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P R E F A C E

It has become fashionable among authors of ethics books to tout the timeliness of their work. When said about the content of the present volume, this is anything but cliché. Coalescing scientific, clinical, and social developments make this a relevant, even urgent, and highly salient offering. Every month there are new reports of addictive drugs from clandestine laboratories hitting the streets, joining the age-old scourges of alcohol and tobacco. Even discoveries for severe and chronic pain have been distorted in their misuse to create an epidemic of addiction to novel prescription narcotics.

Policymakers, society, and people with addiction struggle with competing and often conflicting models of addiction, whether seen as disease, crime, personal weakness, genetic determinism, or a hybrid of all the above. At the heart of these contemporary debates are ethical questions as ancient as philosophy: free will versus responsibility, choice versus determinism, treatment versus punishment. But a modern understanding and a new paradigm for care are now possible. Emerging neurobiological evidence illuminates the circuits and transmitters involved in craving and reward, dependence and withdrawal, and the genetic precursors to addiction itself. With greater understanding of the biological basis of addiction and substance use disorders, we may now begin to make some progress in this field, particularly from an ethical perspective.

No one confronts these questions with as much immediacy and poignancy as addiction professionals, who daily face complex ethical dilemmas regarding issues of confidentiality, consent, and the balance of harm and benefit. These questions affect clients and their families but also society as a whole. Although, as this volume shows, law often provides the framework in which these decisions can be made, legal requirements and regulations do not provide

trim and tidy packaged solutions to the ethical problems of caring for people with substance use disorders. Nor can the present volume offer such ready-made answers.

What this book on addiction ethics does provide is general guidance and guidelines on key issues stemming from the accumulated wisdom of a group of clinician-educators and researchers with extensive experience and diverse expertise in the addictions field. This text also presents emerging controversies and novel, as yet untested ideas around age-old questions in the care of people with addictions. For this reason, we offer this work modestly in the hope that it will stir new thinking and opportunities to substantiate (or not) these claims. Addiction is a rapidly evolving field of clinical science and one in which consensus on many questions has not yet been established. Thus, this book, as the work of many expert authors, represents innovative thinking and in some instances even contradictory views.

It is incumbent upon all authors (but particularly those who are also ethicists) to give credit where credit is due. In this case we wish to acknowledge LeClair Bissell and James E. Royce's pioneering volume *Ethics for Addiction Professionals*, first published by Hazelden in 1987. Building on this and other sources cited in the book, the authors strive to expand the humanistic and clinically oriented approach to addiction ethics to a host of new stakeholders and issues that have arisen since the earlier volume was published. *The Book of Ethics: Expert Guidance for Professionals Who Treat Addiction* explores new territory in discussing the specific ethical concerns involved in treating women, children and adolescents, and patients with dual diagnoses. The emerging consensus regarding the importance of recognizing cultural and spiritual aspects in caring for patients with addiction is addressed in these pages, as is the more controversial role of harm reduction in therapy for substance use disorders.

The Book of Ethics also attends to the ethical ground of clinical work by introducing addiction professionals from all disciplines to the fundamental principles and practices of modern clinical

ethics, such as informed consent, confidentiality, and scarce resource allocation. Forensic concerns—so prevalent in all of mental health treatment—are presented, as are the parameters of the therapeutic relationship with adaptation and adoption for the field of addictions.

Perhaps no illness has resulted in as much tragedy for patients, families, and health care professionals as addictions have. Fortunately, emerging pharmacological and behavioral treatments offer hope for sustained recovery for millions of people for whom even five years ago there were far fewer options. Yet with these new therapies, experience has shown us, will come new ethical dilemmas that will require ethically informed and clinically skilled addiction professionals who can address these challenges for the good of the patient and the culture. It is to facilitate this honorable effort that we have written this text, and we trust it will serve those navigating this ever-more-complex landscape of addictions as a worthy compass.

C. G. and L. R.



Ethical Foundations of Substance Abuse Treatment

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Substance abuse affects all of us, and the personal and societal costs of substance-related disorders are both real and significant. One in six individuals in the United States experiences addiction over the course of his or her lifetime (Kessler et al. 2005). The burden of addiction is amplified when one considers the people who love, live with, and work with individuals with addiction. Health professionals—irrespective of specialty or discipline—will encounter consequences of substance abuse in their clinical work. Caring for patients with the complex issues that accompany addiction creates many challenges: biological, psychological, social, spiritual—and ethical. Whether indirectly, through the societal costs of alcohol or other drug use, or more directly, through contact with an individual suffering with these conditions, the burdens are great.

Pervasiveness of Substance Abuse

Addiction is a wide and deep public health problem in the United States. The 2007 National Survey on Drug Use and Health found that an estimated 22.6 million people—an alarming 9.2 percent of the U.S. population—met the criteria for either substance abuse or dependence in 2006. This survey reports that 3.2 million people abused or were dependent on alcohol and illicit drugs. An additional 3.8 million misused or were dependent on drugs alone, and 15.6 million abused or were dependent on alcohol alone.

Approximately one-quarter of all mortality in the United States can be attributed to alcohol and drugs. During 2001 there were 75,766 alcohol-attributable deaths and 2.3 million years of potential life lost, or 30 years of life on average, per death related to alcohol (Substance Abuse and Mental Health Services Administration 2006). Addiction accounts for 40 million illnesses and injuries each year and over \$400 billion in health care costs, lost productivity, and crime (McGinnis and Foege 1999).

Psychological distress was strongly associated with the use of substances in this National Survey on Drug Use and Health, with 22.3 million adults reporting both serious mental health problems and abuse or dependence on drugs or alcohol, compared with a 7.7 percent rate of abuse or dependence for those who did not report psychological distress (Substance Abuse and Mental Health Services Administration 2007a). The Centers for Disease Control and Prevention (CDC) estimates that excessive alcohol consumption is the third-leading cause of preventable death, with fatal consequences from cirrhosis, cancer, domestic violence, and motor vehicle crashes, among others (Centers for Disease Control and Prevention 2004).

While the human toll of addiction is immeasurable, the economic price is also striking, at \$180.9 billion related to drug abuse in 2002. This figure encompasses both the use of health care resources and the ramifications of crime, along with loss of potential productivity from disability, death, and withdrawal from the workforce (Lewin Group 2004).

People living with addictions in this country receive little in the way of substance-related health care. Only 2.5 million of the 23 million persons with substance abuse or dependence in the United States received treatment at a specialty facility in 2006. Indeed, it appears that most treatment for addiction-related illness in the United States is managed in acute care settings such as emergency departments (Substance Abuse and Mental Health Services Administration 2007a). The Drug Abuse Warning Network provides data regarding emergency department visits

involving illicit drugs, alcohol, or the nonmedical use of prescription medications. In 2005, the latest date for which a report is available, there were 1,449,154 visits for abuse of substances. The majority of these visits resulted from a combination of drugs and alcohol, and there was a 21 percent increase since 2004 in the misuse or abuse of pharmaceuticals (Substance Abuse and Mental Health Services Administration 2007b).

In 2006, 940,000 persons reported feeling that they needed treatment for an illicit drug or alcohol use problem, but 625,000 of these individuals made no effort to obtain treatment. This underscores that education, outreach, and an increase in services are desperately needed if the health care community is to address this public health crisis (Substance Abuse and Mental Health Services Administration 2007a).

This lack of engagement in treatment is itself a symptom of addiction, which adversely affects the mind, the will, and the emotions. Persons with a serious substance abuse problem often lack insight into their own disorders and are not fully aware of the havoc that addiction is wreaking on their health, families, careers, and community. The exercise of poor judgment, obsessive efforts to obtain the substance, and compulsive prioritizing of intoxication with drugs or alcohol over other values are integral aspects of addiction that endanger the individual and may harm relatives, friends, and even strangers.

The Moral and Ethical Salience of Living with Addictions

The distinct nature of substance misuse—for its specific biological, psychological, social, and spiritual consequences—renders it intrinsically and ineluctably moral. Caring for people living with addictions thus requires a high standard of ethical knowledge and professional skill. Substance use disorders are highly stigmatized and hence require more rigorous confidentiality protections than do other medical conditions. Addiction often involves illicit drugs, high-risk behaviors (including suicidal and homicidal ideas and impulses), and other actions that intersect with the law (such

as criminal conduct), making it imperative that addiction professionals understand their professional and legal obligations and how these impact the therapeutic alliance.

Because persons with substance abuse or dependence often have cognitive and volitional impairments and are frequently subject to coercion to enter treatment from employers, families, the courts, and health care providers, scrupulous attention to full and authentic informed patient consent is highly salient.

Several issues may complicate the therapeutic relationship. Clinicians may have internalized cultural biases and personal prejudices regarding addiction. Moreover, many health care providers involved in addiction treatment may themselves be in recovery. This special aspect of addiction therapy will require self-awareness, frequent consultation, and monitoring of therapeutic boundaries for the well-being of both patient and professional. Finally, as opposed to other areas of health care and biomedicine, clinical ethics in relation to addiction and co-occurring conditions is comparatively underdeveloped, with little research and education focused on the topic (Walker et al. 2005).

Ethics in Health Care

Ethics is the branch of philosophy that describes values related to human conduct and explores what is right and wrong about certain actions and decisions. Historically, those involved in the law, the clergy, and medicine have been granted a substantial measure of self-governance in return for their pledge to observe explicit and agreed-upon ethical standards. This places the well-being and interests of the client or patient above all other interests that may encroach upon the situation, whether personal, economic, or political. The professional ethics of health care practitioners, including addiction professionals, is often called medical ethics.

Many recognize the origin of medical ethics in the Hippocratic School of 200 B.C. The duties expressed in the famous Oath of the Hippocratic School, such as confidentiality, nonmaleficence, and beneficence, remain fundamental principles

of modern health care. Other core concepts of contemporary bioethics in the United States, such as autonomy and respect for persons, emerged in response to the rise of technology in medical practice, evolving appreciation of ethical issues in human research, and the larger human rights movement. The specialty of addiction treatment, which includes physicians, psychologists, social workers, licensed addiction counselors, and other health care disciplines, is relatively new and intrinsically multidisciplinary. Thus, the ethical codes of each type of practitioner will have specific emphases, yet all share the commitment to the essential ethical principles and virtues discussed in this chapter.

Ethical Principles

Ethical principles are general standards or maxims that guide ethical reasoning and conduct. Principles reflect an expert consensus on ethical priorities and values that frames ethical decision making in clinical care. Principles are sometimes also called rules or laws and, when applied to specific clinical cases, indicate broadly what decisions and actions may be ethically acceptable or justifiable. Closely related and often overlapping with principles are virtues such as compassion and honesty. Principles are a form of knowledge or reasoning, while virtues are habitual qualities of a person's character that incline him or her to choose the good and do what is right.

The principles of respect for persons, autonomy, compassion, confidentiality, privacy, truth telling, nonmaleficence, and beneficence form a necessary foundation for clinicians who treat patients with substance abuse or dependence. To be effective, professionals caring for individuals with addictions will ideally embody the virtuous dispositions of altruism and fidelity, among others, if they are to internalize and integrate the cognitive principles into their practice. The following principles and their application to addiction treatment are summarized in Table 1.1, Application of Ethical Principles to Addiction.

Respect for Persons

Respect for persons is the idea that every individual is endowed with dignity and worth, no matter what his or her ethnicity, income, social status, sexual orientation, cognitive function, judicial standing, or diagnoses. Substance abuse clinicians will find some of their greatest ethical challenges in facing both internalized prejudices against their patients and, even more, cultural and organizational discrimination.

Autonomy

Autonomy, or self-determination, has its origin in the concept of respect for persons and is arguably the overriding principle in U.S. medical ethics. It is inculcated in Anglo-American law and instantiated in health care chiefly through the practices of informed consent and confidentiality. “Autonomy” literally means “self-rule” and is the right and ability to make one’s own decisions—in the present context, decisions related to health care in general and addiction treatment specifically.

Addiction professionals who work with diverse populations and patients across the life cycle recognize that not all cultures or generations unilaterally or uniformly endorse autonomy in its individual form. For many cultures, and among some older persons, respect for authority is not tantamount to paternalism, and the family or community is the locus of decision making (Carrese and Rhodes 1995).

Compassion

The Latin source for the word “compassion” means “to suffer with” and is closely related to empathy, “feeling with.” Sympathy, which is literally “feeling for,” is a reaction characterized more by distance and pity than compassion, which is an active involvement to relieve another’s distress.

Confidentiality

Confidentiality requires that the clinician not disclose information obtained in the treatment relationship to third parties (unless

required by law) without the consent of the patient. Because confidentiality is constrained by law, it is regarded as a privilege (i.e., not an inherent “right”). Although confidentiality is important in all of medical ethics, the stigma and criminal charges connected to the abuse of alcohol and drugs in our society make confidentiality of vital significance to addiction professionals.

Privacy

Closely related to, but distinct from, confidentiality is the right of privacy. Privacy is defined as the right to be free from intrusions into one’s physical body, space, mind, and personal information.

Truth Telling

Also closely related to confidentiality is the obligation to be honest. Truth telling includes the positive duty to tell the truth and the negative duty not to mislead others. Truth telling requires clinicians to fully and accurately disclose health information to patients and their surrogates on the basis of informed consent and simultaneously to avoid misrepresenting such information to or withholding it from those who have a legitimate claim to receive it. Perhaps the most complicated and agonizing ethical conflicts substance-use clinicians will confront are those related to confidentiality and truth telling, such as mandatory reporting of pregnant women living with addictions in some jurisdictions (Roberts and Dunn 2003).

Nonmaleficence

Nonmaleficence is the ethical duty to “do no harm.” The protean and pervasive damage of addiction gives, some say, this principle of nonmaleficence the greatest weight in the ethics of addiction treatment.

A related concept is that of harm reduction—that is, creating treatments that help minimize the burdens associated with disease. Harm reduction, despite some detractors, is rationalized as a valid and valuable form of treatment because of the devastating consequences of addiction. This is especially true because, contrary

to much popular and even professional opinion, there are effective treatments, both established psychosocial interventions, like cognitive-behavioral and contingency modalities, and emerging and unprecedented pharmacological therapies, like those for alcohol and opioid dependence (Rawson et al. 2002). Thus harm reduction is possible and therefore creates its own ethical imperative, in the eyes of many. See Chapter 3 for more information on the harm reduction approach.

Beneficence

Beneficence is the ethical duty to seek to do good—to bring about benefits to individual patients and, many would argue, improve conditions in society as well. The efficacy of addiction treatments in real-world clinical settings enables substance abuse clinicians to practice beneficence to an extent not previously achievable. Addiction clinicians in the twenty-first century can have the same confidence in their abilities to do good for their patients and the same hope for their patients' participation in, and response to, treatment as providers treating other chronic medical illnesses, such as hypertension and diabetes (McLellan et al. 2000).

Ethical Decision Making

Addiction, particularly in the United States, is a complex phenomenon, with history and meanings beyond the clinical realm. The social, political, and cultural associations of addiction often intensify the ethical dilemmas shared with other forms of medical treatment and extend the ethical questions into legal, public policy, and even spiritual spheres (Room 2006). Four ethical aspects of addiction—stigma, legal implications, voluntarism, and justice—specifically affect a clinician's ethical decision making to a greater degree than perhaps any other area of health care.

Stigma

The first, and most powerful, aspect of addiction is stigma. “Stigma” literally means “branding or labeling.” This term connotes disgrace or diminishment of the person by virtue of some

attribute or characteristic. For persons with addiction, stigma plays out in diverse ways—nuances of what is said or not said at one end of the spectrum to social rejection, loss of or inability to obtain employment or insurance, alienation from family and friends, political marginalization, and other forms of subtle and overt discrimination (Roberts and Dunn 2003).

TABLE 1.1

Application of Ethical Principles to Addiction

Ethical Principle	Example of Dilemma
Autonomy	<i>A patient diagnosed with problem drinking by his primary care provider refuses referral to a substance abuse counselor.</i>
Respect for persons	<i>An addiction psychiatrist is treating an HIV-positive, homeless sex worker for amphetamine dependence in his private practice. His staff members tell the doctor they should not have to treat this kind of patient.</i>
Confidentiality	<i>A counselor in a substance abuse program is asked by a patient she is seeing for alcohol dependence to not tell the psychologist (who is the counselor's supervisor) that the patient is suicidal.</i>
Truth telling	<i>A patient in an outpatient substance abuse program asks the psychologist working there to not report a toxicology screen positive for opioids to her probation officer.</i>
Nonmaleficence	<i>A psychiatrist is treating a patient who has a history of cocaine dependence in remission and has developed chronic back pain. The primary care provider asks if it is safe to prescribe opioids to the patient.</i>
Beneficence	<i>A social worker exerts considerable effort to arrange housing for a homeless patient recovering from opioid dependence. The patient then is threatened with eviction for allowing drug-using friends to stay in his apartment.</i>

Many studies demonstrate the powerful impact of stigma on people with substance-related conditions. Studies of medical students and physicians suggest that stigma is associated with substance use and may discourage appropriate care-seeking as well as lead colleagues to “collude” with impaired peers to prevent their discovery (Roberts et al. 2001). For example, in a study of 1,027 medical students at nine training institutions, researchers found that 47 percent endorsed having concern about at least one mental health or substance-related condition and that concern about confidentiality and stigma discouraged them from obtaining appropriate care. Students were concerned that they would be jeopardized academically if they sought treatment. Moreover, most students would remain silent even if they suspected life-threatening substance abuse problems in another student.

In a second study conducted with 107 multidisciplinary clinicians in Alaska and New Mexico, researchers found that caregivers were reluctant to talk about alcohol abuse, mental health, drug abuse, and sexual life issues with their personal caregivers. For more stigmatizing conditions or issues, these clinicians preferred to avoid or delay necessary care or to go to other cities for treatment (Roberts et al. 2003).

In a third study, which took place in 2006, 197 patients in fifteen residential and outpatient substance abuse treatment facilities reported that the participants experienced high levels of enacted stigma, perceived stigma, and even self-stigma related to substance abuse. Most disturbing, the patients reported that the treatment system itself stigmatized people in recovery (Luoma et al. 2006).

Legal Implications

A second and distinct aspect of addiction is its legal implications. Although the law is often a considerable factor in medical decision making, in no other area does it weigh as heavily as in substance use treatment, where stimulants, opioids, and marijuana remain illegal drugs and where alcohol use too often involves charges of driving while intoxicated. Consider that among the 3.7 million adults on probation in 2000, 24.2 percent reported using an illicit

drug in the month prior to the survey, compared with 5.5 percent of adults not on probation. The Federal Bureau of Justice reported that two-thirds of victims of violence from a spouse or partner stated that the perpetrator had been drinking, in contrast to one-third of victims whose attackers were strangers. Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) found that children of parents with addictions were nearly three times more likely to be abused and four times more commonly neglected than children of parents who did not abuse substances (Stone 2000).

These and other grim statistics imply that most clinicians working in substance abuse treatment will routinely encounter ethical conflicts with the law, such as how to manage a positive “tox screen” in a patient who is on parole or alcohol-impaired driving by a patient in an intensive outpatient treatment program.

Voluntarism

The third aspect of addiction is that drugs and alcohol negatively affect the self-determination and voluntarism that are requisite for self-knowledge, careful and intentional conduct needed for moral responsibility and social accountability. Increasing evidence from the neurosciences indicates that the longer and heavier an addictive substance is used, the more probable it is for the user to be impulsive and unable to forgo short-term rewards for long-term gains (Vuchinich and Simpson 1998). Neurobiology is elucidating the role of genetics, the neuro-circuits, and endocrine stress responses in vulnerability to addiction and the long-term potentiation involved in the craving and cueing that drive compulsive use and relapse (Weiss 2005). Although few experts would say that even a severe and chronic substance-abusing individual is without legal culpability or completely unable to stop using substances, many thoughtful researchers and ethicists are examining the implications of these impairments for decisional capacity, informed consent, refusal of care, and even for mandated or coerced treatment of addictions (Caplan 2006).

Justice

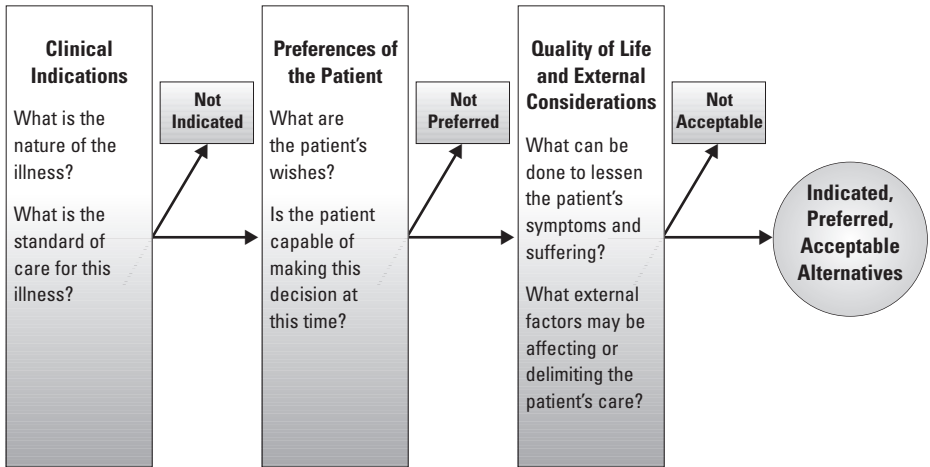
The fourth and final distinguishing aspect of addiction ethics is the enormous treatment gap, which has professional and public policy implications. Lack of parity in funding for mental health treatment, including addictions, represents a substantial health disparity in the U.S. system of medical care. Indeed an overwhelming majority of persons who struggle with addiction also have other disadvantages. Ethnic, economic, social, and cultural backgrounds and medical and psychiatric comorbidities all compound one's status in an underserved group. For this reason, we have argued that people with addictions have overlapping sources of vulnerability when seeking health care resources. In the 2005 National Survey on Drug Use and Health, 23.2 million Americans age twelve and older needed treatment for a drug or alcohol problem, but only 2.3 million received treatment at a facility specializing in addictions. This amounts to nearly 21 million individuals who did not obtain treatment for their substance abuse disorder. Even more ethically relevant, of those who received treatment at a specialty facility, 45 percent paid for it out of their own income or savings (Substance Abuse and Mental Health Services Administration 2006). Issues of social justice and fairness related to the lack of parity for treatment of substance use disorders can develop into ethical dilemmas for addiction practitioners regarding accuracy and veracity in documentation and medical record keeping and truth telling to third parties such as insurance companies or employers.

Ethical Dilemmas

An ethical dilemma is a situation in which a person is faced with one or more ethical obligations that cannot be fulfilled equally or at the same time. The choices are generally good and valuable, such as wanting to honor the confidentiality of a suicidal patient while also wishing to protect him or her from self-harm.

The first step in resolving an ethical dilemma is to recognize it as a true moral conflict rather than a legal question, clinical problem,

FIGURE 1.1

Ethical Decision Making

Adapted from Roberts and Dyer (2004: 307).

or institutional matter, all of which have somewhat different approaches and resources for their respective management. Clinicians can improve their understanding of ethical dilemmas by reading articles and books on ethics; obtaining continuing education credits in ethics, which are now required in several addiction disciplines; seeking supervision from clinicians with more experience and wisdom; and consulting with ethics consultants, ethics committees, attorneys, or professional associations.

The second step in dilemma resolution is to analyze the situation in a deliberate and systematic fashion, just as would be done with a clinical case. The National Center for Ethics in Health Care of the Veterans Administration has adapted the widely used model of Jonsen, Siegler, and Winslade (1998) into an even more

practical approach to ethical decision making in clinical care. This approach examines three factors: (1) the medical facts involved in a case, (2) the patient's preferences for treatment, and (3) the interests of other parties.

The qualities of good ethical decision making require that the process, justifications, and actual decisions are legally permissible, clinically appropriate and ethically acceptable, and, most important, represent patient-centered care. A practical example of how this approach can be employed can be found in Table 1.2, Case Illustration: A Model for Ethical Decision Making. This table demonstrates the primary factors that should be considered—including medical facts, patient preferences, and the interests of other parties—and that affect a clinician's ethical decision making. Consider the ethical question about whether to report (or not to report), for example, a forty-five-year-old female airline pilot with twenty years of alcohol dependence. This pilot has chosen to drink and to fly, placing passengers and the general public in jeopardy. Given the priority of the flying public, the most ethically appropriate decision will protect the public while also attempting to respect the patient's preferences. For instance, the clinician in this case could try to persuade the pilot to disclose her drinking problem to the airline and advocate for a treatment plan that would allow her to return to flying at an appropriate time in the future (once she is sober for a specified period of time). However, if persuasion is unsuccessful, the good of the public requires that the pilot be reported.

Using a model like the one shown in Table 1.2 helps organize the elements of the dilemma, making it easier to see that there may be a range of ethically justifiable actions (whereas before the analysis, there appeared to be only unacceptable or conflicting options). The most appropriate decisions will share certain characteristics of being clinically sound, legally permissible, ethically balanced, and respectful of a patient's values whenever possible. For instance, refusing to treat a patient's hypertension because it is at least partially due to alcohol use would not be good medical

judgment on the part of the practitioner. The most preferable decisions are those that balance the major ethical principles involved within the specific context at hand, rather than weighing one ethical principle more heavily due to subjective considerations by the clinician.

TABLE 1.2

Case Illustration: A Model for Ethical Decision Making

Factor	Case
<p>Medical facts</p> <ul style="list-style-type: none"> • Diagnoses • Treatment history • Comorbidity • Prognoses 	<ul style="list-style-type: none"> • <i>The patient is a forty-five-year-old pilot with twenty years of alcohol dependence.</i> • <i>She has been drinking two mixed drinks a night and up to five drinks in one sitting several times a month, even when she is scheduled to fly the next day.</i> • <i>She has hypertension and evidence of liver disease, both attributed to alcohol.</i>
<p>Patient preferences</p> <ul style="list-style-type: none"> • Informed consent • Decisional capacity • Surrogate decision makers 	<ul style="list-style-type: none"> • <i>She wants to attend AA regularly because it is anonymous.</i> • <i>She is willing to try acamprosate, a medication that may reduce drinking.</i> • <i>She does not wish to enter any formal substance use treatment program because she fears her employer, who pays her health insurance, will find out.</i>
<p>Interests of other parties</p> <ul style="list-style-type: none"> • Family • Health care providers • Employers • Public 	<ul style="list-style-type: none"> • <i>She may lose her job, affecting her partner and two children, if she is reported to the airline.</i> • <i>If she is reported, she may leave treatment and drink even more heavily.</i> • <i>The airline may have an employee assistance program that deals with addiction.</i> • <i>The public is in danger when she flies after drinking because she may be impaired.</i> • <i>The provider has an ethical obligation to protect patient confidentiality and public safety.</i>

Once the clinician understands the advantages and disadvantages of different decision options, the clinician's ethical knowledge base, skills, and consultation network can be employed to review and vet the decision. Another benefit of adopting a structured, consultative means of resolving ethical dilemmas is that it aids in accurate and clear documentation of the clinician's thinking, which is crucial in responding to legal, institutional, or professional issues pertaining to the case.

Confidentiality, Truth Telling, and Clinical Practice

Confidentiality and truth-telling issues are among the most common, complex, and challenging ethical dilemmas addiction professionals confront in their daily practice. The principle of confidentiality is one of the most ancient in professional ethical codes, dating back to the Oath of Hippocrates, which states, "Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one" (Lloyd 1983). The modern definition of confidentiality retains the essence of the oath, that information disclosed to a health care professional in the course of a therapeutic relationship should not be disclosed to other parties without the patient's permission unless required by law. Although technological innovations like cellular phones and the Internet, and system changes such as managed care and revisions in federal regulations have all eroded traditional confidentiality protections in most of health care, addiction treatment retains some of the strongest safeguards for patient information (Appelbaum 2002).

The rationale for more robust confidentiality protections in addiction treatment than in other forms of medical care lies in the greater stigma attached to substance use disorders. Only in a confidential setting can patients discuss sensitive, painful, and often stigmatized concerns such as sexual practice, drug and alcohol use, and homicidal or suicidal impulses. Unless patients are assured that their private disclosures to their practitioner will not be used to their detriment through loss of insurance or employment,

criminal action, or family conflicts, they will not provide the open, full, and detailed information regarding symptoms and lifestyle necessary for accurate diagnosis and effective treatment. Patients with addictive disorders may be so fearful that their personal health information will be exploited that they may not even come for treatment, resulting in late diagnosis, self-medication, and unnecessary morbidity and mortality.

Adolescents with addictions and women of reproductive age with addictions are two groups in which these tensions between need for treatment and protection of privacy become particularly poignant and complicated (Roberts and Dunn 2003). A study in the *Journal of the American Medical Association* anonymously surveyed 1,295 high school students, and 25 percent said they would not seek help for a health care problem if they knew their parents would be informed. Even among those students who had an established relationship with a provider, 86 percent would seek help for a medical problem, but only 57 percent for a substance abuse issue. Unfortunately, only one-third of respondents were aware of confidentiality safeguards for specific health concerns (Cheng et al. 1993). Specific confidentiality concerns that can arise when treating women are addressed in Chapter 7 and concerns regarding children and adolescents are addressed in Chapter 8.

Closely aligned to the duty of addiction professionals to protect patient information is their obligation to tell patients and others legitimately involved in care the truth regarding their diagnosis, prognosis, and treatment options and the adverse clinical, social, and even legal consequences of continuing to use substances of abuse. Truth telling encompasses the obligation not to deceive patients or others with valid rights to information, such as surrogates and colleagues, and the duty to present scientifically accurate clinical data in a manner that is respectful, nonjudgmental, and empathetic. Clinicians who avoid discussing substance use for fear of alienating a patient or because they do not consider it an appropriate medical issue do a disservice as much as practitioners who are confrontational, stigmatizing, and rejecting (Miller et al. 2001).

Legal Considerations

Legal requirements may shape or at times largely dictate ethical and clinical responsibilities. Although many times respect for the law, good patient care, and ethical practice coincide, there are instances in which they are at odds. It is incumbent upon addiction professionals to possess a working knowledge of the federal and state statutes and regulations applicable to their practice environment and discipline and to have access to competent legal and ethical counsel. See Table 1.3, Key Confidentiality Regulations, for a list of the key confidentiality regulations.

The two federal regulations listed in Table 1.3 take precedence over every other federal, state, or local policy regulation and mandate the circumstances and conditions under which information pertaining to addiction treatment may be disclosed. The following general points provide an outline of the implications of these regulations for clinical care (Brooks 2005).

- The regulations apply to any program that specializes, in whole or in part, in providing substance use disorder assessment, diagnosis, counseling, treatment, or referral and that receives federal assistance, such as any government funding or tax-exempt status.
- The regulations do not allow health information, either written or oral, to be disclosed about any patient who has

TABLE 1.3

Key Confidentiality Regulations

- Confidentiality of Alcohol and Drug Abuse Patient Records, Part 2 of Title 42 (Public Health) of the Code of Federal Regulations (CFR).
- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Parts 160 and 164 of Title 45 (Public Welfare) of the Code of Federal Regulations.
- Applicable state law.

applied for future treatment, who has received treatment in the past, or who is currently in treatment unless the patient has consented to the release or in the case of specific exceptions detailed below.

- The regulations apply to patients who are committed involuntarily or mandated to treatment by the criminal justice system.
- The regulations pertain to any data identifying the patient as having a substance use disorder directly or indirectly from the point the patient makes an appointment.
- The regulations are applicable even if the party requesting the information already possesses it from another source, presents a warrant or subpoena, or has other official status.
- Disclosures are permitted if a patient has signed a valid consent form, but such information cannot be used to criminally investigate or prosecute the patient without a special court order.

For addiction clinicians and programs, the strictest rule usually takes precedence (Clark and Brooks 2003). However there are instances in which there may be conflicts between the regulations themselves or state law beyond the scope of this introductory chapter. For this reason it is important for practitioners to have a working knowledge of the local applicable laws and access to good legal counsel and the privacy officer responsible for confidentiality protections at their practice setting.

The relevance of the statutes in terms of the six general key provisions that each regulation affirms—autonomy, respect for persons, confidentiality, truth telling, nonmaleficence, and beneficence—is what is most important for clinicians to understand.

Clinical Considerations

Faced with the tightness of these regulations and the fact that programs found in violation of the provisions can be fined heavily

for breaches, addiction professionals may feel seriously constrained in their ability to obtain the collateral information vital to comprehensive addiction treatment, to arrange mental health treatment, to provide medical care for patients with comorbidities, and to manage any emergencies. Clinical common sense, some basic guidelines for handling confidential information, and an understanding of the available exceptions to disclosure can assist the addiction professional in handling most ethical conundrums. For more difficult cases, appropriate legal consultation should be obtained.

Clinicians ideally will inform substance use disorder clients of confidentiality protections and limitations as soon as they enter treatment and explain the importance of both safeguarding information that could be stigmatizing and obtaining consultations and collateral reports that may improve care. Substance use professionals also must always inform patients about the specific circumstances in which confidentiality protections do not apply. These circumstances—child abuse, infectious diseases, suicide or homicide, and crimes committed against staff, among others—are listed in Table 1.4, General Exceptions to Confidentiality Regulations.

All state laws mandate reporting of certain infectious diseases, such as tuberculosis and sexually transmitted diseases, to public health authorities. Every state has laws that require health care professionals to report suspected child abuse; this exception pertains only to the initial reporting and not to follow-up requests for information, whether in the context of civil or criminal action.

The “duty to warn” is based on an extension of the 1974 *Tarasoff* case in California in which a therapist treating a graduate student failed to warn an identifiable victim whom the student threatened to murder and subsequently killed. Both a duty to warn and to protect emerged from these rulings, which can be discharged through warning a victim, notifying law enforcement, or hospitalizing or otherwise intervening clinically to reduce or

TABLE 1.4

General Exceptions to Confidentiality Regulations

- Patient consent in accordance with the specified form and requirements of the regulations (however, this information may not be used in a criminal investigation or prosecution of a patient without special court order)
- Infectious diseases
- Child abuse
- Suicide and homicide
- Medical emergencies
- Patient information that does not disclose that the patient has a substance use disorder
- Disclosure under special court order
- Staff communications within a program
- Communication with an outside entity that provided support to the program
- Appropriately authorized research, auditing, or evaluation
- Disclosure to a qualified service organization assisting program
- Crimes committed on program premises or against staff members

eliminate the threat (Felthous 1993). Even in states without *Tarasoff*-type legislation, it is understood that there may be a clear professional and moral obligation to warn potential victims of violence if the victim is identifiable, the threat is feasible and imminent, and the warning has a realistic chance of preventing harm. It should be noted that when fulfilling the duty to warn and protect, the clinician should, whenever possible, honor confidentiality safeguards that require that the identity of individuals using substances or in treatment not be disclosed to law enforcement or even the victim.

When in high-risk physical situations (for instance, a patient threatens a staff member or commits a crime on program grounds), the law allows program staff to report the crime to law

enforcement and to disclose the identifying information about the client, including status in a substance use disorder program. This authorization does not extend to admission of past crimes, even those crimes that are unsolved. Information necessary to treat a patient in a medical emergency that immediately threatens the patient's life can and should always be disclosed to medical staff, even when it involves data about a patient's substance use disorder, such as a patient using cocaine who presents to a local hospital with chest pain and no cardiac history. Those disclosing the information must document the circumstances surrounding the disclosure. To facilitate treatment, addiction professionals within a single program may communicate with one another, for instance, when a patient is transferred from an outpatient to a residential setting. Communications are also permitted with data processing or billing agencies that manage patient records on behalf of a substance use disorder program, with the caveat that these entities agree to abide by the regnant confidentiality regulations, including not releasing the information to a third party without consent (Center for Substance Abuse Treatment 1994).

It is a useful standard for all disclosures or requests for information for other collateral or referral sources, such as family members, employers, or other clinicians, to only reveal the type and quantity of information that is necessary to answer the specific query. This rule holds even when communications are made with patient consent, such as when an addiction treatment counselor is seeking or providing reports to a mental health provider who is treating the counselor's alcohol-dependent patient for co-occurring depression. The request should be limited to information directly related to the mood disorder and include a caution to the other party that he or she is bound by the confidentiality restrictions as well. This norm is particularly important when communicating with insurance companies, employers, or criminal justice officials, who have particular interests, which may not always coincide with the concerns and goals of the patient.

Conflicts between Confidentiality and Truth Telling

Providers caring for patients with substance use disorders all too frequently experience a conflict between protecting patient privacy and autonomy and preventing harm to others. The patient who appears intoxicated at the program or health care facility should be provided with an opportunity to sober up or given safe transportation home. The patient who continues to drive while intoxicated despite counseling and warning is best reported to the state motor vehicle department (in those jurisdictions that allow providers to do so) as being impaired without disclosing substance abuse. Law enforcement operating under different legal warrants can then ascertain whether the patient is intoxicated and take proper action (U.S. Department of Health and Human Services 1994). In situations where disclosure is required (against the patient's wishes) and may result in adverse consequences, such as the loss of a driver's license, clinicians should approach the task therapeutically, attempting to minimize damage, maximize authority, and preserve the treatment relationship when possible (Felthous 1993).

Addiction professionals frequently are involved with clients whose treatment is mandatory. This coercive aspect of care can generate conflicts between the professional's duty to honor the autonomy of the patient and to observe the constraints of adjudication, probation, or parole. Confidentiality regulations apply even to mandated clients unless disclosure is an official condition of judicial proceedings. Confidentiality protections still apply to this criminal justice consent, but there are also specialized criteria, and clinicians should obtain expert consultation on handling these cases. It is also prudent to obtain consent for disclosure that will remain in effect throughout the treatment period when criminal justice consent is not applicable. This consent should, where possible, limit disclosures to reporting on adherence and progress in treatment or danger to self or others (Brooks 2005). This approach equally satisfies the law and enables a clinician to

establish an atmosphere of at least circumscribed trust, honesty, and privacy in which to do clinical work (Center for Substance Abuse Treatment 1994).

Even when consents have been obtained, the clinician should remember that he or she is first and foremost a health care professional (not a police officer!). The health professional has a positive duty to bring benefit to the patient as a priority, whereas a police officer must think about community needs and protection as a priority. It is the court's responsibility to identify positive toxicology screens and to take appropriate action; it is the provider's duty to address any substance use therapeutically. Holding the patient appropriately accountable may not only resolve the ethical dilemma but also be therapeutic. Coercion is a quality not of treatment but of criminal justice involvement, and the client has made certain choices related to substance use that in our society result in legal restrictions of the right to confidentiality and self-determination. Operating out of motives of compassion and respect for persons, clinicians can in fact utilize these very constraints for the good of the patient through reporting regular attendance and participation in treatment—conditions to be fulfilled for the patient to regain autonomy and privacy.

Perhaps the most difficult example of the conflict between beneficence toward the patient and truth telling is when the mandated client “uses” his or her limited autonomy to relapse or not adhere with recommended treatment. Yet even here, truth telling from the addiction professional may lead to short-term adverse consequences, such as incarceration, but long-term achievement of treatment goals. For some clients, external consequences, which may be experienced as coercive, may be necessary “drivers” toward motivation for recovery (Bogenschutz 2004).

Pressure from families, employers, or insurance companies is a far more pervasive and subtle form of coercion, but the same patient-centered gyroscope will help an addiction professional navigate these situations (Marlowe et al. 1996). Clinicians should acknowledge to patients and themselves the unfortunate reality

that disclosing a substance use disorder may cause a patient to lose employment or health insurance. Although it is tempting to “doctor the chart” to avoid documenting substance use, the better practice is to objectively and nonjudgmentally record the substance use disorder and its relevant medical or psychosocial implications. The clinician should not embellish with extensive details that could be misused or misinterpreted, but all information necessary or valuable to patient care should be recorded. Although many providers disagree with the lack of parity for substance use treatment and government policy that funds a forensic rather than disease model of addictions, these political beliefs must not compromise accurate record keeping, which is essential for patient safety and the integrity of professional judgment (Dwyer and Shih 1998). More appropriate action on the part of the clinician is working through professional organizations and the political process to change funding mandates, organizational policies, and social attitudes that adversely affect addiction treatment. Clinicians and patients can together decide whether and what type of data to disclose to employers or insurance companies and may decide that the wisest course is to pursue self-help groups or sliding-scale treatment that protects patient privacy and livelihood.

Conclusion

Three of the top five most common reasons individuals did not receive treatment for drug or alcohol use in 2005 have an inherent ethical valence that will require substance abuse clinicians to make difficult ethical decisions, often without clear policy direction or established legal precedent. First, 38 percent of patients were not ready to stop reinforcing the neurobiological alterations of their thinking and willing. Second, 35 percent cited cost or insurance barriers, which challenges clinicians to act personally and politically to advocate on behalf of addiction treatment while respecting the law and professional ethics. Third, 24 percent cited stigma or negative opinions as the major barrier, underscoring the

balancing of risks and benefits inherent in treating persons with substance use disorders (Substance Abuse and Mental Health Services Administration 2006). Despite these formidable challenges, the skill set and body of practical knowledge presented in this book can guide addiction clinicians to identify and resolve the practical moral and legal dilemmas encountered in the daily hard and good work of caring for persons with addictions.

Confidentiality and truth telling carry a special significance in the treatment of substance use disorders because of the stigma associated with addiction and the far more prominent role of the criminal justice system in addiction treatment than in other branches of health care. Federal regulations provide a higher level of protection for health information regarding substance use disorders yet also create ethical dilemmas for addiction professionals who must balance considerations of autonomy and confidentiality toward the patient with those of safeguarding the public, preventing harm, and respecting the law. Practical knowledge of the applicable law, discreet documentation, frequent consultation, and a commitment to a comprehensive view of the patient's good can help providers successfully resolve even the most troubling and complex cases.

Core Concepts

- Substance use disorders as biopsychosocial spiritual conditions require a high standard of ethical knowledge and professional skill among those caring for patients with addictions.
- Substance use disorder patients may have limited internal autonomy due to their addiction and are frequently subject to coercion from external sources, requiring the clinician to ensure that full and authentic informed patient consent is respected.
- Substance use disorders often involve illicit drugs, high-risk behaviors, and criminal conduct intersecting with the legal system, making it imperative that addiction professionals

understand their professional and legal obligations and how these affect the therapeutic alliance.

- Substance use disorders are the object of powerful social stigma, and clinicians need to be aware of their own biases, which could negatively affect the therapeutic relationship.
- Substance use disorders do not have parity in funding compared to other medical conditions, leading to an immense treatment gap and the need for clinicians to act professionally for social justice.
- Substance use disorders are given higher levels of federal confidentiality protection to facilitate treatment and protect against discrimination, and clinicians need to be aware of these more rigorous standards.

Recommended Readings

- Brooks, M. K. 2005. Legal aspects of confidentiality and patient information. In *Substance abuse: A comprehensive textbook*, ed. J. H. Lowinson, P. Ruiz, R. B. Millman, and J. G. Langrod, 1361–82. 4th ed. Philadelphia: Lippincott Williams & Wilkins.
- Roberts, L. W., and A. R. Dyer, eds. 2004. *Concise guide to ethics in mental health care*. Washington, D.C.: American Psychiatric Publishing.

Case Examples	Core Concepts
<p>A psychologist working in a veteran's affairs hospital is asked to evaluate Bob, a fifty-six-year-old with alcohol dependence, for a liver transplant. Bob had been abstinent for five years but recently relapsed when he learned his liver was failing. If the psychologist documents the resumed drinking, it is likely that Bob will be removed from the waiting list.</p>	<p>The optimal approach to disclosure of information in treatment of substance use disorders, even when mandated, is to obtain patient consent.</p>
<p>Rita, who works as a bus driver, seeks treatment for cocaine dependence at a local treatment center. She is a single mother supporting her three children below the age of ten. Her last two urine toxicology screens have been positive despite regular attendance at group and individual counseling, and she requests that the social worker managing her case not report her use.</p>	<p>A useful standard of disclosure is to release only the type and amount of information necessary to answer a specific query.</p>
<p>Nick, a twenty-five-year-old entering mandated treatment for amphetamine dependence and manufacturing, discloses to his addiction counselor that he killed a man several years ago during a fight over drugs. Nick and the court have each signed a consent to disclose. The counselor is unsure of her obligations.</p>	<p>Federal regulations provide a higher level of protection for patient confidentiality in addiction treatment.</p>
<p>Beth, a pediatric nurse, has achieved nearly a year of recovery working closely with an addiction therapist. As the result of severe family stresses, Beth relapses and while intoxicated calls her therapist and says she will drink herself to death. She hangs up on her therapist when he asks her to come in voluntarily. The therapist worries that if he sends the police to bring her into the emergency department for evaluation, Beth will no longer trust him and may discontinue treatment.</p>	<p>Truth telling and confidentiality obligations may conflict with other major ethical duties, such as nonmaleficence, autonomy, and respect for the law.</p>
<p>An addiction psychiatrist is caring for Tyrone, a forty-five-year-old veteran with chronic pain whose pain has been well controlled on opioids. Tyrone has been abstinent from alcohol for five years. A routine "tox screen" shows that Tyrone is positive for marijuana, which according to facility policy will mean the opioids will likely be tapered. Tyrone indicates he is using the marijuana only periodically to help him sleep.</p>	<p>Stigma and legal involvement heighten the importance of confidentiality in addiction treatment.</p>