Roemer. Int Arch Addict Res Med 2015, 1:2
ISSN: 2474-3631

International Archives of
Addiction Research and Medicine

Review Article: Open Access

# Ethical Issues Surrounding In-Patient Treatment for Adolescents with Substance Use Disorders

***Audra Roemer****

*University of Victoria, Canada*

***Corresponding author:** *Audra Roemer, M.Sc Student, University of Victoria, Technology Enterprise Facility, Room 284, McKenzie Ave, Victoria, BC V8P 5C2, Canada, Tel: 778-350-8390, E-mail: aroemer@uvic.ca*

**Abstract**

The following article reviews the literature on ethical issues surrounding in-patient treatment of adolescents with substance use disorders. Ethical issues surrounding confidentiality, informed consent, competency, multiple relationships and boundaries, working on a multi-disciplinary team, responsible caring, and termination of services are discussed. There is a gap in the literature regarding the ethical issues associated with this specific population; however, given the sensitive nature of this population and treatment setting, knowledge and understanding of these ethical issues are critical to competent care and effective treatment.

## Introduction

Inpatient settings are one form of treatment method for adolescents with substance use disorders (SUD). Inpatient treatment centers for substance use typically involve a combination of group work, group therapy, and individual therapy [1]. The combination of treatment is derived from the idea that effective treatment for SUD involves treatment that is directed at drug and/or alcohol use as well as other issues such as deficient social skills or antisocial personality [1,2]. The benefits of this type of treatment for SUD are numerous, including: a reduction or cessation of alcohol and drug use, improved psychological functioning, increased employment status, and reduction in criminal behavior [3]. Although there are advantages to inpatient treatment for adolescents, there are some ethical issues that arise and need to be considered when providing this type of treatment. For example, issues surrounding confidentiality may arise as adolescents are considered minors. Moreover, the adolescents are participating in both individual and group therapy and may wish to keep information shared in individual therapy private from group therapy sessions. Additionally, treatment in these settings typically involve working with a multidisciplinary team in which all, or some information may or may not be shared between team members. Following from this, ethical issues surrounding informed consent should be considered, as clear informed consent processes can often act as a preventative measure in terms of misunderstandings regarding confidentiality; or, minimize harm if confidentiality is breached. Moreover, responsible caring may be more difficult to maintain in group therapy sessions, as it is more difficult to regulate behaviors of all members of the group. In attempting to maintain some control in group therapy sessions it is important to find a balance between control and respect for autonomy. The purpose of this paper is to review and discuss the current literature on the ethical issues relevant to providing public inpatient treatment for adolescents (aged 13-18) presenting primarily with SUD. More specifically, this paper will cover issues of competency, informed consent and confidentiality, multiple relationships and boundaries, working on a multi-disciplinary team, responsible caring, and termination of services.

One of the prominent ethical issues arising in the treatment of adolescents with SUD is competency. All psychologists have an ethical responsibility to ensure they are properly trained and competent in their specific area of practice [4]. With regards to treating adolescents with SUD, this would mean not only being competent in the treatment of SUD, but also have a thorough understanding of adolescents and their development. The literature recognizes adolescence as a distinct developmental phase with unique factors that influence and impact developmental trajectories [5,6]. The developmental fluidity of adolescents means that their treatment needs are different from adults [7,8]. Additionally, there are numerous systems, such as family, school, peers, and community that are interacting with, and influencing these changes. Successful adolescent psychotherapy requires specialized knowledge and skills in working with this population and a thorough understanding of the larger systemic context influencing the adolescent's life [6]. Previous research has indicated that effective adolescent psychotherapy involves integration of knowledge of family systems and developmental psychology into clinical interventions [9,10].

There are many different methods of treatment that have been used for SUD, and inpatient treatment centers typically involve both individual and group therapy. In order to be competent in treating SUD the psychologist needs to ensure they have a strong knowledge base of these treatment methods, as well as the risk and protective factors associated with adolescent substance use, the biological, individual, and social consequences of substance use, and any other factors associated with or contributing to the maintenance of SUD [7,8]. Moreover the psychologist is ethically responsible to ensure continuing competency in the treatment of SUD, which includes remaining up to date on the most effective methods of treating substance use. In addition, the clinician needs to be aware of the comorbid disorders that are commonly associated with substance use and ensure they are competent in treating these

ClinMed International Library

**Citation:** Roemer A (2015) Ethical Issues Surrounding In-Patient Treatment for Adolescents with Substance Use Disorders. Int Arch Addict Res Med 1:007

**Received:** June 17, 2015: **Accepted:** August 09, 2015: **Published:** August 12, 2015

as well. Finally, as working with adolescents with SUD can be very difficult and straining, the psychologist should engage in self-care activities in order to avoid burn out [7]. If a psychologist finds himself or herself in a position of incompetence it is their responsibility to acquire the necessary training, knowledge, and consultation to become competent. According to [10], a failure to recognize one's incompetence with working with the adolescent population would be considered a substantial ethical hazard.

The research indicates two other prominent ethical issues in the treatment of adolescents with SUD: informed consent and confidentiality. The adolescent may be at the treatment center involuntary due to court-ordered treatment or on their parents' request. Furthermore, as the adolescent is considered a minor, consent needs to be obtained from the parents or legal guardians. However, research has shown that the therapeutic relationship is strengthened and treatment outcomes are improved when the adolescent feels as if he/she has participated in the informed decision process to receive therapy [11]. Providing the opportunity for the adolescent to be involved in the informed consent process protects their right to autonomy [9]. Therefore, the psychologist should make every effort to obtain assent form the adolescent prior to beginning treatment [12].

In order to obtain informed consent and assent, the psychologist needs to provide all the information necessary for the individual to make an informed decision, ensure the adolescent and parents understand the information, have the capacity to understand the risks and benefits of their decision, and has the ability to make a free and uncoerced decision [13,14]. As the education level and/or language ability of adolescents may vary in this setting and therefore, all language surrounding the informed consent should be presented to the adolescent in a manner they can understand in order to avoid any misunderstanding [7,12]. The literature outlines some the necessary information that needs to be contained on the consent form, including: information about the nature of the treatment, the anticipated course of treatment, the potential benefits and risks of treatment, and alternative forms of treatment [15]. An important part of this process also includes explaining the limits to confidentiality [12,16]. The adolescent needs to understand all limits of confidentiality including: mandatory reporting, legal proceedings, emergency and/or dangerous behaviors, shared information between team members, and parents' access to records. [17]. Including this information in the informed consent process can work to avoid misunderstandings in the future [18]. Furthermore, explaining limits to confidentiality protects the adolescent's autonomy and reduces the risk of harm in situations where confidentiality is breached [12].

Issues of confidentiality are complex in treating adolescents, as their parents or legal guardians are often involved in the treatment process and have access to their health records [9]. Moreover, substance use can be a sensitive issue that the adolescent may not feel comfortable sharing with the psychologist, knowing this information might be shared parents. Some of the most difficult ethical issues that arise in treating adolescents involve issues of confidentiality when there is disagreement between family members or between the adolescent and their parents [14]. The psychologist may find himself or herself in a conflict as they have a legal obligation to the parents, but a moral obligation to the adolescent [19]. It is important for the psychologist to find a balance between their ethical responsibility to inform the parents about any treatment conducted and progress of treatment, and the adolescents' right to privacy and autonomy [11]. The literature recommends that the psychologist have a discussion with the parents about the challenges in finding this balance [11]. Moreover, there should be a clear discussion with both the parents and the adolescent prior to beginning treatment regarding limits of confidentiality, including what is considered reasonable information relative to the adolescent's right for reasonable privacy [11,20]. It is also recommended that the psychologist asks follow-up questions to ensure all parties understand that limits of confidentiality [21] and the issue of confidentiality be periodically discussed throughout treatment to ensure continued understanding [22]. Given these issues of confidentiality, the psychologist needs to keep in mind that the adolescent's awareness of the limits to confidentiality can have a negative impact in therapy, as the establishment of trust is essential to forming a therapeutic alliance with the adolescent [10,11]. According to Koocher [10] the key issue in respecting the adolescent's right to confidentiality is to raise any issues early and deal with them in a direct manner that facilitates the therapeutic alliance. Martin [7] recommends that the best approach to forming a positive relationship with adolescents in treatment is to maintain an open, honest, and nonjudgmental communication style.

In working with adolescents with SUD the issue of breaching confidentiality is more likely to occur given that substance use is a risky, and sometimes illegal, behavior and there are numerous associated risks and harms [22,23]. The literature suggests that psychologists consider a multitude of factors when deciding whether to break confidentiality. For example, in a survey of pediatric psychologists [22], the two factors accounting for the largest portion of the variance when deciding whether to break confidentiality were the negative nature of the behavior and maintaining the therapeutic process. The authors explained that the competing nature of these factors could lead one individual to break confidentiality and another to maintain confidentiality, depending on the importance the individual assigns to each factor. Given the nature of an inpatient treatment it is likely that their parents will already have some awareness of the their adolescent's risk taking behavior; however having a thorough knowledge base on normative adolescent risk–taking behavior would be central to issues of competency [22].

If a situation arises in which confidentiality does need to be breached, the literature explains that the psychologist should first contemplate how all involved parties would best be served. Furthermore, the psychologist should explain to the adolescent why confidentiality needs to be broken and the possible consequences that may arise as this works to help maintain rapport with the adolescent [24,25]. Finally, the psychologist should encourage the adolescent to be involved in the process as much as possible, as this could work to minimize any feelings of resentment or betrayal the adolescent may have [22]. In contrast, if a situation arises in which the parents want to know information that the psychologist believes should remain confidential, referring back to the consent form and explaining the limits to confidentiality and the adolescent's right to privacy may be helpful [11].

The principles guiding communication with parents can also serve to guide communication with members on a multi-disciplinary team [11]. In-patient treatment typically involves working with a team of professionals, often from other disciplines. The adolescent and the team members need to know at the outset what information is going to be shared with the team, and only information essential to providing treatment should be shared [4]. Sometimes adolescents with SUD work simultaneously with more than one psychologist, with one psychologist focusing exclusively on the substance use and the other fulfilling a role of supporting the adolescent's overall growth and development [11]. In such cases, continuous communication between the two psychologists is essential to treatment and proper coordination of care.

Working on a multidisciplinary team also brings up ethical issues surrounding the therapeutic environment of the treatment center. The recovery environment of an inpatient treatment center is unique in that it offers adolescents an environment of round-the-clock support and structure [8]. One of the key issues in this setting is that the work environment in an inpatient setting is also the clients' temporary living space; therefore creating and maintaining a positive, professional work environment that is ethically sensitive and supportive is essential to the treatment of clients. With this in mind, it becomes important for all individuals working at the inpatient treatment center to maintain a professional stance at all times. The literature identifies key aspects to a successful therapeutic milieu. Team members need to be cooperative [26] and respectful of each other, even when differences of opinion occur [14]. Furthermore, continuous communication that is clear, open, and respectful

contributes to a supportive environment that facilitates positive treatment outcomes [16]. The most important aspect of working successfully with a team is that the focus of the team remains on what is best for the adolescent [27].

Another important factor to consider when working on a multi-disciplinary team is ethical issues around reporting and record keeping. All team members need to be aware of confidentiality issues when sharing information with each other [26]. In regards to report writing, Recupero [12] suggests that psychologists keep in mind everyone who will, or could, read the report. For example, both the parents and the adolescent could ask to see their report, and in court-ordered situations individuals involved in the legal proceedings have access to the records. With this in mind, it is important to be thorough while ensuring only relevant information is included. This process may involve not including any unnecessary information that could be misunderstood or harmful to the adolescent. Additionally, truthfulness is paramount in all records and professional communications. The psychologist should ensure that all information included in the report is objective and neutral, and any limitations to professional opinions are recognized [11]. Moreover, in providing feedback to the adolescent the psychologist should make sure they use language that is appropriate to their developmental and maturity level [12]. Finally, the psychologist should ensure that the way in which they are reporting or communicating information works to maintain the adolescent's sense of autonomy and dignity [12,24]. Recupero [12] argues that this type of censorship falls in line with the ethical principle of nonmalificence.

The ethical principle of nonmalificence, or do no harm, is closely tied with ethical issues of responsible care. These issues become relevant in this area of practice, particularly because of the age of the adolescents and the more intimate nature of the treatment setting. There is a strong power differential between the psychologist and the adolescent and the psychologist needs to take care that they do not use this power for any form of exploitation [9]. In addition, it is also important for the psychologist to recognize their own personal biases when working with adolescents [10]. For example, psychologists should be aware of their own views of adolescents and of individuals with substance use disorders and ensures that these biases are not impacting the treatment process.

The ethical principle of responsible caring also involves developing a positive therapeutic alliance with the adolescent, as the therapeutic relationship is particular salient when working with this age group [7,28]. One aspect essential to the development of a positive therapeutic alliance is respecting and understanding the diversity of adolescents that come into the treatment center [29]. It is likely that the psychologist will encounter adolescents and families coming from different religious, cultural, ethnic, and political backgrounds. Therefore, it is important for the psychologist to understand the adolescent's background as it may have a significant impact on treatment outcome [11]. Additionally, respecting the adolescent's right to autonomy is fundamental, as research indicates an association between self-reported improvement from inpatient treatment and perceived respect for autonomy [24,16,30]. Church [28] argued that the foundation for a positive therapeutic alliance will be, in part, based on the psychologist's ability to conceptualize the adolescent's autonomy in a relational context, while establishing conditions for building a sense of independence and self-reliance.

Another ethical issue that arises when working with adolescents is the concern regarding multiple and sometimes conflicting roles [10]. Although the adolescent is the one receiving treatment, the parents or guardians are the paying clients and it is possible that the adolescent and adults have incongruent treatment goals [10]. In such cases, it becomes the psychologist's responsibility to understand, navigate, and strike a balance between the parents' wishes or goals and the adolescent's needs and wishes. However, because the adolescent is considered the most vulnerable, the psychologist needs to ensure that in formulating a treatment plan the best interest of the adolescent remains paramount [10].

On a similar note, when working with adolescents in an inpatient setting, there is a key issue of maintaining boundaries. Inpatient settings often provide more opportunity for the development of multiple roles and for boundary crossing to occur. The short-term benefits of boundary crossing can appear very attractive and psychologists sometimes have a desire to reach out and help adolescents [31]. However, boundaries are intended to protect against any possible misbehavior between the psychologist and the client [32]. Therefore, psychologists need to maintain an awareness of the allure of crossing boundaries [31] and ensure their actions are benefiting the client and not serving their own needs in any way [4,33]. The psychologist also needs to make sure they maintain a professional role that does not impair their effectiveness, competence, or objectivity in treatment [15]. Adolescents may challenge boundaries by trying to have therapeutic interactions outside of the therapy session, or by asking personal questions [11]. In an effort to maintain boundaries it is recommended that the psychologist maintain a stance of therapeutic neutrality. Ascherman and Rubin [11] describe this as remaining interested, but neutral to the conflicts and desires of the adolescent. This therapeutic neutrality will help maintain and protect the therapeutic space that the psychologist has developed with the adolescent.

A final ethical issue that is important to consider when treating adolescents in an in-patient setting is in regards to the termination of services. The code of conduct states that termination of services should occur when the client is not benefiting from the services, is being harmed, or no longer needs the service. However, the decision of when to terminate is not always clear, as there are multiple factors that contribute to this decision [15]. For example, one of the drawbacks to inpatient treatment centers is that when the adolescent leaves, they have to deal with the stresses of reentering back into the environment that may have contributed to their substance use problems [8]. Therefore, in determining whether treatment at the inpatient center should be terminated, the psychologist needs to ensure the adolescent is prepared to deal with these stresses. This could involve setting up additional resources outside the treatment center, psychoeducation, and relapse prevention services [7].

When treatment is ending, the psychologist has an ethical responsibility to ensure that the adolescent is prepared for treatment to end. This may include scheduling a session with the adolescent in which termination is discussed and clarifying recommendations for after discharge from the treatment center [7]. Within this setting, it is particular important for the adolescent to understand that leaving the treatment center does not mean the treatment process is ending; it just means that the location of treatment is being changed and continued progress towards treatment goals should be encouraged. Finally, the parents or legal guardians should be given feedback regarding the treatment process, the reasons for termination, and detailed recommendations for after discharge [34].

The treatment of adolescents with SUD in a public in-patient treatment center involves the careful consideration of a compendium of ethical issues. First and foremost, psychologists should be cognizant of the ethical issues of informed consent and confidentiality, as they are particularly salient when working with minors. Moreover, the clinician needs to be aware of their own biases and reactions in situations in order to avoid engaging in unethical behavior. Issues of respect for autonomy, dignity of persons, and responsible care are also essential to ethical practice when treating adolescents; particularly because of the vulnerable nature of the clients, the sensitive nature of SUDs, and the significant impact the treatment environment has in in-patient settings. Ultimately, the psychologist should ensure they are always working to serve the best interest of the client, and to uphold the ethical principles outlined by their regulatory body, in order to ensure they are providing the most ethical, professional, and best care they can provide.

## References

1. Grieve P, Jaffe L (2002) In-patient treatment of substance abuse. Int J Psychoanal 83: 253-256.

2. National Institute on Drug Abuse (2009) Drug Facts: Treatment approaches for drug addiction.

3. Kelly JF, Myers MG, Brown SA (2000) A multivariate process model of adolescent 12-step attendance and substance use outcome following inpatient treatment. Psychol Addict Behav 14: 376-389.

4. Edge R, Groves J (2005) Professional gatekeeping as a function of role fidelity. In: Clifton Park (ed) Ethics of health care: A guide for clinical practice 3rd (edn). Thomson Delmar Learning, 119-141.

5. Cicchetti D, Rogosh FA (2002) A developmental psychology perspective on adolescence. Journal of Consulting and Clinical Psychology 70: 6-20.

6. Rubenstein A (2003) Adolescent psychotherapy: An introduction. J Clin Psychol 59: 1169-1175.

7. Martin, DG (2003) Clinical practice with adolescents. Pacific Grove, CA: Thomson Learning.

8. Muisener P (1994) Servicing adolescent substance users: Part II treatment planning. In: Understanding and treating adolescent substance abuse, Thousand Oak, CA: SAGE Publications Inc.,133-157.

9. Goldsmith M, Joshi S (2012) Ethical considerations in child and adolescent psychiatry. Child and Adolescent Psychiatry: Life Cycle and Family 315-320.

10. Koocher G.P (2003) Ethical issues in psychotherapy with adolescents. Journal of Clinical Psychology 59: 1247-1256.

11. Ascherman L, Rubin S (2008) Current ethical issues in child and adolescent psychotherapy. Child Adolesc Psychiatr Clin N Am 17: 21-35.

12. Recupero PR (2008) Ethics of medical records and professional communications. Child Adolesc Psychiatr Clin N Am 17: 37-51.

13. Hoop JG, Smyth AC, Roberts L (2008) Ethical issues in psychiatric research on children and adolescents. Child Adolesc Psychiatr Clin N Am 17: 127-48.

14. Roberts LW (2002) Informed consent and the capacity for voluntarism. Am J Psychiatry 159: 705-712.

15. Rae W, Fournier C (2007) Evidence-based therapy and ethical practice. In: Steele R, Elkin T, Roberts M (eds) Handbook of evidence-based therapies for children and adolescents. NY: Springer Science and Business Media, New York 505-519.

16. Lyman R, Campbell N (1996) Treating children and adolescents in residential and inpatient settings. Thousand Oaks, CA: SAGE Publications, USA.

17. Bird H.R (2004) Presentation of findings and recommendations. In: Wiener J, Dulcan M. Textbook of child and adolescent psychiatry. (3rd edn). Washington DC: American Psychiatric Publishing: 215-218.

18. Rae WA (2001) Common teen-parent problems. In: Walker CE, Roberts MC (eds) Handbook of clinical child psychology 3rd edition. NY: Wiley 621–637.

19. Adam MB (2011) Adolescent confidentiality: An uneasy truce. Clinical Ethical Dilemmas 27: 75-78.

20. Melton GB, Ehrenreich NS, Lyons PM (2001) Ethical and legal issues in mental health services for children. In: Walker CE, Roberts MC (eds) Handbook of clinical child psychology 3rd edn. NY: Wiley 1074-1093.

21. Ford CA, Thomsen SL, Compton B (2001) Adolescents' interpretations of conditional confidentiality assurances. J Adolesc Health 29: 156-159.

22. Sullivan J, Ramirez A, Rae W, Razo N, George C (2002) Factors contributing to breaking confidentiality with adolescent clients: A survey of pediatric psychologists. Professional Psychology: Research and Practice 4: 396-401.

23. Brooks M K (1999) Legal and ethical issues. In: Winters K (ed) Treatment of adolescents with substance use disorders.

24. Dingle A (2011) Ethics overview. American Academy of Child and Adolescent Psychiatry.

25. Taylor L, Adelman H (1998) Confidentiality: Competing principles, inevitable dilemmas 9: 267-275.

26. Stowell RJ, Estroff TW (2001) Inpatient programs. In: Estroff TW (ed) Manual of adolescent substance abuse treatment. Washington, DC: American Psychiatric Publishing, 165-186.

27. Mental Health Commission (2006) Multidisciplinary team working: From theory to practice.

28. Church E (1994) The role of autonomy in adolescent psychotherapy. Psychotherapy 31: 101-108.

29. Kraft, Kristin, Anna Pond, Marlyin (2006) Adolescent treatment services: Context of care. In: Liddle HA, Rowe CL (eds) Adolescent substance abuse research and clinical advances. NY: Cambridge University Press.

30. Kjellin L, Anderson K, Candefjord I, Palmstierna T & Wallsten T (1997) Ethical benefits and costs of coercion in short-term inpatient psychiatric care. Psychiatric Services 48: 1567-2670.

31. Sondheimer A (2010) Ethical boundaries - Do they limit care to children? American Academy of Child and Adolescent Psychology 18-19.

32. Gabbard G (2009) Boundary violations. In: S Bloch, S Green. Psychiatric ethics Oxford: Oxford University Press: 25-48.

33. Schetky D (1995) Boundaries in child and adolescent psychiatry. Child and Adolescent Psychiatric Clinics of North America 4: 769-78

34. Brewer T, Faitak MF (1989) Ethical guidelines for the inpatient psychiatric care of children. Prof Psychol Res Pr 20: 142-147.