Clinical Consultations

Addressing Dilemmas in Ethics, Supervision and Treatment

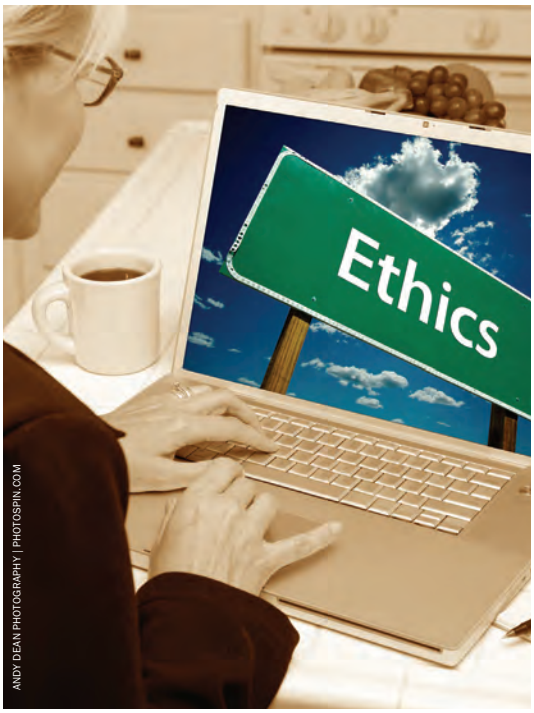
By Kathy Benson, NCAC II, QCS, Tom Durham, PhD, LADC, and Frances Patterson, PhD, MAC, SAP, QCS

Clinical Consultations aims to address real questions and dilemmas that practitioners encounter in their daily practice. Have a question or advice to share? Send your thoughts to Donovan Kuehn, Managing Editor, at dkuehn@naadac.org.

Disclosing information when a client has a communicable disease.

I took an Essential Learning course on Ethics and in this course it said the following: "When consumers disclose that they have a communicable disease that is also life-threatening, counselors may be justified in informing third parties who are known to be at high risk of contracting the disease."

I have never heard this before. Is this something the State Licensing Boards tell us to do or is this an error? If this is correct, under what circumstances would we break confidentiality?



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Thomas Durham: I agree. 42 CFR does not mandate such a report (i.e. this type of release of information) and, as noted, this doesn't seem to qualify as a Duty to Warn as no one has threatened to do harm. On the other hand, what about a client who is intending to deliberately transmit harm through a communicable disease?

So, is there ever a Duty to Warn when it comes to communicable diseases, such as HIV? Each state regulates Duty to Warn with respect to HIV infection. Again, this is regulated by each state. But, the need to warn must be limited to risk. For example, casual contact, such as sharing eating utensils and kissing doesn't seem to qualify as Duty to Warn, but exchange of bodily fluids through needle sharing or sexual contact may fall under mandated reporting. It is important that treatment agencies/providers know their state law regarding this issue and consult an attorney who is familiar with 42 CFR Part 2 when a legal question arises.

Resource

Applying the Substance Abuse Confidentiality Regulations 42 CFR Part 2 (REVISED), published by the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, December 2011. Online at www.samhsa.gov/about/laws/SAMHSA_42CFRPART2FAQII_Revised.pdf

Kathryn Benson: It would be my position with this amount of information that it does not meet the criteria for Duty to Warn, as in threat of harm to self or others. As a therapist, my approach would be to explore with identified client their sharing info with other person, reasons for doing so and not doing so, facilitate that conversation if deemed helpful, etc. If in the course of this exchange I became aware that the identified client intended deliberate transmission as a way of harming the other person(s) than I would respond according to Duty to Warn with additional communication with health department, etc. Of course, my determination would be based on more than my inference, speculation and would be supported by actual statements of intent.

Frances Patterson: When I worked at our local public health department there were diseases that had to be reported to the Health Department by doctors, labs and hospitals for tracking and surveillance — HIV, TB or other STIs (sexually transmitted infections) to mention a few. As counselors, we have a different relationship with clients. We are given information in confidence. We are under strict guidelines about exceptions to confidentiality.

The licensure board does not tell us to do this. It would fall under other state or federal notification laws. Always remember that the most stringent of the confidentiality laws is the one to follow. For instance, if a law says you have to notify, but 42 CFR Part 2 says you cannot notify, then you have to follow 42 CFR.

There are options to resolving the dilemma. Of course, if there is a written release of information from the client to comply with state-mandated reporting and follow up, a report can be made.

Anonymous reporting is permitted in some states. This is often done with codes rather than client names. A report could include a client name if it is not disclosed that the client is in an addictions treatment program.

If the program has entered into a Qualified Service/Business Organization Agreement (QSO/BA) with a medical provider that is a mandated reporter, the health care provider can make the report when it is learned, through testing, that the client has a communicable disease. This does not allow the outside medical provider to redisclose information that identifies the client as being in an addictions program. This can also be achieved by entering into a QSO/BA directly with the local public health department where preventing, treating, and controlling communicable disease is

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Patterson, continued from page 20 within their responsibility. Under this agreement, the agency would refer clients to the health department for testing, monitoring, possible treatment and follow up, thus allowing the treatment agency to comply with mandatory reporting of communicable diseases. The QSO/BA must specify services to be provided by the public health department. Again, redisclosure of information by the health department identifying persons as substance abuse treatment clients is prohibited without the client's consent.

When the communicable disease creates a medical emergency then it becomes necessary to report to medical personnel. Keep in mind that it must be an immediate threat to the client's personal health. An example would be a person with untreated TB. If the client is already under medical care for the condition, this does not constitute a medical emergency.

And, last but not least, if a court order is obtained by a program that authorizes reporting, the court can only issue an order when it is for good cause and is executed according to 42CFR Part 2.

Reference:

Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPPA: Legal Action Center, N.Y., N.Y. 2012

Frances Patterson, PhD, MAC, SAP, QCS, is board certified as a professional counselor with the American Psychotherapy Association (APA) and is a NAADAC, the Association for Addiction Professionals certified Masters Addictions Counselor and Qualified Substance Abuse Professional. She is certified by the State of Tennessee as a Clinical Supervisor for A&D licensure and serves as an oral examiner for people seeking licensure. Dr. Patterson has worked as a counselor and program administrator in treatment programs in Virginia and Tennessee over the past 24 years and is the owner of Footprints Consulting Services, LLC in Nashville, Tenn.

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Kathryn Benson, NCAC II, QCS, SAP, has worked in the counseling profession since 1972, with an initial emphasis on domestic violence, intervention and re-parenting of abusive parents. She has specialized in addiction issues since 1978. She maintains a clinical consulting practice in Nashville, Tenn., where she provides therapeutic services, clinical and program development and supervision services. She currently serves as the Chair of the National Certification Commission for Addiction Professionals (NCC AP) – the NAADAC Certification Board – and has received numerous professional awards.

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ments allows them to feel a connectedness to advancing the field, vicariously connecting on an emotional level with a wide range of clients through those clinicians who may learn from their work.

Conclusion

"Despite the many challenges that substance abuse counselors … voiced and the impact that burnout can have on client outcomes, … {counselors} recognized that burnout is not an inevitable outcome of their work. … (T)he counselors identified a positive working atmosphere can also help them to cope with these strains, thereby protecting them from burnout." (Oser, C. B., 2013)

Christopher Shea is a nationally and state certified addiction counselor in Maryland. Shea has worked for almost 20 years in the addiction field as a counselor, case manager, clinical director and administrator. Shea presents seminars and conferences across the country and is published in medical and peer-reviewed journals. Shea is currently the Director of Campus Ministry at St. Mary's Ryken high school as well as an adjunct professor at Towson University. He is also the founder and author of Life's Journey blog at www.lifesjourneyblog.com.

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