. Addiction professionals should be familiar with 42 CFR Part 2 as well as the changes made to 42 CFR Part 2 by the final rule in order to optimize their ability to maintain patient/client confidentiality.

Section 4: Personal Reflection Question

How do the changes made to 42 CFR Part 2 by the final rule protect client confidentiality while allowing for greater flexibility in disclosing patient identifying information within the health care system?

Section 5: Resolving Ethical Dilemmas

At the beginning of this course, 3 case studies were presented to highlight the types of ethical dilemmas addiction professionals may face in the delivery of care to individuals in need. Each of the aforementioned case studies was different and presented a very difficult and complex ethical dilemma. The following question was then posed: how can addiction professionals effectively manage and resolve

the ethical dilemmas and challenges put forth while delivering care to individuals seeking their services? The following answer was provided: addiction professionals can effectively manage and resolve the ethical dilemmas and challenges put forth while delivering care to individuals seeking their services by, first and foremost, understanding their ethical obligations and responsibilities to their clients. As outlined in the previous sections, addiction professionals can obtain an understanding of their ethical obligations and responsibilities to their clients by reviewing related codes of ethics as well as state and federal laws which apply to their delivery of care. It is imperative for addiction professionals to understand their ethical obligations and responsibilities to their clients when resolving complex ethical dilemmas - however, that is only the first part of the resolution process. The second part of the resolution process involves the use of a multi step decision-making model to analyze and break down ethical dilemmas to arrive at a conclusion and/or resolution. In this case, a decision-making model can refer to a step-by-step process which may be used to reach an informed decision or necessary course of action to resolve an ethical dilemma². The remainder of this section will examine the fundamental steps of a decision-making model and revisit the 3 case studies presented at the beginning of this course to explore the application and use of a decision-making model in the resolution of ethical dilemmas.

The Fundamental Steps of Decision-making Models

There are many different types of decision-making models which may be used by addiction professionals to resolve ethical dilemmas. That being said, the various types of decision-making models have core, fundamental steps in common which form the basis for all such models. Therefore, it is essential that addiction professionals understand the core, fundamental steps of decision-making models so they may use any such model to efficiently and effectively resolve ethical dilemmas. The only question that remains is: what are the fundamental steps of decision-making models? There are 7 fundamental steps which comprise most decision-making models, the first of which is gathering information.

Gathering information is essential to any endeavor, especially when it comes to making a decision. After all, how can individuals make decisions if they do not know what they are making decisions about? In essence, information is the foundation on which a decision is built on or made. In other words, without the foundation of information, an effective decision cannot be made. Thus, information relevant to a decision must be obtained before any other step is taken, especially when it comes to making an ethical decision related to health care. Simply put, health care-related information is essential to health care decisions - so much so, it has often been argued, that without relevant health care information, effective health care decisions cannot be made. For example, a physician cannot make a safe and effective decision regarding a patient's blood pressure if the physician does not have any information indicating what the patient's blood pressure is or has been over a certain period of time. The same principles from the previous example can be applied to addiction professionals and ethical decisions. An addiction professional cannot make a decision regarding an ethical dilemma if the addiction professional does not have any information indicating what the dilemma is, who it involves and any other related health care information. Thus, when an addiction professional is presented with an ethical dilemma the first thing he or she should do is gather relevant information, i.e. determine all of the facts of the situation such as:

what is going on, who is involved, what is the mental status of the client involved, how is the client dealing with recovery, what are the clients comorbidities, what medications is the client on and what are the side effects of those medications, what counseling or advice could fellow addiction professionals offer, etc. Essentially, the addiction professional should obtain any information which may shed light on the situation/dilemma and allow the addiction professional to adequately take the next fundamental step of decision-making models, which is to clarify the actual ethical issue involved in the dilemma.

When an ethical dilemma arises, an addiction professional may have an initial idea of what the ethical issue involved in the dilemma is - however, an addiction professional can only be truly sure what the ethical issue is after he or she obtains the relevant information, which is why clarifying and identifying the actual ethical issue involved in the dilemma is the second fundamental step of decision-making models.

Often in health care, things are not always what they appear to be. The following example will highlight the previous concept. A 50-year-old male patient presents to his primary care physician. The patient reports he is experiencing dizziness and light-headedness upon standing. After the initial exam, the patient's physician believes the patient's dizziness and light-headedness may be related to blood sugar issues or even nutritional issues. The physician orders blood tests, checks the patient's blood pressure and conducts a medication reconciliation to determine what medications the patient is currently taking. The physician then collects all of the relevant information regarding the patient's medications and test results to examine possible factors which may be contributing to the patient's dizziness and light-headedness. After some deliberation the physician believes the actual cause of the patient's dizziness and light-headedness upon standing is orthostatic hypertension, a potential side effect of one of the patient's recently initiated medications.

In the previous example, the physician had an initial idea of what might be causing the patient's dizziness and light-headedness upon standing. However, only after obtaining information related to the patient was the physician able to accurately identify the true issue at hand. The same can be said for addiction professionals when it comes to ethical decision-making. Only after relevant information pertaining to an ethical dilemma is gathered can addiction professionals accurately identify the ethical issue at hand. Ethical issues that may lead to ethical dilemmas can include: confidentiality, boundaries, client anonymity and the addiction professional-client relationship. Addiction professionals should keep in mind that it is possible for an ethical dilemma to have one or more ethical issues.

The third fundamental step of decision-making models is to identify and consider relevant ethical standards, principles and laws which apply to the dilemma's ethical issue or issues. In other words, once an addiction professional understands what the ethical issue behind a dilemma is, then the addiction professional should consider what laws and ethical principles apply to the particular ethical issue of concern. For example, if an addiction professional identifies confidentiality as the main ethical issue behind an ethical dilemma, then the addiction professional should review all of the state and federal laws which apply to confidentiality, as well as the sections of the various codes of ethics which provide insight into confidentiality. Addiction professionals should use state and federal laws in conjunction with

different applicable codes of ethics to guide their decision making process when resolving ethical dilemmas.

The fourth fundamental step of decision-making models is to develop potential courses of action. In this case, a course of action can refer to the possible solutions or methods which may be used to resolve an ethical dilemma. When faced with ethical dilemmas, it is always a good idea to conceive or develop many different potential solutions or methods to obtain a solution to the ethical dilemma at hand. One can never be quite sure as to what may occur to prevent a possible solution from taking action. Having multiple potential solutions at hand can provide addiction professionals with several options to have at their disposal in case events do not proceed as planned and the addiction professional has to change his or her course of action. Additionally, generating multiple courses of action can help provide the addiction professional with perspective on the ethical dilemma. Contemplating events and pondering possible solutions may allow the addiction professional to view an ethical dilemma from a different perspective, which in turn may shed new light on the ethical dilemma and open up additional potential options for resolution. Often when presented with a challenge, it is typically better to have more options for resolution, than few or no options. Thus, by developing potential courses of action regarding an ethical dilemma, addiction professionals can provide themselves with multiple options to efficiently and effectively resolve the ethical dilemma at hand.

Once an addiction professional develops multiple, possible courses of action regarding an ethical dilemma, he or she can then move on to step five, which is to identify and consider the pros and cons of each potential course of action. When a decision is reached regarding a client and a related ethical dilemma it possesses the potential to affect many other individuals connected to the client. In other words, addiction professionals' decisions may not only impact their lives and the client's life but also the individuals around them.

To fully understand the potential of an addiction professional's decisions, one can think of an individual throwing a small rock into a pond. When the small rock is thrown into the pond it creates ripples or waves which travel throughout the pond affecting and impacting everything with which they come into contact - the same can be said for an addiction professional's decisions. Much like the small rock in the previous example, one small decision can create waves which may affect everything and everyone around it. Therefore, it is important for addiction professionals to understand the weight of their decisions.

Identifying the pros and cons or risks and benefits of each potential course of action can help addiction professionals understand how their decisions or courses of action will affect the people around them including the client and the client's loved ones. After all, no one individual exists in a vacuum. Individuals are typically linked to others like links in a chain - affecting one link can affect the entire chain. Thus, it is imperative for addiction professionals to grasp the significance of their decisions and courses of action. Analyzing and identifying the pros and cons or risks and benefits of each potential course of action regarding an ethical dilemma can go a long way in helping addiction professionals grasp the relevance of their decisions. With that said, how can addiction professionals identify the possible pros and cons of potential courses of action regarding an ethical dilemma?

Addiction professionals may identify the possible pros and cons of potential courses of action regarding an ethical dilemma by several different methods. The first method involves simply writing out each course of action and then creating a list of possible pros and cons for each course of action. The aforementioned method of examining the possible pros and cons of potential courses of action can help addiction professionals visualize the risks and benefits of each course of action. By generating a pros-cons list, the addiction professional may be able to clearly see which course of action has the most pros and which courses of action have the most cons, allowing the addiction professional to eliminate the course of action with the most cons and select the course of action with the most pros. When creating the pros-cons list for each possible course of action, addiction professionals should ask themselves several questions to help them create each list. Examples of the types of questions addiction professionals should ask themselves include the following:

- How will this course of action affect the client?
- How will this course of action affect the client's recovery?
- How will this course of action affect the client's overall health?
- How will this course of action affect the client's loved ones?
- How will this course of action affect my colleagues?
- Is this course of action in line with state and federal laws?
- Is this course of action in line with applicable codes of ethics?
- Will this course of action resolve the dilemma or intensify the dilemma?
- What steps may have to be taken to fulfill this course of action?

By asking the previous types of questions for each potential course of action, it may help the addiction professional identify possible pros and cons that were not previously considered.

Another method addiction professionals may use to identify the possible pros and cons of each potential course of action is to use a quantifying system. A quantifying system involves generating a list of the possible pros and cons for each potential course of action and then associating a numerical value, based on a scale from 0 to 10 with each pro and con - 0 meaning no importance, 10 meaning the most important. Once numerical values have been associated with each pro and each con, all of the pro values can be tabulated and all of the con values can be tabulated to arrive at a total value for the pro list and a total value for the con list. The total pro value and the total con value can then be compared to provide an established quantified insight into each potential course of action. For, example, if the total con value greatly exceeds the total pro value of a potential course of action, then perhaps that particular course of action is not a possible option to resolve the ethical dilemma. If the opposite is true, and the total pro value greatly exceeds the total con value, then that course of action may prove to be a viable

solution for the ethical dilemma at hand. The quantifying system may be beneficial to those addiction professionals who prefer to rate information and view information numerically.

Lastly, the "Chess Method" may also be used by addiction professionals to identify the possible pros and cons of potential courses of action. The Chess Method utilizes a similar method of thinking or strategy chess players employ while playing a game of chess. Often when individuals play chess they think several steps ahead before they move their chess pieces, e.g. if this chess piece is moved in this specific way, the following events may or will occur. By thinking several steps ahead of their moves chess players can anticipate the consequences of their actions before they are made, allowing chess players to avoid danger and/or negative outcomes whenever possible. The Chess Method encourages individuals to think as chess players do so they too can avoid danger and/or negative outcomes when making important decisions. To effectively use the Chess Method, addiction professionals should first generate a pros-cons list for each potential course of action. Secondly, the addiction professional should select the best courses of action available based on their respective pros-cons list. Next, the addiction professional should then create a separate list of all of the possible consequences or outcomes that may occur if a specific course of action is taken, i.e. the addiction professional should develop a list of possible consequences or outcomes for each remaining potential course of action. While creating the list of possible consequences or outcomes for each remaining course of action, addiction professionals should ask themselves the following types of questions:

-If this course of action is taken to resolve the ethical dilemma at hand then what following events or outcomes may and/or will occur?

-If this course of action is taken to resolve the ethical dilemma at hand then how may it or will it affect the client?

-If this course of action is taken to resolve the ethical dilemma at hand then what are the following steps that need to be taken in order to ensure the course of action is successful?

Finally, the addiction professional should compare the possible consequences and/or outcomes of each remaining course of action to determine which course of action is most appropriate to achieve resolution. The Chess Method may be used by addiction professionals to narrow down potential courses of action in order to optimize the resolution process and maximize outcomes. Addiction professionals may use one or a combination of one or more of the aforementioned pros-cons methods to develop potential courses of action and to ultimately resolve an ethical dilemma.

Once an addiction professional has completed the previous five steps, he or she is ready to move on to arguably the most important fundamental step of decision-making models, step six - selecting a course of action to resolve the ethical dilemma at hand. At this point in the decision-making process, addiction professionals should have a clear understanding and a clear choice for a course of action for resolution. The previous five steps should have provided the addiction professional with the optimal course of action required for his or her ethical dilemma. If, at this point, the addiction professional does not have a clear choice for a course of action to resolve the pressing ethical dilemma, then the addiction professional should repeat the previous five steps until one emerges. Once a clear course of action

presents itself, addiction professionals should document the selected course of action, as well as the steps taken to obtain it. When the appropriate documentation is complete, all that remains is for the addiction professional to set the selected course of action in motion and resolve the ethical dilemma with which he or she is faced.

Finally, once the addiction professional's chosen course of action has been implemented, the addiction professional can take the last fundamental step of decision-making models, step 7 - reflection and redirection, if necessary. Reflection, in this case, can refer to a process of thought and/or consideration. Anytime a major decision is made, it is best to reflect on that decision to ensure it is the best possible decision available to achieve desired outcomes. Reflection on decisions can come in many forms such as: deep thought, journaling and/or discussions with colleagues. Whatever form of reflection addiction professionals chose to take they should ask themselves certain questions to facilitate the reflection process and to achieve a clear perspective on the chosen course of action's ability to resolve the ethical dilemma at hand. The types of questions addiction professionals should ask themselves during the reflection process may include:

- Is the selected course of action the best possible method to resolve the ethical dilemma?
- Will the selected course of action achieve desired results and/or outcomes?
- Will the selected course of action benefit the parties involved?
- Is the selected course of action objective in nature?
- How is the selected course of action impacting the situation and the individuals involved now that it has been set in motion?
- How is the selected course of action affecting the client's addiction recovery and overall health?
- Is the selected course of action improving the situation regarding the ethical dilemma?
- How is the selected course of action improving the situation regarding the ethical dilemma?

If any of the aforementioned types of questions cannot be answered or if the addiction professional determines that the chosen course of action may not be the best possible solution to achieve desired outcomes after all, then the addiction professional may have to act and redirect the course of action if necessary.

Redirection, as it pertains to ethical decision-making, can refer to the process of assessing, altering, adjusting and/or changing the course of action selected to resolve an ethical dilemma. Redirection may be necessary when resolving an ethical dilemma for several different reasons. For example, perhaps the chosen course of action proves to be harmful to the individuals involved in the ethical dilemma as opposed to beneficial or perhaps the selected course of action requires altering, adjustments or subtle modifications because new information regarding the ethical dilemma has surfaced, or perhaps the selected course of action needs to be completely changed or replaced because it is no longer legally

feasible. Whatever the case may be, if an addiction professional determines upon reflection that a selected course of action is not working as desired or requires adjustments for any other appropriate reason, he or she should not hesitate in redirecting the selected course of action to ensure optimal outcomes are achieved. If redirection is necessary, addiction professionals should document why it was required, what adjustments were made and/or how a new course of action was selected.

Making a decision regarding an ethical dilemma and developing a course of action to resolve an ethical dilemma can be challenging. However, the use of a decision-making model can potentially make the process much easier. Decision-making models can help addiction professionals focus their efforts and maximize outcomes. As previously mentioned, there are various types of decision-making models available to addiction professionals. That being said, the various types of decision-making models have fundamental steps in common which form the basis for such models. Addiction professionals may follow the previously outlined 7 fundamental steps of decision-making models to aid in the development of a course of action needed for an ethical dilemma and to, ultimately, efficiently and effectively resolve ethical dilemmas.

Case Studies Revisited

At the beginning of this course, 3 case studies were presented. Each case study outlined a different ethical dilemma. The remainder of this section will revisit the 3 case studies presented at the beginning of this course to explore the application and use of a decision-making model in the resolution of an ethical dilemma. Each case study will be presented in its entirety below, followed by the step-by-step application of the previously highlighted 7 fundamental steps of decision-making models. At the end of each step, a reflection question will be posed to encourage further internal debate and consideration regarding the presented case.

Case 1

Alex is a 24-year-old female client with a history of drug abuse and anxiety. Alex's drug abuse began in her late teens and has continued up until recently. Initially, Alex began using drugs such as ketamine, cocaine and cannabis in social situations. However, Alex reports her drug abuse quickly escalated to an "almost everyday occurrence." Alex also reports she continued to use drugs to help her anxiety. Alex attributes her anxiety to the "traumas" she experienced during childhood. Alex's mother passed away when she was 10 years old and subsequently Alex grew up in a single parent home. Alex reports she was often left alone as a child and did not get along well with her father, who possesses a history of alcohol abuse. Alex recalls her anxiety began shortly after her mother's death. She felt like she could not relate well to her father and was often terrified by his "drunken tirades." Alex's father eventually obtained treatment for his alcohol abuse, however, Alex's anxiety continued after her father's sobriety. Eventually, in her late teens Alex began using drugs in college when she "hung out with friends" to help with her anxiety. Alex reports at that time she entered into a relationship with a male individual who

lived in her dorm. As the relationship progressed she continued to use drugs on a consistent basis. Alex's drug use continued through college and intensified as her relationships with men continued. After college, as her relationships became increasingly serious, Alex began using drugs on a "semi-daily basis" until her drug use escalated to an "every day thing." Alex's drug use continued until her recent relationship ended. Upon the termination of her most recent relationship, which Alex has described as "pretty much toxic," Alex began seeking help for her drug abuse. She entered substance abuse counseling and has been sober for several months. Alex attributes her sobriety to her determination, will for a healthier lifestyle and her counselor. As time progresses, Alex feels quite close to her counselor and begins to develop romantic feelings for him. After counseling sessions, Alex often initiates conversation with her counselor regarding personal topics and attempts to subtly ask him out on dates. Alex's counselor does not take Alex up on her invitations, although he does not make any attempt to quell Alex's advancements. Alex continues to flirt with her counselor for the next few weeks. During that time, Alex's counselor begins to develop a personal connection with Alex and seemingly appears to flirt back with her. As the flirtations continue, Alex begins to develop anxiety about her relationship with her counselor. Over the next few days, Alex's anxiety increases and so does her desire to use drugs. At the same time, Alex's counselor begins to become conflicted about his personal feelings for Alex. He is not sure if he should continue to meet with her or end the professional relationship between them in order to continue a personal relationship. At their next session, Alex's anxiety begins to intensify beyond her control and she expresses her interest in using drugs. Alex's counselor reaches an impasse and is not sure where his professional relationship with Alex ends and his personal relationship begins.

How a Decision-Making Model May Be Used to Resolve Case 1

Step 1: Gather information: An addiction professional may identify several important pieces of information related to Case 1 including the following relevant details. The client's name is Alex. She is a 24-year-old female with a history of drug abuse and anxiety. Alex has struggled with substance abuse for years, however she has been sober for several months. Alex's substance abuse appears to be related to anxiety associated with relationships. Alex has developed romantic feelings for her addiction professional. *What other details are relevant to the potential ethical dilemma presented in Case 1?*

Step 2: Identify the ethical dilemma/issue: An addiction professional may identify one or more ethical dilemmas/issues related to Case 1. However, the main ethical dilemma centers around the addiction professional's relationship with the client and the relevant ethical issues may be associated with the addiction professional-client relationship and related boundaries. *What other ethical dilemmas/issues may be present in Case 1?*

Step 3: Identify and consider relevant ethical standards, principles and laws which apply to the dilemma's ethical issue(s): There are various relevant ethical standards, principles and laws which apply to addiction professional-client relationships and boundaries. An example of related laws can be found in the California State Code of Ethics for Alcohol/Drug Counselors Holding A CCAPP Endorsement (Principle 9: Client Relationships; Section C. Dual Relationships (iii - iv)). The aforementioned laws can be

observed below. *What other ethical standards, principles and laws apply to the ethical dilemma presented in Case 1?*

iii. Because all relationships begin with a power differential, the alcoholism and drug abuse counselor/registrant must not exploit relationships with current or former clients for personal gain, including social or business relationships⁸.

iv. Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an alcohol and other drug abuse counselor⁸.

Step 4: Develop potential courses of action to resolve the ethical dilemma: An addiction professional may design or develop several potential courses of action to resolve the ethical dilemma involved in Case 1. One such course of action may be for the addiction professional to end the budding personal relationship emerging with the client. *What other potential courses of action may be used to resolve the ethical dilemma presented in Case 1?*

Step 5: Identify and consider the pros and cons of each potential course of action: An addiction professional may identify several pros and cons for each potential course of action related to Case 1. An example of a pro regarding the potential course of action posed in Step 4 (the addiction professional will end the budding personal relationship emerging with the client) may be as follows: the client obtains an understanding that a personal romantic relationship with her addiction professional is not possible and refocuses her attention on maintaining sobriety. An example of a con regarding the potential course of action posed in Step 4 (the addiction professional will end the budding personal relationship emerging with the client) may be as follows: the client continues her attempts to engage in a romantic relationship with the addiction professional, becomes increasingly anxious and eventually begins to abuse drugs in order to cope with her overwhelming anxiety. *What additional pros and cons may be relevant to the following potential course of action: the addiction professional will end the budding personal relationship emerging with the client?*

Step 6: Select a course of action to resolve the ethical dilemma at hand: As previously mentioned, there are several potential courses of action which may be used to resolve the ethical dilemma involved in Case 1. In this particular case, the addiction professional has chosen to end the budding personal relationship emerging with the client. *Is the aforementioned selected course of action appropriate, i.e. will it efficiently and effectively resolve the ethical dilemma presented in Case 1?*

Step 7: Reflection and redirection if necessary: Reflection on decisions can come in many forms such as: deep thought, journaling and/or discussions with colleagues. The addiction professional in Case 1 chooses to engage in a discussion with a colleague to reflect on the selected course of action. After the discussion, the addiction professional chooses to redirect the selected course of action. The adjustments made to the addiction professional's course of action include the following: the addiction professional chooses to have a conversation with the client about the importance of an appropriate addiction

professional-client relationship before the budding personal relationship is ended. *Should any additional efforts be made to redirect the selected course of action? If so, how can the selected course of action be adequately redirected to resolve the ethical dilemma presented in Case 1?*

Case 2

Jane is a 42-year-old alcoholic and single mother of two children, ages 12 and 9. Recently Jane has entered counseling for her alcohol addiction. She is trying to maintain her sobriety for the sake of her health and children. Jane has battled alcoholism since her early 20s; however, her struggle with alcohol intensified after her divorce approximately 8 years ago. Jane has remained single since her divorce and does not often see or interact with her ex-husband. Along the same lines, her children do not have a relationship with their father. Jane has maintained a job as an accountant for the past 15 years. After the recent death of her parents, Jane has expressed that it has become harder for her to balance her career with being a single parent. Jane feels like she has no personal time for herself and can never "truly unwind." As a result, she is finding it harder to refrain from alcohol. Over the past several weeks, she reports drinking up to "5 - 6 gin and tonics" per evening. She also reports that she often sends her children to bed with no dinner and locks them in their rooms for long periods of time so she can "drink and relax." Jane also admits that she has not been very patient with her children recently and has resorted "striking them when they misbehave." Furthermore, Jane reports she often leaves her children alone for long periods of time on the weekends to "go out for a drink." Jane fears she is losing control of her life and her ability to control her drinking. Jane is not sure what she will do next but firmly believes her children need to be by her side for her to succeed. Upon hearing the aforementioned reports from Jane, Jane's addiction professional becomes concerned for Jane's well-being. Moreover, the addiction professional becomes concerned for the well-being of Jane's children. Jane's addiction professional is not confident in Jane's ability to care for her children and feels Jane's children may be in danger. It appears Jane can no longer maintain her sobriety and effectively care for her children. It also appears that Jane does not have much support to help her maintain her professional, personal and family responsibilities. Jane's addiction professional believes Jane needs additional treatment for her alcoholism. At the same time, Jane's addiction professional believes Jane's children also need help. At the conclusion of their latest meeting, where Jane admits to further neglect of her children, Jane's addiction professional feels action is necessary. However, Jane's addiction professional feels torn. On one hand, Jane's addiction professional feels Jane's children need help before they are put in serious danger. On the other hand, Jane's addiction professional believes that any action taken towards Jane and her children may have severe consequences for Jane's health and battle with alcoholism. Jane's addiction professional is left struggling with the aforementioned internal debate and is unsure about what to do next.

How a Decision-Making Model May Be Used to Resolve Case 2

Step 1: Gather information: An addiction professional may identify several important pieces of information related to Case 2 including the following relevant details. The client's name is Jane. Jane is a 42-year-old alcoholic and single mother of two children, ages 12 and 9. Jane has recently entered counseling for her alcohol addiction. Jane is divorced and her parents are deceased. Jane reports drinking "5 - 6 gin and tonics per evening" over the past several weeks. Jane also reports that over the past several weeks she has sent her children to bed without dinner, left them unattended at home for several hours at a time and has employed physical violence to help manage them. *What other details are relevant to the potential ethical dilemma presented in Case 2?*

Step 2: Identify the ethical dilemma/issue: An addiction professional may identify one or more ethical dilemmas/issues related to Case 2. However, the main ethical dilemma centers around the addiction professional's concern for the client's children and the relevant ethical issues may be associated with confidentiality, client welfare and the identification of potential child abuse. *What other ethical dilemmas/issues may be present in Case 2?*

Step 3: Identify and consider relevant ethical standards, principles and laws which apply to the dilemma's ethical issue(s): There are various relevant ethical standards, principles and laws which apply to confidentiality, client welfare and the identification of potential child abuse. An example of a related law can be found in the Iowa State Code of Ethics For All IBC Certified Professionals (Principle III: Confidentiality D.). The aforementioned law can be observed below. *What other ethical standards, principles and laws apply to the ethical dilemma presented in Case 2?*

D. IBC certified professionals reveal information received in confidence only when there is a clear and imminent danger to the client or other persons, and then only to appropriate workers, public authorities, and threatened parties⁵.

Step 4: Develop potential courses of action to resolve the ethical dilemma: An addiction professional may design or develop several potential courses of action to resolve the ethical dilemma involved in Case 2. One such course of action may be for the addiction professional to notify the local child protective services organization about the potential child abuse. *What other potential courses of action may be used to resolve the ethical dilemma presented in Case 2?*

Step 5: Identify and consider the pros and cons of each potential course of action: An addiction professional may identify several pros and cons for each potential course of action related to Case 2. An example of a pro regarding the potential course of action posed in Step 4 (the addiction professional will notify the local child protective services organization about the potential child abuse) may be as follows: the client's children may be taken out of harm's way and protected from potential child abuse. An example of a con regarding the potential course of action posed in Step 4 (the addiction professional will notify the local child protective services organization about the potential child abuse) may be as follows: the client becomes overwhelmed with stress and grief due to a potential intervention from the local child protective services organization regarding her children. Subsequently, the client eventually begins to increase her alcohol use and abuse in order to cope with the situation related to her children, leading

to further complications with her family, overall health and sobriety. *What additional pros and cons may be relevant to the following potential course of action: the addiction professional will notify the local child protective services organization about the potential child abuse?*

Step 6: Select a course of action to resolve the ethical dilemma at hand: As previously mentioned, there are several potential courses of action which may be used to resolve the ethical dilemma involved in Case 2. In this particular case, the addiction professional has chosen to notify the local child protective services organization about the potential child abuse. *Is the aforementioned selected course of action appropriate, i.e. will it efficiently and effectively resolve the ethical dilemma presented in Case 2?*

Step 7: Reflection and redirection if necessary: Reflection on decisions can come in many forms such as: deep thought, journaling and/or discussions with colleague. The addiction professional in Case 2 chooses to revisit the pros-cons list of each potential course of action in a journaling session to reflect on the selected course of action. After the journaling session the addiction professional does not choose to redirect the selected course of action. *Should any additional efforts be made to redirect the selected course of action? If so, how can the selected course of action be adequately redirected to resolve the ethical dilemma presented in Case 2?*

Case 3

Frank is a 29-year-old male client with a history of drug and alcohol abuse. Frank has entered counseling to achieve sobriety. Frank reports his battle with drugs and alcohol began in college. While attending college, Frank would often go to parties and/or bars and use drugs or drink excessively. Frank admits he often would "black-out" and wake up in random places and in "strange" women's beds after a night out drinking. After college Frank continued to binge drink and use drugs. Frank also admits his "black-outs" continued and he would often "pick up" women while he was out "partying." Frank has tested positive for several sexually transmitted diseases (STDs); however, he has continued to engage in unprotected intercourse under the influence of drugs and alcohol. Frank reports he often "dates" multiple women at one time and combines binge alcohol drinking, drugs such as cocaine and sex to numb the depression he feels over his past actions. Frank is not sure if he can stop his previously mentioned actions because they have been "an intricate part of his life for so long". Additionally, Frank reports he does enjoy himself when he is drinking and doing drugs even if it brings him depression later on. With that said, Frank understands he needs to stop his unhealthy lifestyle because his actions are putting his health, and the health of others, in jeopardy. Several weeks pass and Frank makes positive progress with his drug and alcohol addiction, although he reports he is still having trouble refraining from unprotected sex with multiple partners. As time progresses, Frank continues to tell his addiction professional stories about his past drinking episodes and drug abuse. Frank's addiction professional listens carefully to Frank's reports and picks up several details which peak interest. Several days later, via social media outlets, Frank's addiction professional discovers that a close friend is romantically linked to Frank. Although Frank's addiction professional is not certain of the details regarding the relationship between the close friend and Frank, the addiction professional is concerned for the health of both parties. Stuck in the middle of

loyalty to a friend and professional obligations to Frank, the addiction professional is not sure how to proceed with the professional information obtained through counseling sessions with Frank and the observations made via various social media outlets.

How a Decision-Making Model May Be Used to Resolve Case 3

Step 1: Gather information: An addiction professional may identify several important pieces of information related to Case 3 including the following relevant details. The client's name is Frank. Frank is a 29-year-old male client with a history of drug and alcohol abuse. Frank reports he suffers from depression. Frank also reports he often goes out and abuses drugs and alcohol to the point of "black-outs" and frequently engages in unprotected sex with multiple partners. Frank has tested positive for several STDs. *What other details are relevant to the potential ethical dilemma presented in Case 3?*

Step 2: Identify the ethical dilemma/issue: An addiction professional may identify one or more ethical dilemmas/issues related to Case 3. However, the main ethical dilemma centers around the addiction professional's concern for the client's health as well as a friend's health. The relevant ethical issues may be associated with confidentiality. *What other ethical dilemmas/issues may be present in Case 3?*

Step 3: Identify and consider relevant ethical standards, principles and laws which apply to the dilemma's ethical issue(s): There are various relevant ethical standards, principles and laws which apply to confidentiality. An example of a related standard/principle can be found in the NAADAC's code of ethics (Principle II: Confidentiality and Privileged Communication). The aforementioned standard/principle can be observed below. *What other ethical standards, principles and laws apply to the ethical dilemma presented in Case 3?*

- Addiction professionals should understand that confidentiality and anonymity are foundational to addiction treatment and embrace the duty of protecting the identity and privacy of each client as a primary obligation.

Step 4: Develop potential courses of action to resolve the ethical dilemma: An addiction professional may design or develop several potential courses of action to resolve the ethical dilemma involved in Case 3. One such course of action may be for the addiction professional to educate the client on the importance of safe sex. *What other potential courses of action may be used to resolve the ethical dilemma presented in Case 3?*

Step 5: Identify and consider the pros and cons of each potential course of action: An addiction professional may identify several pros and cons for each potential course of action related to Case 3. An example of a pro regarding the potential course of action posed in Step 4 (the addiction professional will educate the client on the importance of safe sex) may be as follows: the client finally grasps the importance of safe sex and begins to use safe sex practices at all times. An example of a con regarding the potential course of action posed in Step 4 (the addiction professional will educate the client on the importance of safe sex) may be as follows: the client does not grasp the importance of safe sex and continues to engage in unprotected sex, placing his health and the health of others in jeopardy. *What*

additional pros and cons may be relevant to the following potential course of action: the addiction professional will educate the client about the importance of safe sex?

Step 6: Select a course of action to resolve the ethical dilemma at hand: As previously mentioned, there are several potential courses of action which may be used to resolve the ethical dilemma involved in Case 3. In this particular case, the addiction professional has chosen to educate the client on the importance of safe sex. *Is the aforementioned selected course of action appropriate, i.e. will it efficiently and effectively resolve the ethical dilemma presented in Case 3?*

Step 7: Reflection and redirection if necessary: Reflection on decisions can come in many forms such as: deep thought, journaling and/or discussions with colleague. The addiction professional in Case 3 chooses to engage in a session of deep thought to reflect on the selected course of action. After some consideration, the addiction professional chooses to redirect the selected course of action. The adjustments made to the addiction professional's course of action include the following: the addiction professional will attempt to educate the close friend, romantically linked to the client, on the importance of safe sex via a personal conversation. *Should any additional efforts be made to redirect the selected course of action? If so, how can the selected course of action be adequately redirected to resolve the ethical dilemma presented in Case 3?*

Section 5: Summary

Making a decision regarding an ethical dilemma and developing a course of action to resolve an ethical dilemma can be a challenge for addiction professionals. However, the use of a decision-making model can potentially make the process much easier. Decision-making models can help addiction professionals focus their efforts and maximize outcomes. When selecting a decision-making model to help resolve an ethical dilemma, addiction professionals should choose a model consisting of the fundamental steps found below. Addiction professionals may follow the fundamental steps of decision-making models to aid in the development of a course of action needed for an ethical dilemma and to, ultimately, efficiently and effectively resolve an ethical dilemma.

The 7 Fundamental Steps of Decision-Making Models

Step 1: Gather information

Step 2: Identify the ethical dilemma/issue

Step 3: Identify and consider relevant ethical standards, principles and laws which apply to the dilemma's ethical issue

Step 4: Develop potential courses of action to resolve the ethical dilemma

Step 5: Identify and consider the pros and cons of each potential course of action

Step 6: Select a course of action to resolve the ethical dilemma at hand

Step 7: Reflection and redirection if necessary

Section 5: Personal Reflection Question

Why is it important for an addiction professional to follow the 7 fundamental steps of decision-making models when resolving an ethical dilemma?

Conclusion

Ethics can refer to the moral principles which guide an individual's behavior and/or actions¹. At the basic level, ethics and the principles related to ethics help individuals distinguish right from wrong. On the broader scale, ethics can help forge an individual's character, personality, decision making process and how he or she views the world. In essence, ethics and the principles related to ethics are major determining factors in what makes a person an individual and how individuals interact with the greater world around them. Due to the individual nature of ethics, every person possesses the potential to have distinct and different ethical principles. Nevertheless, individuals have to coexist and work together side by side. Cooperation is essential for the betterment of mankind and it is absolutely necessary in the workplace. Individuals have to work together as a team to accomplish goals and achieve success, especially in health care settings. Team work is essential to the safe and effective administration of health care, regardless of what form it takes. Therefore, it is paramount that individuals work together in a cohesive manner under a unifying set of ethical principles.

Oaths and/or professional agreements are made by health care professionals to uphold specific, unifying ethical standards. Among those agreed upon ethical standards are the four cornerstones of health care ethics, which include: autonomy, justice, beneficence and nonmaleficence. Each of the aforementioned principles have specific meanings when applied to health care and health care related fields. For example, the principle of autonomy can refer to the acceptance or acknowledgement that individuals possess the capacity to think, act and form decisions about themselves and their own life, free from external control, influence, force and/or coercion^{1,2}. The principle of justice can refer to the fair and legal allocation of health care resources to patients/clients^{1,2}. Beneficence can refer to the act of doing what is best for the patient, while nonmaleficence can refer to the ideal of inflicting no harm to patients - do no harm to patients/clients^{1,2}. Addiction professionals should strive to maintain the aforementioned four principles at all times to best serve their clients and manage any ethical dilemma and/or challenge placed before them.

Due to the importance of ethics in health care, professional organizations, such as the NAADAC, have developed codes of ethics to help guide addiction professionals in their delivery of professional care to individuals seeking their services. Additionally, individual states, such as Iowa and California, have established specific codes of ethics to provide addiction professionals with further guidance regarding the delivery of care to individuals in need. Also, both state and federal laws have been enacted to ensure addiction professionals adhere to the various codes of ethics as well as to protect and safeguard individual patient/client rights. Addiction professionals should have an understanding of applicable

codes of ethic as well as state and federal laws to adequately deliver care in accordance with the established requirements.

Even with the aforementioned guidance, addiction professionals may face complex and challenging ethical dilemmas. To resolve ethical dilemmas, addiction professionals must first understand their ethical obligations and responsibilities to those who seek their care. Secondly, addiction professionals must develop and analyze objective courses of action. To develop an objective course of action in order to, ultimately, resolve an ethical dilemma, addiction professionals may use a decision-making model. When selecting a decision-making model, addiction professionals should be sure to choose one which includes the following core, fundamental steps: gather information; identify the ethical dilemma/issue; identify and consider relevant ethical standards, principles and laws which apply to the dilemma's ethical issue; develop potential courses of action to resolve the ethical dilemma; identify and consider the pros and cons of each potential course of action; select a course of action to resolve the ethical dilemma at hand; reflect and redirection, if necessary.

Finally, it is the responsibility of the addiction professional to safeguard the integrity of the counseling relationship and to ensure clients are provided with services grounded in the universal principles of health care ethics. Additionally, when clients enter addiction treatment, they rely on the addiction professional for ethical care to help them maintain their sobriety, health, overall well-being and quality of life. Therefore, addiction professionals must ensure they deliver care in accordance with the various codes of ethics, as well as state and federal laws to effectively deliver the care individuals require and rely on.

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Macera, Marc, PharmD. (September 2018).
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