Confidentiality in Adolescent Addiction Treatment

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Abstract

Confidentiality is an essential component of addiction treatment though achieving it with adolescent addiction treatment can be more complex than adult addiction treatment. Understanding both federal and state laws is crucial for a practitioner to know to better achieve confidentiality. The Health Insurance Portability and Accountability Act (HIPAA), Washington confidentiality laws, and Code of Federal Regulation Title 42: Public health (CFR-42) are the three main laws covered in this paper. There are factors that limit confidentiality that are also discussed such as conflicting duties of the practitioner, the practitioner's agency setting and parental involvement in the adolescent's treatment. A practitioner is well prepared to handle such complexities around confidentiality when they are well informed in the law and discuss the limits to confidentiality at the onset and throughout the therapeutic relationship.

Confidentiality in Adolescent Addiction Treatment

When it comes to addiction treatment, confidentiality is foundational (NAADAC, 2021). Even though minors typically do not have the same rights and access to health care services as adults, confidentiality remains an essential part of their treatment. Because of this, as a practitioner, navigating confidentiality with adolescents in addiction treatment can seem daunting. Federal and state laws on confidentiality are in place to help guide a practitioner, though also to hold them accountable. Thus, understanding how federal and state laws interact is crucial for a practitioner when ensuring confidentiality. Factors that can limit confidentiality and make it a complex task for practitioners include conflicting duties, the practitioner's agency setting and parental involvement in treatment. These limits and complexities can be managed by a practitioner when they are well informed of the law and ethical considerations and make sure to discuss the limits to confidentiality with clients at the onset of and throughout the therapeutic relationship.

Confidentiality

There are many reasons why keeping one's information confidential is important when it comes to addiction treatment. Decades of research has shown both adolescents and adults are more inclined to access treatment if they know their actions to do so will remain private, especially when it comes to the use of substances (Weinstock, 2013). English (2019) states that youth might even seek necessary care in a timelier manner and feel more inclined to provide accurate health information if they believe this information will not be shared with parents or others. They also point out that when adolescents have control of their private matters this

further develops their sense of privacy and autonomy which in turn will make them more confident in engaging with the health care system independently. From a practitioner's perspective, confidentiality is important because it is an essential element to the therapeutic relationship. Arguably the most salient reason for keeping confidentiality of a client is it creates a secure way for individuals to access needed treatment, which promotes the health of them and society.

Federal and Washington State Laws

When it comes to federal and state laws on confidentiality of addiction treatment for adolescents, there are three laws a Washington practitioner should be well informed in, Health Insurance Portability and Accountability Act (HIPAA), Washington confidentiality laws, and Code of Federal Regulation Title 42: Public health (CFR-42). Navigating these laws can often feel overwhelming on where to begin. Logically, one can think of HIPPA as the baseline or a starting point.

The HIPPA privacy rules cover confidentiality of the patient receiving a health care service. When it comes to a patient's confidentiality in health care services, "the HIPAA privacy protections for young adults are the same as for other adults: they are entitled to access their protected health information and to control the disclosure of that information in some circumstances" (English 2019). Typically, under the HIPAA Privacy Rule, parents still have access to the health information of their children. However, when a minor has a right to consent to a health care service *without* parental involvement, the HIPAA Privacy Rule allows minors to exercise rights over their own protected health information. HIPPA defers to state laws for clarification on if the minor can consent to treatment without parental involvement. For a practitioner to know if a minor is able to consent to their own treatment and if they are required,

permitted, or prohibited from disclosing information to a parent, they must look to their state laws (English, 2019).

From there, a practitioner needs to know if a minor can consent to addiction treatment or if they need parental consent. Typically, in Washington state a minor who is under 18 needs parental consent for general health care services though minor consent laws in WA make an exception for *specific* health care services such as chemical dependency treatment. To reiterate, WA law states that a minor can consent to addiction treatment without parental consent. "When a minor is authorized under federal or state law to consent to health care without parental consent only the minor may exercise the rights of a patient under the Washington Health Care Information Act" (English, 2019). Since minors in WA have a privilege to consent to addiction treatment, they typically have the same confidentiality protection as adults when it comes to their health care (English, 2019). Of course, there are always limits to confidentiality which will be discussed in more detail later.

Once a minor is determined they have rights to informed consent to addiction treatment, then the federal law, 42 CFR comes into play that specifically covers addiction treatment services. Since a minor in WA is allowed to consent for addiction treatment under state law, they have independent rights under these federal regulations. This law establishes special confidentiality protections for substance use disorder programs that apply to all federally assisted programs (English, 2019). "The regulations impose strict confidentiality requirements that do not allow disclosure without the consent of the patient except in specific circumstances that pose a substantial threat to the life or physical wellbeing of the patient or another person" (English 2019). If a practitioner is to disclose any information to parents, they will need a minor's written consent (42 C.F.R.§ 2.14).

Limits to Confidentiality

As stated, one of the main factors that limit confidentiality is conflicting duties of the practitioner. All therapists have reporting duties that sometimes can go counter to a patient's welfare (Weinstock, 2013). These duties include mandated reporting of child abuse, duty to warn, and duty to protect. “The Washington definition of reportable abuse includes sexual abuse, sexual exploitation, or injury by any person or negligent treatment by any person responsible for the child” (English, 2019). Mandated reporting can be conflicting for a practitioner because it could compromise the therapeutic relationship and lead to the adolescent leaving treatment. Duty to protect may be less conflicting for a practitioner because when a patient is a danger to others or themselves most clinicians agree that harm to others or themselves would not be in the best interest of the client (Weinstock, 2013). 42 CFR outlines three conditions that must be met before confidentiality can be breached in duty to protect, “1.) the minor's situation poses a substantial threat to the life or physical well-being of the minor or another; 2.) this threat may be reduced by communicating relevant facts to the minor's parents; and 3.) the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to his parents” (42 C.F.R.§2.14). As for Tarasoff like situations, duty to warn requires therapists to make reasonable effort to warn and protect the potential victim from the actions of a patient (Weinstock, 2013). Again, this can be conflicting for practitioners because it affects the therapeutic relationship, though since stopping a patient from doing something dangerous would protect the patient from serious consequences most clinicians do not

have a problem with this ethical and legal obligation. Discussing with the adolescent patient of these duties on the onset of treatment is essential to not betray the client's trust.

Agency Setting

The organization a practitioner works for is another factor that can limit confidentiality when it comes to adolescent addiction treatment. An organization can create role conflicts because the needs of the client and the needs of the organization may contradict. Weinstock (2013) states that the most common time you see this in a school setting. Upon learning of patient's substance use, the practitioner employed at the school is faced with the question, are they more obligated to the student or the school (Weinstock, 2013)? For instance, Weinstock (2013) states some schools have a zero-tolerance rule thus the issue might be whether to dismiss the student in obligation to protect other students from substance use. It's important to note, confidentiality of the adolescent patient can even further be limited at a school because the HIPAA Privacy rule explicitly excludes from its purview health educational records (English, 2019). "Family Educational Rights and Privacy Act (FERPA) defines "education record" in a way that sometimes can include health records created by a health care provider—such as a school nurse—employed by or acting on behalf of a school or university. Thus, health records created by medical professionals employed by a school or university may be part of an "education record" and subject to FERPA rather than HIPAA" (English, 2019). The most important implication of all of this is that each organization has their own explicit limitations to confidentiality because of variations in setting, agency mission and agenda, and set of rules for a practitioner to follow. The only way a practitioner can manage this complex limitation of

confidentiality is by knowing the organizations logistics and being clear with their patient whether things like drug use by the adolescent are confidential (Weinstock, 2013).

Parental involvement

A third factor that can limit confidentiality is parental involvement. “Treatment of adolescents differs from treatment of adults, insofar as involvement of the parents directly in the treatment commonly is an integral part of the treatment” (Weinstock, 2013). Although a minor in WA can consent to their own addiction treatment without parental involvement, that doesn’t mean parents should not be involved at all. In fact, a practitioner should strive for parental involvement in their adolescent patient’s addiction treatment because a considerable amount of research supports it as a significant predictor in treatment outcomes (Uliaszek et al., 2019). Uliaszek et al. (2019) found that less parental involvement in treatment predicted greater attrition rates for the adolescent. An important component of parental involvement in treatment often involves them attending family therapy (Lakin et al., 2004). On top of that, over the last 20 years many child welfare/federally funded programs serving and treating children have shifted to family centered, rather than child centered (Lakin et al., 2004). Thus, a practitioner can almost guarantee a parent will be involved or at least should be involved in their child’s addiction treatment at some point. Of course, confidentiality remains essential to addiction treatment. A practitioner should count on parental involvement at some point in the adolescent’s addiction treatment and be aware that the laws of confidentiality remain even when parental involvement occurs. This can be tricky for a practitioner because parental involvement in treatment can create

dual roles (Weinstock, 2013). Discussing the limits of confidentiality is an ethical obligation at the start of the therapeutic relationship with the adolescent and should again be discussed when parents are involved. A therapist should work out an understanding with the parent and make sure that everybody is clear what will be shared Weinstock, 2013). An agreement about this understood by both the adolescent and the parent at the outset of treatment, generally is the best clinical and ethical way to address such a situation.

Conclusion, Note from Author

I chose each source to highlight the complexities of confidentiality of adolescent addiction treatment. I find understanding the law to be difficult but the more one reviews the law the better a grasp one has over it. The source the Washington-AYAH-Confidentiality-Guide was very useful in navigating adolescents' rights in confidentiality and informed consent in health care settings and I highly recommend it to anyone working with adolescents in addiction treatment. This article broke down relevant federal and state laws and ethical considerations. Another source I used was the book *Clinical Handbook for Adolescent Addiction* as a source which is an extremely helpful guide for addiction treatment counselors working with adolescents. I specifically used the chapter labeled *Confidentiality and Informed Consent Issues in Treatment for Adolescent Substance*. This source was great for analyzing the pros and cons to specific ethical dilemmas around confidentiality. Lastly, I used two research articles to show that parental involvement is an important component to an adolescent addiction treatment. At some point the practitioner should count on the family entering the adolescent's addiction treatment plan. Once the family is involved confidentiality laws remain. What I learned from all of this, is all the factors that limit confidentiality mentioned in this paper, conflicting duties, agency setting, and parental involvement, all can be managed by understanding the laws around

confidentiality for adolescent addiction treatment and discussing the limits to confidentiality at the onset and throughout the therapeutic relationship with the adolescent patient.

References:

Electronic Code of Federal Regulations. Electronic Code of Federal Regulations (eCFR). (n.d.). https://www.ecfr.gov/cgi-bin/text-idx?SID=2af5605ec8425bc7d69e974c0087b473&mc=true&node=pt42.1.2&rgn=div5.

English, A. (2019, March). *Adolescent & Young Adult Health Care in Washington*. The National Adolescent & Young Adult Health Information Center. https://nahic.ucsf.edu/wp-content/uploads/2019/01/Washington-AYAH-Confidentiality-Guide_FInal.pdf.

Lakin, B. L., Brambila, A. D., & Sigda, K. B. (2004). Parental Involvement as a Factor in the Readmission to a Residential Treatment Center. *Residential Treatment For Children & Youth, 22*(2), 37–52. https://doi.org/10.1300/j007v22n02_03

National Association for Alcoholism and Drug Abuse Counselors. (2021). Code of Ethics. https://www.naadac.org/code-of-ethics.

Uliaszek, A. A., Al-Dajani, N., & Mills, L. (2019). Predictors of Attrition From Residential Treatment for Youths With Addictive Behaviors. *Journal of Child & Adolescent Substance Abuse, 28*(1), 1–7. https://doi.org/10.1080/1067828x.2018.1561574

Weinstock, R. (2013). Ethical Considerations in Adolescent Addiction. In *Clinical handbook of adolescent addiction* (pp. 54–58). essay, John Wiley & Sons.