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Citation: Published in revised form in White, W., Popovits, R. & Donahue, E. (2007) Ethical, legal and policy issues in the treatment of co-occurring substance use and psychiatric disorders among adolescents. In Y. Kaminer & O. Bukstein (Eds.) *Adolescent Substance Abuse: Dual Diagnosis & High Risk Behaviors*. New York: Haworth Press, pp. 473-492. Posted at www.williamwhitepapers.com

Ethical, Legal and Policy Issues in the Treatment of Co-occurring Substance Use and Psychiatric Disorders among Adolescents

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Introduction

Complex ethical and legal issues arise in the treatment of co-occurring substance use and psychiatric disorders among adolescents. This chapter charts that ethical and legal terrain, outlines general and specific response procedures and concludes with a discussion of some of the broader policy issues raised by the co-occurrence of substance use and psychiatric disorders among adolescents. The ethical and legal issues discussed here will focus primarily upon those related to consent procedures, parental involvement in treatment, threats to the safety of the adolescent or the community, and service relationship boundaries.

Many of the most difficult situations that arise in the context of adolescent treatment contain a combination of complex clinical, ethical, legal and administrative issues. Working through such complexity and the potential for one dimension to obscure other dimensions can be aided by the use of one or more ethical decision-

making models (Wagner, 2001). In our earlier work (White & Popovits, 2001), the authors proposed a three-step model to help identify the existence and potential severity of ethical/legal conflicts and to generate response alternatives. The first step in that model involves analysis of a situation to determine the potential and degree (minimal, moderate, significant) of benefit and harm that could accrue to the adolescent, his or her family, the service delivery staff, the service institution, the professional field and the larger community. The second step identifies any universal or culturally relevant values that apply to the situation and explores the actions that would flow out of the application of those particular values. (See Table 1)

Table 1 Universal Values Imbedded within Professional Codes of Ethics

Autonomy (Freedom over one's destiny)
Obedience (Obey legal and ethically permissible directives)

Conscientious Refusal (Disobey illegal or unethical directives)
Beneficence (Do good; help others)
Gratitude (Pass good along to others)
Competence (Be knowledgeable and skilled)
Justice (Be fair; distribute by merit)
Stewardship (Use resources wisely)
Honesty and Candor (Tell the truth)
Fidelity (Keep your promises)
Loyalty (Don't abandon)
Diligence (Work hard)
Discretion (Respect confidence and privacy)
Self-improvement (Be the best that you can be)
Nonmaleficence (Don't hurt anyone)
Restitution (Make amends to persons injured)
Self-interest (Protect yourself)

Source: White & Popovits, 2001.

The addition of culturally relevant values suggests that actions that could be beneficial within the dominant cultural context might do harm or injury when misapplied to another context, e.g., relationship engagement/disengagement rituals, nuances of verbal intimacy or physical touch, or gift giving and receiving. The third step identifies existing ethical codes, laws, regulations, organizational policies or historical practices that apply to the situation in question. Models of ethical decision-making can provide great assistance, particularly when used within the more general prescriptions to 1) seek consultation, 2) increase documentation and 3) debrief each incident for its organizational policy and clinical practice implications.

As long-tenured ethical and legal consultants to behavioral health organizations, we have found that ethical and legal issues involved in the treatment of adolescents are less well marked, more frequent and more complex than those encountered in the treatment of adults, and that ethical and legal issues arising in the treatment of adolescents with co-occurring disorders are among the most difficult. The latter is related to more difficult determinations of competence (both

developmentally and in terms of mental status), the involvement of multiple systems of care/supervision with frequently conflicting policies, potentially greater threats to self and public safety and the need for more nuanced and prolonged management of service relationship boundaries. In the discussions below, we will try to illuminate some of the poorly lit ethical and legal pitfalls within this territory.

Consent to Treat and Informed Consent

The most common legal question raised about treating adolescents pertains to the issue of consent. So many clinicians are perplexed by the multiple legal meanings and applications of consent which are further exacerbated by the complex rules relating to a minor's legal right, ability and capacity to execute consents. "Consent" means the voluntary agreement by a person who possesses and exercises sufficient mental capacity to make an intelligent choice to do something proposed by another. Consent implies that this agreement is unclouded by fraud, duress or mistake.

The legal concept of consent requires a provider to obtain a patient's permission prior to treating. Without it, physical touching has been ruled by courts to constitute battery. This is why virtually all treatment centers have patients execute "Consents to Treatment". A Consent to Treatment form typically describes the "informed consent process" and the voluntary nature of the treatment program, references client rights and confidentiality, addresses cooperation in treatment, expressly authorizes specific treatment services, including a number of psychiatric and medical services, discusses withdrawal of consent, and may include specific consent provisions relating to photographs, transportation, personal property and financial responsibility.

As mentioned above, informed consent is one element embodied within the consent to treatment. "Informed Consent" is a fundamental principle grounded in both the law and ethics. Patients should be provided sufficient information to enable them to make

an informed choice regarding a proposed course of treatment by balancing the probable risks against the probable benefits. This principle of informed consent requires disclosure of: the nature and purpose of the procedure/treatment, the risks and consequences, the alternatives and the risks of no treatment (Popovits, 2004).

Those issues related to a minor's ability to provide consent to treatment are determined by state law. For example, under Illinois law (410 ILCS 210/4), a minor 12 years of age or older who is determined to be an addict, alcoholic or intoxicated person under the Alcoholism and Other Drug Abuse and Dependency Act, or who may have a family member who is a substance abuser, may consent to receiving medical care or counseling related to the diagnosis or treatment of the disease. The consent of the parent or legal guardian of a minor is not necessary to authorize medical care or counseling related to the diagnosis or treatment of substance abuse or the effects on the minor of substance abuse by a member of the minor's family. The minor's consent is valid and binding as if the minor had achieved his or her majority and the minor's consent is not voidable or subject to later disaffirmance because of his or her age. Other states however, may only permit a minor to enter treatment with a written consent signed by the parents. Even in the those states that permit minors to consent on their own to treatment, because of liability concerns the facility will often have both the minor and the parent sign the consent for treatment. These legal requirements vary among states so be sure to check your applicable state laws. Requiring dual signatures of the minor and the parents for consents, including waivers for recreation activities, field trips, sports participation or use of exercise equipment is also common. Generally, such consents outline the specific activity the patient will be engaged in (using the gym), any inherent risks in that activity (such as an injury), and a release of the provider from liability for engaging in that activity. For adolescents, a provider will usually request that both the adolescent and the parents sign the waiver. Guardians or

authorized agents may also sign the consent. It is also a good idea for the provider to have a witness sign a consent that includes any waiver provisions. It is important to understand that "waivers" are not bulletproof vests shielding the provider from lawsuits or liability. Although in our experience, it often deters the patient or family from bringing claims. In those cases where the Consent to Treatment may also include provisions granting special permission for other medical care, dental care, photographing or videotaping of the minor for staff education, training and supervision purposes, the authors recommend signing by the parent or guardian. In these cases, the minor's signature generally would not be legally required but it is recommended so the minor is aware of his or her rights and responsibilities relating to those issues identified.

Consent for Disclosure

A "consent for disclosure" is yet another type of consent which has separate and distinct legal meaning. Federal confidentiality statutes and regulations, as well as the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Standards, govern written consents for disclosure. These "written consents" authorize the provider to disclose information about the patient that would otherwise not be legally permissible. To satisfy the requirements under the HIPAA Privacy Standards, many treatment facilities are now referring to consents for disclosure as "authorizations". A facility may also call these legal documents "releases". What is important is not the title or name on the document but the elements included (Popovits, 2005).

42 C.F.R Part 2.31 specifies the required elements for a valid written consent and 45 C.F.R. Part 164.508 sets forth the authorization requirements mandated by the HIPAA Privacy Standards. The authorization must be written in plain language and may contain additional elements as long as they

do not contradict the required elements of both 42 C.F.R. Part 2 and the HIPAA Privacy Standards. An authorization may be combined with another authorization to create a compound authorization, except that authorizations for use or disclosure of psychotherapy notes may be combined only with another authorization for psychotherapy notes. An authorization cannot be combined with any other type of written permission for the same research study. A multi-party authorization is permissible if the information to be disclosed and the purpose for the disclosure are the same for all parties. However, if the client revokes the authorization for one party, the entire authorization is revoked (Popovits, 2005).

In determining whose written consent is required for the disclosure of information when the client is a minor, the federal confidentiality regulations (42 C.F.R. 2.14) defer to state law. The federal confidentiality regulations provide that parental or guardian consent for disclosure (for purposes herein, this includes consent by any other person legally responsible for the minor) is required only if the applicable state law requires parental or guardian consent before providing substance abuse treatment to a minor. A "minor" is defined as a person who has not attained the age of majority specified under applicable state law. If there is not specified an age of majority under applicable state law, then 18 years will be the requisite age. It is also important to note that if the state allows minors this right, it generally applies to minors between twelve to eighteen years of age. For children under twelve, parents would typically sign in their stead because the child would be deemed incapable of offering consent under the law.

Thus, if a minor client acting alone has the legal capacity under state law to apply for and receive substance abuse treatment, written consent for disclosure may be given by the minor only; parental or guardian consent will not be required under the federal confidentiality rules. This restriction includes the disclosure of privileged client information to the parent or guardian of the minor client for the purpose of obtaining financial reimbursement. However, the federal

regulations do not prohibit a program from refusing to provide treatment until the minor consents to the disclosure necessary to obtain reimbursement. Programs must be careful about the refusal to provide treatment based upon their State Substance Abuse Agency contracts or other applicable funding source agreements. Alternatively, if the state law requires the consent of the parent or guardian for a minor to obtain substance abuse treatment, written consent for disclosure must be given by both the minor and his or her parent or guardian.

The federal regulations also provide an exception if a minor has applied for services and refuses to consent to parental notification. The program may contact the parent without the minor's consent only if the program director: believes that the minor, because of extreme youth or medical condition, does not have the capacity to decide rationally whether to consent to parental notification; and the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or someone else.

Special Consents Issues Concerning Adolescents

Additional issues arise when adolescents are receiving substance abuse treatment and are wards of a state child welfare agency or are currently part of the criminal justice system. Criminal justice consents differ from other consents in that 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, provided that the patient has signed a written consent meeting the general requirements of the regulations. There are three items that are different about criminal justice consents: (1) the duration is typically tied to the proceeding; (2) these consents are NOT revocable; and (3) the persons receiving the information can redisclose the information in connection with their official duties. When an adolescent is a ward of a child welfare agency, the child welfare agency acts in the role of a guardian,

and must be informed of, and give consent to, any treatment or research projects in which the adolescent may participate.

Consent for Research Purposes

The principles of effective consent discussed above also apply to an informed consent given for research purposes. However, the unique issues and possible intrusions that may occur when involving human subjects require additional safeguards to ensure that those subjects are fully informed of the risks involved in consenting to be a part of a research project. At its most basic, informed consent recognizes the right of all persons to be treated with respect, and to treat all persons in an ethical manner that protects them, to the greatest extent possible, from harm. However, the need for protection increases depending on the level of autonomy of the subject. Persons who are completely autonomous (able to deliberate about personal goals and act on such deliberation) need less protection from the point of view that their reasoned opinions and choices should be given weight, and these persons should be given the freedom to act on their considered judgments unless there are other compelling reasons not to do so. On the other hand, some persons who have decreased autonomy require more extensive protection. Prisoners, for example, may be coerced or unduly influenced into entering research projects that may be detrimental to them. Children in general are perceived as possessing diminished capacity to understand and knowingly balance the risks that research may present. The federal regulations governing the protection of human subjects (45 CFR Part 46) detail specific requirements of research informed consents. (See also Scott & White, 2005).

Dual Disorder Clients

Obtaining an informed consent can be especially difficult when dealing with patients who have a dual diagnosis of both mental illness and substance abuse. The difficulty is in determining whether the

consent is truly informed if they are mentally impaired. Often, if mental impairment is due to substance use alone, consent can be obtained and then revisited when the patient is no longer under the immediate influence of an illegal substance. However, in a dual diagnosis patient the underlying mental illness may be present even after the substance use has ended, or the mental illness has been exacerbated by the use of illegal substances. Such issues may call into question the legal capacity to execute a valid consent. In these cases, the provider should first determine whether the substance abuse or the mental illness is the “primary” disorder. To make a proper identification, a thorough psychiatric and drug history must be taken. If a determination is made that the primary disorder is psychiatric, then the client must be stabilized before substance abuse treatment should be attempted. Once the mental illness has been addressed, the client is more likely to be able to provide an informed consent to enter into treatment. (See also White & Popovits, 2001).

Parental Involvement

A growing number of adolescent programs that we consult with are insisting on parental involvement in treatment as a precondition for admission of an adolescent. They view such involvement as crucial to the transfer of learning from the institutional environment to the child’s natural environment and crucial to the achievement of long-term recovery. Even where family environments are not conducive to recovery and the treatment goal is the physical and emotional emancipation of the adolescent from the family, communications between the treatment staff and the family are often needed to achieve this goal. Parental involvement is becoming the norm as more treatment programs develop family-oriented treatment philosophies and utilize particular family therapy approaches.

Protection of Child and Community

Our laws, from their Anglo-Saxon beginnings to their present incarnation, are

based on the notion of protection. Governments enact laws on the basis that they have an obligation to protect all citizens and, in particular, children and adolescents, from harm. This concept assumes that governments, acting on behalf of their citizens, know what is best for them and therefore enact laws to protect them. Most of these laws are enacted on a state level, and therefore the kinds of laws and extent of protection vary from state to state.

Added to this is the notion that a parent, like the state, knows what is best for their children and should therefore be allowed to make decisions for their children's best interests, including decisions concerning their health. However, in juxtaposition to the role of parent, and state, as the protector of children is the position that children, especially adolescents, should be allowed to make their own decisions regarding their lives, including decisions concerning their health. These two positions are often at odds with one another and lead to the current patchwork of state laws that provide a varying degree of rights to adolescents concerning their own health issues.

Lastly, the state also has a heightened interest in the protection of adolescents from other adolescents who, in the eyes of the state, may pose risks to the majority of the population, whether through drug use, sexually transmitted diseases, gang activity, or other socially unacceptable activities. The problem however is that the state, in enacting laws that "protect" others from a perceived threat, often infringe on the rights of the adolescents who are perceived as a threat. In this context, consent and reporting requirements attempt to strike a balance between protection and the ability to make one's own choices, while maintaining confidentiality and lessening the stigma for those who are receiving substance abuse treatment. In the following section we discuss unique problems that may arise when dealing with adolescents in a treatment setting that require actions by providers that, while protecting adolescent patients, may conflict with the goals of confidentiality.

Child Abuse Reporting

Reports of incidents of suspected child abuse or neglect made to the appropriate state or local authorities as required by state law are permissible under the federal confidentiality regulations. No patient consent, court order, or other authorization is needed. However, the restrictions on disclosure continue to apply to the original alcohol or drug abuse patient records maintained by the program, including their disclosure and use for civil or criminal proceedings that may arise out of the report of suspected child abuse and neglect. Note that this exception does not apply to the reporting of other types of suspected abuse or neglect, such as elder abuse or domestic violence (White & Popovits, 2001).

Responding to Self-injury and Threats to Injure Others

A patient who has been using illegal substances often does so to numb or mask some kind of emotional pain or injury. When the coping mechanism of substance use is gone, these feelings can become overwhelming, and a newly sober patient needs to develop skills to deal with these feelings. Sometimes, these feelings can overwhelm a patient, leading to a threat or attempt to injure oneself or another. Add to this the often intense and shifting emotional states that typical adolescents manifest, and a potentially volatile situation can unfold. Ideally, staff can verbally deescalate the situation and help the patient achieve control. However, sometimes the use of restraint or seclusion is necessary for the patient's safety or for the safety of others.

Special Problems Related to Isolation and Restraint

While balancing the need to prevent injuries to patients while using restraint and seclusion, there is also a need to protect patients from harming themselves or others. Adolescent substance abuse treatment patients are considered especially

vulnerable, and those that provide treatment services are therefore subject to additional scrutiny, no more so than in the area of restraint and seclusion. The Centers for Medicare and Medicaid Services (“CMS”) are in the process of enacting rules concerning the use of restraint and seclusion in Psychiatric Residential Treatment Facilities (“PRTF’s”) that provide inpatient psychiatric services for individuals under 21. If your facility receives Medicaid funding, you need to determine if your state classifies your facility as a PRTF, thus triggering applicability of a number of federal requirements discussed below.

Due to the potential for serious psychological or physical injury that may result from the use of restraint or seclusion, CMS has established additional safeguards for providers who treat patients under 21 years of age. The proposed regulations establish Conditions of Participation (“COP’s”) that must be adhered to when using restraint and seclusion. The COP’s cover the following areas: resident protections; orders for the use of restraint and seclusion; consultation with a treatment team physician; monitoring of residents in and or immediately following restraint or seclusion; requirements for notifying parents or legal guardians; application of time out; post-intervention debriefing; medical treatment for injuries resulting from an emergency safety intervention; facility reporting requirements; and facility responsibility in educating and training its staff. States have also begun conducting unannounced surveys of covered providers to ensure compliance.

Consent for Medical Treatment during Addiction Treatment

While the focus of many consents is the need for substance abuse treatment, patients often, due to their substance abuse, neglect their health or exacerbate existing health problems. Therefore, while the patient may need substance abuse treatment, it is possible that they will also need medical treatment for a variety of ailments. Many state licensure regulations require a physical

examination upon intake, as well as TB tests. Depending on the results of the exam and the patient history, additional tests or x-rays may also be needed. The patient may also need dental care or eye care. From a medical perspective, a thorough examination is necessary to properly document the patient’s health. However, in order to successfully treat a patient who is recovering from substance abuse, the patient needs to be made whole both physically and mentally. If the program treats only the substance abuse issue, without addressing other health issues, the probability of a relapse or unsuccessful treatment episode is increased because the patient is physically less able to continue their sobriety.

Medical treatment issues are even more complex when they involve adolescent patients. States differ on when, and what kind, of medical treatment they should allow a minor to consent to without the involvement of a parent. Some states allow minors to authorize any type of medical care, including contraception. Many states allow minors to consent to only general medical treatment without parental consent. Other states only allow “mature” minors to make healthcare decisions. A mature minor has been determined to be sufficiently mature to make their own healthcare decisions without parental involvement. However, what constitutes a mature minor is left to individual determination by a judge. Still other states only allow “emancipated” minors to make healthcare decisions. An emancipated minor, unlike a “mature” minor, is usually defined by state statute. Generally, the youth must be at least 16, live apart from their parents, and be economically self-sufficient.

However, despite laws that allow minors to make medical decisions, parents or guardians will likely wish to be informed of any medical treatment their child may receive. Programs try to avoid this dilemma by requiring parent or guardian consent to any necessary medical treatment upon intake of the adolescent patient. However, programs may be faced with the scenario where a client requests treatment without the consent or notification of their parents or

guardians. Programs need to weigh the best interests of the patient, as well as complying with state law. Lastly, in some cases the federal confidentiality regulations also allow the program to notify a parent or guardian if the program director believes that, because of extreme youth or medical condition, the adolescent does not have the capacity to decide rationally whether to consent to parental notification, and the disclosure is necessary to cope with a substantial threat to the life or wellbeing of the minor or someone else.

Sexual Activity between Clients in Treatment

Any provider of adolescent treatment recognizes that hormones are raging in this population. Sexual experimentation occurs among adolescents in general and when confined to a residential setting where the youth may be less than enthusiastic about participation, the temptation to engage in sexual activity exponentially increases.

Obviously, sexual activity between clients in a program raises numerous legal and ethical concerns for the program as well as the patients. First and foremost, a program has a responsibility to protect patients while they are residents of the program. It can be argued that not prohibiting sexual activity between clients is harmful to them due to their vulnerability and immaturity, regardless of whether there was mutual consent. Also, it can be physically harmful to patients because of the spread of HIV and other sexually transmitted diseases as well as other health concerns such as hepatitis or pregnancy. Legally, while there are technically no prohibitions against minors having sex, depending on the minor's age they may be charged with statutory rape, regardless of the consent of either party.

Ethically, patients in substance abuse treatment are emotionally vulnerable and are trying to cope with a variety of emotions. Adolescents in such a state can be presumed to be unprepared to make a reasoned decision regarding their sexuality. Additionally, if the patient also has a dual diagnosis, their mental health issues could

result in poor judgment or impulse control, leading to irresponsible sexual encounters. Furthermore, the goal of treatment is to teach the patient how to deal with the pressures of life and their own personal problems without resorting to the use of illegal substances. Arguably, impulsive sexual encounters are another way to avoid feelings or mask issues without the use of an illegal substance, and may reflect a breakdown in the recovery process.

Health Issues

All states have statutes regarding public safety and mandatory reporting of communicable diseases to public health officials. Most states also have laws that explicitly allow adolescents to consent to treatment for sexually transmitted diseases, and to contraceptive services. However, state laws vary widely on the level of consent, the age of consent, and to which services a minor may be allowed to consent.

At the federal level, Title X of the Public Health Services Act, passed in 1970, provides that all clinics that receive federal funding must provide confidential sexual health services to all clients, regardless of age. However, numerous efforts have been made to limit this mandate to include parental involvement. Many adults advocate laws that conclude parental involvement, whether through notification or consent, on the basis that government policies that give minors the right to consent to sexual health services without parental involvement undermine parental authority and condone sexual activity. Without such access, adolescents may avoid obtaining contraceptives or sexually transmitted disease treatment because they do not want to involve their parents. (Maradiegue, 2003).

Facilities need to be cognizant of peer pressure among adolescents for gang activities, cult or other ceremonial activities, and acts of self-mutilation that are becoming more commonplace among our youth. We have learned of adolescents engaging in devil worshipping ceremonies exchanging blood, only to learn that one of the youths, who had hepatitis, freely shared his fluids but

failed to share his hepatitis status with his peers. Transmission of communicable diseases does not just occur by sexual activity. Make sure to keep razors and shaving equipment locked up and inventoried. Be mindful of silverware leaving your dining halls. Check belongings upon returns from passes.

Runaways

Adolescents who run away from treatment pose serious ethical and legal issues for programs. Programs may use temporary restraint to deter a patient from leaving the program (see the discussion of restraint and seclusion above), but patients often find a way to leave the program without being detected, or while on an outing or otherwise while off the program premises. Staff members will need to determine when and how to contact law enforcement and other individuals (parents, guardians, child welfare caseworkers, or probation officers) when an adolescent patient leaves the program. The program should also have a valid consent in place authorizing them to contact the parent or guardian. Additionally, the program will need to decide whether, if the patient is found or returns to the program, the program will allow the patient to return to treatment. The program will need to weigh the circumstances surrounding the incident, the patient's need for treatment, the patient's chances of successfully complying with their treatment goals, and the disruption to other patients. Many safety committees within facilities also view runaway/AMA trends as a key quality improvement indicator to monitor. Strategies to reduce runaways have included increased monitoring and motivation enhancement, staff training in de-escalation issues, locked doors and the use of security cameras.

Smoking Policies in Inpatient/Residential Treatment

While treatment programs have long focused on alcohol and other substance abuse issues, tobacco use has become a

more recent focus of treatment efforts. Tobacco use has long been viewed as an acceptable crutch for recovering addicts. However, with increased awareness of the negative health effects of smoking, treatment providers have begun to counsel patients on these negative effects and the addictive nature of smoking. For adolescents, this issue is even more pertinent because many studies show that if adolescents can be persuaded to not use cigarettes by the time they reach the age of 18, they are much less likely to take up smoking as adults. Additionally, use of nicotine by anyone under the age of 18 is illegal in all 50 states.

Federal attempts to limit adolescents' access to cigarettes gained significant momentum in 1992 with the passage of the Synar Amendment. This Amendment made substance abuse funding from the Substance Abuse and Mental Health Services Administration ("SAMHSA") contingent on states enacting and enforcing laws prohibiting the sale of tobacco to minors. However, state enforcement continues to be uneven, and federal support has been unsuccessful because of limited authority to implement sanctions and limited funding to support states efforts to curb cigarette sales to minors (Brainard, 2003).

Ethically, providers are obligated to help adolescents avoid or stop using nicotine. While focusing on other drug dependence issues is important, the cessation of nicotine use is no less important for the overall health of adolescents. Many providers are faced with a dilemma, however, when many of their staff smoke in the building or on the grounds. In response, some providers have declared their buildings smoke-free in an effort to eliminate conflicting messages and to promote abstinence (Patten, Order-Connors & Sussman, 2004).

Discharging Adolescents to the Correct Party

Providers are required to provide for the safety of their adolescents clients while they are in treatment. This requirement extends to their discharge. Providers must

ensure that clients leave the program in the company of a parent or guardian that has legal custody of the client. This can become an issue where, for instance, the parents are divorced and it is unclear who has custody of the child, or if the parents are absent and another family member or friend comes to pick up the child. It should be clarified at intake which persons are legally authorized to pick up the adolescent at discharge. However, in instances where the authorized parent or guardian is not available, if that person cannot be contacted, it may be necessary for the program to retain custody of the child until an appropriate party is identified who can take custody of the child. If the child is released to someone who, it is later learned, did not have legal custody to take the child at discharge, the program could be held liable for any negative outcome that may result from that discharge. Alternatively, if upon discharge the parent or guardian who arrives to take custody of the child appears impaired or otherwise unable to safely take the adolescent, the program may again have to retain custody of the child, or find a suitable temporary placement until other arrangements can be made.

Relationship Boundaries

At their most primary level, professional codes of ethics seek to prevent harm and injury that can occur in the name of help. Such codes implicitly affirm the potential for harm within professional interventions and explicitly assert that the potential for such harm must be actively managed. A focal point of that management is the relationship between service provider and service recipient. Two related concepts, *boundary* and *dual relationship*, are central to this management process.

Boundary is the demarcation of roles within the professional helping relationship. The ongoing management of this boundary governs the pace and degree of intimacy in the service relationship. Dual relationships occur when a service provider occupies more than one role relationship with a client and his or her family and, as a result, blurs

this boundary. Because multiple role relationships compromise the service provider's objectivity and often threaten the client's/family's comfort and safety, professional certification/licensure bodies either prohibit or discourage entering into or continuing a counseling relationship when a non-clinical relationship also exists.

Relationship boundary problems frequently arise in the treatment of adolescents with co-occurring disorders. These problems flow from the clinical characteristics of clients (e.g., histories of traumatic victimization, chaotic relationships, emotional volatility), the duration of the service relationship (often more prolonged) and the nature of the service relationship (often quite intense). The personal and professional histories of service providers (e.g., persons in various stages of personal/family recovery from substance use or psychiatric disorders) can also heighten the potential for problems of transference and countertransference.

A continuum of intimacy exists within service relationships: 1) a zone of safety for clinician and client (actions that are always okay), 2) a zone of vulnerability resulting from increased attachment or sudden disengagement (actions that are sometimes okay and sometimes not okay), and 3) a zone of abuse resulting from harmful intimacy or precipitous detachment (actions that are never okay) (Milgrom, 1992). The boundaries between these zones are not always clear, can vary from client to client, and can also vary with the same client at different stages in the service relationship.

Some of the most common boundary problems that arise in behavioral health treatment include a lack of clarity about when an individual's status as a client begins and ends (if ever); social encounters with clients; preexisting relationships with clients or their families; dual service relationships (e.g., serving as a client's counselor and A.A. sponsor, simultaneously seeing a client/family at an agency and in private practice); gift giving and receiving; and the emotional, social, financial or sexual exploitation of clients. In reviewing complaints of ethical breaches filed with

state licensing boards for addiction counselors, sexual exploitation is the most frequent cause of such complaints (St. Germaine, 1996).

Boundary violations, whether in the form of sexual exploitation or clinical abandonment, often constitute the end stage of the intensification or weakening of the service relationship rather than an event without history or context. As such, there are progressive warning signs of such drift that can be self-monitored or monitored in clinical supervision. Warning signs of enmeshment include preoccupation with a client, paternalistic ownership of a client, increased frequency and durations of sessions with a client, deprofessionalization of contact setting, heightened self-disclosure, sexualization of session content, heightened dependence of client on therapist, reluctance in bringing the case to supervision, resistance to terminate or refer, and courtship behavior (dressing up, frequent calls/cards, gifts, verbal intimacy, escalation of touch). Signs of failure to engage or disengagement include tardiness or refusal in returning calls to a client, lowered frequency and duration of sessions, hostile countertransference resulting in administrative discharge, precipitous termination following exhaustion of benefits, objectification of client (focus on diagnosis/disease rather than the person), complaints of therapist disinterest (e.g. daydreaming or dozing in sessions) and medicating rather than listening to the client (White, 1995).

We have found several strategies helpful in minimizing relationship boundary problems in the treatment of adolescent behavioral health disorders. The foundational strategy is the development of an organizational code of professional practice that explicitly defines the service relationship standards to which all organizational members will be held accountable. These codes define "client" (who is encompassed in that term, when that status begins and ends), establish policies governing dual relationships and outline the problem solving process staff are expected to use when relationship boundary questions

arise. Other helpful strategies include orientation to the code of professional practice for all new employees and volunteers, refresher training on relationship boundary management for all staff, rigorous clinical supervision (that includes the identification and active management of transference and countertransference), the use of a corporate compliance officer to investigate allegations of inappropriate professional conduct and access to an outside consultant to process decision-making on difficult ethical/legal issues. A central theme within all training and supervision is the nature of the fiduciary relationship that exists between the behavioral health service provider and the behavioral health service recipient and the demands that this fiduciary responsibility dictate in establishing and maintaining appropriate boundaries within the service relationship.

The authors have experimented with a variety of training formats on boundary issues and have found two that work very well. The first is a critical incident (events that posed a threat of injury to clients, service staff, the service organization, the professional field and the community) approach in which staff members work in small groups to respond to an ethical dilemma presented in the form of a case study. Groups are asked to identify the ethical issues in the situation (who can be harmed and to what degree), identify ethical principles that apply, identify legal standards and professional or organizational standards that would apply to the situation and decide how they would respond to the situation. We have found this format very effective in heightening ethical sensitivities and sharpening ethical decision-making abilities.

A second format is the use of worksheets that explore the appropriateness or inappropriateness of very specific behaviors. Using a format developed by Milgrom (1992), we provide a list of verbal communications (e.g., "You are a beautiful person." "I really care about you." "You are very special to me."), a list of physical contacts (e.g., patting a client on the back, reaching over and patting a client's knee,

holding a client's hand, touching a client's face), or a list of boundary decisions (e.g., giving your home or cell phone number to a client, giving a client a gift, accepting a gift from a client) and then ask staff individually or in small groups to decide whether each action is always okay, sometimes okay or never okay for their service role and service relationships. When "sometimes okay" is chosen, staff must further define under what circumstances the action would be okay and when it would not be okay. We have found this format the most successful vehicle for exploring the subtleties of relationship boundary management in the treatment of adolescents with complex behavioral health disorders.

There are several frontier issues in the service relationship arena in which the ethical and legal responsibilities have not yet been well defined. These include 1) the application or misapplication of professional codes of ethics to peer-based recovery support specialists (paid and volunteer), 2) the degree of responsibility in milieu-oriented programs to manage the relationship boundaries between adolescent clients (e.g., preventing exploitation of one client by another), and 3) ethical issues that arise in the relationships between clients and research staff who are conducting long-term follow-up studies of treated adolescents (White, 2004; Scott & White, 2004).

Policy Issues

This text has provided an in-depth overview of the diverse patterns in which substance use disorders and other psychiatric disorders interact to create unique challenges to youth, their families, their communities and the state and national infrastructures that have been established to respond to these problems. The policy issues raised by these discussions are substantial. It is quite clear that adolescent clients and families with multiple problems (many of which have complex intergenerational histories) are becoming the norm in caseloads across health and social service systems, and that these categorically segregated service systems are ill-prepared

to respond to the wide range of intense needs experienced by these young people and their families. Studies of specific youth problems (e.g., substance use, depression, suicide, truancy/dropout, criminality and violence, homelessness, HIV/AIDS) consistently note the synergistic interaction of numerous problems and the repeated recycling of these adolescents and their families through multiple silos of specialized care that do little to stem the trajectory of relapse and problem intensification. If there is a vision that emerges from these chapters it is of an integrated system of care based on a comprehensive, strengths-based assessment; the delivery of evidence-based treatments delivered by a multidisciplinary (and often multi-agency team); and sustained post-treatment monitoring, support and, when needed, early re-intervention. Fulfilling that vision will require a comprehensive national youth policy, an integration if not consolidation of youth and family serving agencies, the development of integrated funding streams and a shift from acute models of problem stabilization to models of sustained recovery management aimed at the achievement of global health for the adolescent and his or her family. Such a shift will address both the issue of access to services for co-occurring disorders (particularly in rural and historically disempowered communities) and the quality of those services. Many frontline clinicians continue to dream of a system that can facilitate the long-term recovery of adolescents with co-occurring disorders and that is also potent enough to break intergenerational cycles of problem transmission within families and communities.

A national youth policy and integrated systems of care that bring together formal youth serving agencies (e.g., health and human service, criminal justice, child protection) and also integrate indigenous sources of community support (e.g., recovery mutual aid societies, advocacy organizations, churches) will challenge the historical isolation of those with co-occurring disorders. A major challenge will be how to reconcile confidentiality and privacy laws

and regulations whose effect have been to isolate those with psychiatric and substance use disorders from the effects of stigma with new clinical philosophies that focus on enmeshing individuals and their families in a natural web of community support. As we move toward the latter, a major obstacle may be the very laws and regulations we have implemented with the noblest of intentions. This shift will also require an examination of the legal and ethical guidelines that govern our relationships with other professionals and organizations.

These chapters reveal the emergence of treatment protocol based on the best scientific studies. A significant research agenda continues in the area of co-occurring disorders in adolescents, but the need to transfer what is currently known about these disorders and their treatment from the standpoint of science is now upon us. A major policy issue is how this new emerging knowledge can move from research centers to frontline clinicians across the country. That transfer of clinical technology will require infusion of this new information into manual-guided clinical protocol, the integration of these training manuals within education and training institutions, the certification of youth workers in these evidence-based practices and the development of supervisory mechanisms for monitoring clinician fidelity to clinical protocol.

On the ethical front, we see a number of needed technical developments. There exists no ethical casebook focused specifically on the ethical issues that arise in the treatment of adolescent substance use or psychiatric disorders, and there is no model code of ethics specifically defined for agencies serving youth with substance use and psychiatric disorders. Particularly needed is a model code of ethics for the new "recovery coach" or "recovery support specialists" roles that we see being added to multidisciplinary service teams. Filled by volunteers or paid workers without formal clinical training, these positions can play an important role in the delivery of non-clinical, post-treatment support services, but the individuals filling these roles need guidance

on the ethical and relationship boundary issues that arise in this work. Without such guidance, these workers, their clients and their institutions are vulnerable to harm.

Every movement into new clinical frontiers, and every movement toward new clinical service models, moves us as individuals and organizations into unexplored ethical and legal territory. We can minimize harm to multiple parties in this process through the development of codes of professional practice, the orientation and training of all staff and volunteers, the delivery of rigorous supervision, the provision of legal and ethical consultation and the debriefing of all critical incidents.

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