FGI December Webinar Transcript
Confidentiality, Ethics, & SUD
December 7, 2023

[00:00:00] **Michelle Day:** Good afternoon everyone, and welcome to the Fletcher Group Rural Center of Excellence's webinar series. Today's session is scheduled to run from 2:00 PM to 3:00 PM Eastern Standard Time. My name is Michelle Day, and I'm your moderator for the session, along with Janice Fulkerson and Erica Walker. A couple of brief housekeeping items, and then we'll begin.

You entered today's session on mute, and your video was off, and will remain so for the entirety of the webinar. Your chat feature is located at the bottom right of your screen. Use the drop down feature to communicate with either the panelists only or panelists and attendees. Please direct all questions regarding the webinar content to the Q & A section.Be advised that this meeting is being recorded and will be available to you on our website once it has been transcribed. You can access our website at www. fletchergroup.org. Also, at the [00:01:00] conclusion of today's session, there will be a short survey regarding the webinar content. Your participation in that survey is greatly appreciated and will only take a few moments to complete.

Joining us today is Dr. Kenneth Martz, Special Assistant to the Secretary with the Pennsylvania Department of Drug and Alcohol Programs. Dr. Martz is a licensed psychologist. He has worked in higher education for over 15 years. He has worked in treatment and management of addiction and mental health issues for the past 30 years across settings including outpatient, residential, and hospital settings. He was formerly the Special Assistant to the Secretary for the Department of Drug and Alcohol Programs in the Commonwealth of Pennsylvania, where he managed the policy and funding of the treatment system of licensed providers. Dr. Martz has a doctorate in clinical psychology from the American School of Professional Psychology. He [00:02:00] has authored a dozen publications, including the international bestseller, Manage My Emotions. He has over 100 local, national, and international presentations in the addictions and mental health treatment field. Dr. Martz, the floor is yours.

[00:02:20] **Dr. Ken Martz:** Right. Welcome, everybody. Welcome. Good to see everybody this afternoon, looking forward to having the conversation and developing this further. So we are going to be talking today about the secrets of sobriety, taking a look at how confidentiality plays in this process of developing our growth and ability to get into recovery.

So, really appreciate, uh, the work that folks are doing every day with this practice, because I know how sometimes this is a thankless job. So, we really appreciate the team that, that really is working to make sure that our folks can get to [00:03:00] where they need to get to. And that's often why we got into the field. So we'll take a look about some of that and how that interplays with some of our federal and and other regulations and ethics. And I will keep an eye out for, for listening for some of the, uh, any questions along the way, but I'm going to talk a little bit fast. So I will try to get to as much as we can in this bit of time and we will go from there. We're going to cover a little bit of some background information, you know, why this, this, uh, confidentiality is so important. Uh, there will be, uh, a covering the confidentiality laws, how to work effectively within the laws and other considerations, and think about some of the recommendations and next steps that you can do.

One of the things to remember also is that, uh, we will be having continued education credits available through NAADAC, so please stay through to the end to get the final details on that. And so, and enjoy along the way.

So [00:04:00] why is this confidentiality thing so important? Why, you know, there's a conversation about we need to have a space where folks can have their private issues reviewed and get to the steps that are appropriate. And actually, there are multiple reasons why this is so confidentiality is so important. And these actually come from our federal regulations that explain why we have these laws in place. Number one is to increase the likelihood that someone seeking care is protected from stigma. We want to create a safe environment for self exploration.

You know, I've been doing counseling for 30 years now, and I've always said people don't heal until they feel safe. You know, and they're not going to talk about what's important until they feel safe to share them, share those secrets. And so, confidentiality creates a cloak, a safe space, an environment within which they can then share [00:05:00] those self exploration, those issues they've been worried about and scared of and angry about, sometimes for many years. It also helps to minimize a provider's risk of liability. We'll talk about that, as well as so that the client is not made more vulnerable by seeking treatment than by not seeking treatment. So that ties actually back to stigma that I don't want to go to treatment and then suddenly have problems because of it.

So we're going to break down each of these a little bit. Number one, you know, increase the likelihood that someone seeking. Uh, care is protected. So the fear of stigma is one of the primary key reasons why people don't seek treatment. There's a national survey that goes out annually from SAMHSA, and time and again for, for years, the results have been almost exactly the same. The number one, people don't seek [00:06:00] treatment is because I don't believe I have a problem, but if those who need, understand that they have a problem or they have a concern, the reason why they won't enter treatment is I'm scared of what my friends or neighbors will think. I'm scared that I'll lose my job.

I'm scared that there'll be some sort of problems associated. Then it would be, um, detrimental to me. And sometimes this is fear, and sometimes it's more than fear. For example, uh, there are actual harms that occur out there, uh, as a result. So, for example, a young man whose employer refused to allow him to return to work after he successfully treated, treated, completed treatment for alcoholism, saying that they were a safety threat. Even though the physician had cleared him and he returned to work with no restrictions. There was a young mother who was threatened with eviction from a shelter because she was taking prescribed methadone for her opioid addiction. And another young mother had already been evicted from the same facility for the same reason and had become homeless.[00:07:00]

A posting after, uh, there was a, um, A news story I came across not long ago, and you know how people add the add their quotes at the bottom of the comments at the bottom of the news articles. And one of the comments was overdose is nature's way of taking out the trash. So, the stigma out there is runs long and deep. And so this is why confidentiality is still so important today as it was 50 years ago. So, making sure that they are not made more

vulnerable by seeking treatment than if they didn't seek treatment. Actually, let me just check one thing real quick. So, harms could be associated with those breaches. So, a 29 year old mother lost her 3 year old child in custody case because there was an unlawful disclosure of her addiction treatment records.

And because of that, she was deemed an unfit mother by the judge. And the child was put into [00:08:00] protective custody. The young lawyer, there was a young lawyer who learned two weeks after her new job that she would be terminated because of the fact that she was on methadone, came up with a background check, right? There are cases after cases of these issues, and so some of them are fears, and sometimes there are serious impacts. A young woman, uh, had to give up her dream of open and owning her own business because she couldn't get health insurance policy for employees. And a husband of four, uh, who's at high risk for a job fishery's job, was unable to get life insurance.

I've seen this also with the, um, uh, with Narcan. There is, uh, an issue with some life insurance companies that, think about how Narcan works. I might be a parent, and I'm keeping Narcan in the house because I don't know what's going to happen, uh, to my child. I could be the first responder. I may keep, keep [00:09:00] Narcan in the house because my grandma, because my mother is, uh, taking opioids for her back pain and she's 80 years old and she sometimes forgets and, and so she can mismanage her medications and so we're, they're afraid that it would be an accidental overdose. So, some life insurance are saying, well, you, you took Narcan so you're at high risk. Just by virtue of having that prescription. So there's lots of these issues where the stigma runs deep, uh, and lots of efforts being done to, uh, protect confidentiality and. Again, create a safe environment. So, treatment involves sharing of some of our most vulnerable inner shames, secrets, and trauma, and the fear of those consequences.

If I'm scared that something's going to happen, I'm not going to tell you about what happened to you when I was six years old. Okay? Uh, consider the young woman who shares about the rape from a stranger she experienced as a child, never told anybody [00:10:00] until two months into the treatment where she began to due to the feelings of shame. Uh, what about, you know, a client And I've had that case actually multiple times, where it's like, I'm a nice enough guy, and I sometimes had a client who comes in for months, and then they finally say, Dr. Martz, all right, I gotta tell you something. And you know what's come in this session. You know what I'm saying? Also, what happens when you've got a client that's under parole and probation, and they get a pass, and they go out of state, or they go to visit a family for, for the holidays, and there's wine at the dinner table, and the client says, I really want to drink. I really want to drink. It's right there, and does not.

If I'm afraid to tell my therapist about that, That's a problem. If I tell my therapist, they may tell my probation officer, I might get into trouble. You see why the confidentiality is so important because that's [00:11:00] exactly the kind of thing I'd want you to bring to therapy when you're struggling so that we can deal with that in the therapy process. Critical issues. Is confidentiality used only to protect the client from consequences? Uh, not only, but these are, these are some of the top areas. So the next will be also to us. As a benefit to minimize the

risk of provider, uh, provider liability, uh, programs can be sued for these violations of, and this is major across the way.

And we're going to be walking through exactly that. There are fines and criminal penalties available, uh, under, under these offenses. And just to give a taste of some of these. Here are a couple of examples. Uh, there may be as something as ranging from as simple as hospital staff disclosed an HIV testing, uh, to a patient concerning a patient in the waiting room. Staff were required to re, to, to take regular [00:12:00] HIPAA training and, and computer monitors were repositioned and office manager accidentally faxed a confidential medical record to an employer rather than to the rel urologist's office. You know, they read the wrong fax number, as simple as that Resulted in a storm stern warning letter and a mandate for HIPAA training.

But it goes up from there. Private practice lost an unencrypted flash drive containing protected health information and was fined $150,000. Walgreens pharmacist violated confidential information about a customer who dated her husband and resulted in a $1,000, 000 Ford award. Six doctors at UCLA were fired after looking up Britney Spears medical records when they had no legitimate reason to do so. $2,000,000 vendor fined because of a laptop with hundreds of patient medical records stolen from the car. [00:13:00] So, just wants to know about, without all the details yet, that it seems like recently there was the Baptist Medical Center in Texas reported a breach with 1, 600, 000 individuals. And the largest one I could find in recent times was from July of this year, HCA Healthcare in Tennessee reported a breach of 11,000 000 individuals.

So, breaches are real. There's many different ways that these things can happen. Sometimes they're simple things as one individual shared one individual's material with data breaches, with, um, hacking, etc. Very important to kind of think about the wide range of potential issues and how to protect yourself. So it's not only for the clients, but also protecting us. And the field. So, because if we as a field don't have a sense that there's a public trust in us, then clients won't [00:14:00] come in to treatment. Because remember, what I just said a moment ago, one of the top reasons why they don't come to treatment is they're afraid.

What's going to happen if I do? In 1972, when they enacted the confidentiality law, 42 CFR, the legislature added comments. They want to stress their conviction that the strictest adherence to the provisions of this section is absolutely necessary for the success of all drug abuse prevention programs. Everybody has to be assured that the privacy will be protected, because without that assurance It will discourage thousands of people from seeking the treatment, so that we can get past this national, this national problem. This is about supporting the entire country.

The Supreme Court has also weighed in on this, and so they have some interesting comments as well. I'm not going to read this whole thing to you, uh, so, because I hate doing long readings. But just to get a couple of points of it, that [00:15:00] they, um, They found that the relationship is of a counselor is likened to that of priest penitent or the lawyer client. The psychiatrist not only explores the patient's conscious, but their unconscious feelings and attitudes as well. So the therapeutic effectiveness necessitates going beyond the patient's

awareness. So, any threat to secrecy blocks that treatment. They want to say that the psychiatric patient confides more utterly than anyone else in the world, exposes to the therapist not only what his words express, but he lays bare his entire self, his dreams, his fantasies, his sins, and his shame.

And they can't help to get, um, help, get help except on that condition. That it would be too much to expect of them, that if they knew all they would say, and all the psychiatrists would learn from them, it could be revealed to the whole world. Really important. So it goes on and on. [00:16:00] Every area of government understands this element. There's been some questions lately, so a longer answer to the other question. Are there other benefits to confidentiality? Other impacts of confidentiality and 1 of the others. Other elements there is that we are looking at a, um. There's been some weakenings of this, these confidentiality regulations.

There have been multiple changes in the very recent years. There's actually been a law passed the beginning of this year or last year and they are, um. They've taken comments and so they're expecting or expecting at some point, uh, to be a release of, uh, further changes. So, all of this becomes in flux a bit. So, this is why it's so important to maintain some ongoing training of these issues. [00:17:00] There are a range of these laws, and I'm not going to be able to cover everything in the world, but two key areas to hit on, uh, well actually we'll hit three, uh, one is 42 CFR Part 2. This is a federal regulation relative to substance use disorder.

The other one is 45 45 CFR, subtitle a uh, you most likely know that as HIPAA. Okay. There are other re other, uh, regulations out there federally. You should, you need to also check about your state, uh, regulations as well as ethics because each of these areas will start to interact so that your state regulations could be either more stringent or less stringent. Uh, they can vary. Um, there are also other, um. Confidentiality regulations that could be impacted, such as HIV or mental health, uh, separately from drug and alcohol as well. So, watching all the different [00:18:00] playing pieces. The ones that are largest and remote, that are most familiar folks, we're going to, we're going to touch on starting with 42 CFR Part 2.

And a couple of pieces I'm going to actually pull from the, from the citation, so all identifying information as someone has a substance use disorder is confidential. There are nine exceptions for 42 CFR Part 2. Within these exceptions, it has to be limited to that which is required. And once it's disclosed, it cannot be re disclosed. You know, the key point is that we want to make sure that I, as the patient, know who I'm agreeing to give my stuff to. So if you're working with me, you're knowing that you're going to share this secret with me, your counselor. Not your cousin, who [00:19:00] happens to work at my office, or who works over here, or this or that or the other.

And that's often one of the things that people will be asking. My employer is paying for this. What are you going to tell them? I'm here with parole and probation. What are you going to tell them? Et cetera, et cetera, et cetera. So, there are nine exceptions. I'm going to cover two in particular. I'm going to actually start more down at the bottom because one of the exceptions is if there's a crime on the premises. This doesn't happen regularly, but if you are in a facility and a client assaults you, we are permitted to bring charges. Child abuse and

neglect. This varies from state to state, but typically this is one of the exceptions about when and how, uh, you need to make disclosures. If someone has a heart attack or has other medical emergency, uh, we are permitted to call the [00:20:00] ambulance.

Audit and evaluation. So, for example, if you were a licensed program or if you were paid for, if you were, um, being paid for by, um, Medicaid, for example, uh, they may be able to come in for audit and evaluation to make sure that the funds were being properly spent and these types of things. The ones that folks most need to pay attention to are a release of information. This is the most common usage. So, I walk in, everything I tell you is confidential, nobody gets to know it, well, but my spouse wants to come in for, for a family meeting. Well, then we're going to sign this release of information. I'm going to agree that you can talk to my spouse during our family, family session. Or I'm going to agree that you can talk to my spouse when she calls to get, get me a message. The other exception, uh, is really a little, is an [00:21:00] involuntary method, but it is, it is, uh, one that's out there.

It's the one that people get a little antsy about is that if we can release confidential information for a court order, what that means and what that does not mean. So this is what that means is, um, if I, uh, get a knock on the door and the police officer says, I need to see your records on. Client so and so. You can say thank you, you can't turn on, hand over the records at that point. So, in order to have a good cause court order, you have to actually have the opportunity to go in front of the judge and say, Judge, I have this ethical code of conduct which says I'm not permitted to share, uh, these records. Uh, 42 CFR in this case, uh, as well as HIPAA, uh, says that I am not permitted to share this information.

Um, I am [00:22:00] requesting to not share this information. Judge, are you ordering me to release that information despite my objection? You see what just happened here. I remain in the role of a, um, uh, protector of my client. When the judge then says, no, this is needs to be released. There may be other reasons why I might release it. So for example, child abuse and neglect. Other things like if my spouse wants to get my records, you know, not without the court actually saying, because what's going to happen there? My spouse wants to get my therapy records. The client's spouse wants to get their therapy records. What's going to happen to the counseling relationship once that's happened? You see the problem here. So this is why confidentiality is so important. [00:23:00] If it doesn't work out carefully, there will be impacts to the, to the whole process. Um, really important that the facility bears the responsibility for the client's welfare, um, and so it's really only doing a release that is a benefit of the client.

And section 2.3a says that any disclosure made under this must be limited to information which is necessary, necessary to fill the purpose of the disclosure. So I've seen client records that were like 500 pages long. I just want to know if, and the person just wants to know if they're, they're, they're showing up for work, if they just want to know the purpose of this. They may not need to know every word of everything that happened in every session. Got it? So you only give what's necessary, so you don't just say, Well, I got a release, so let me tell you all about it. We have, you know, let's sit down and have a cup of coffee and I'll tell you [00:24:00] all about it. Right? The minimum necessary for the purpose of the disclosure.

Redisclosure. Under 42 CFR, there is a prohibition on redisclosure. So, uh, if you give me that release, I can't give it to others. You know, if I give, if you give me a release to give it to your insurance company, they can't give it to others. So this is one of the areas that they are, uh, has been, uh, moved towards aligning to HIPAA, which does not have this re disclosure prohibition, uh, because it makes it easier to facilitate information sharing.

Do you want your information about what happened when you were six years old freely shared? You see the challenges that this creates. This is the push pull about the importance of Our protections of safety. All right, information shared according to HIPAA. So [00:25:00] I'm switching from 42 CFR over to HIPAA. So, according to HIPAA, when disclosing or requesting personal health information, a covered entity must make reasonable efforts to use the minimum necessary to accomplish the intended purpose. Okay? So, see how these two laws are very similar, but they differ. So, 42 CFR said that it must be limited to the information which is necessary, and HIPAA says it is the minimum. necessary. So, that is a important distinction there. And so even if they read that as we, they update, uh, 42 CFR, uh, if it switches over towards closer to HIPAA, it still maintains this area of we're only going to give the minimum necessary when, when they, when the insurance company says, no, we need the whole record.

[00:26:00] That's not what the permitted disclosure is under audit and evaluation. If they wanted, if they had, if they thought you were doing something fraudulent, they could come into your program and review the record, but that's different. That's not just me making a copy, mailing their, mailing the client record off somewhere. What could go wrong? You see the challenges here. Information shared. So implications of HIPAA, uh, we, uh, HIPAA really doesn't have these restrictions when, when the disclosure is to other, uh, health professionals for the purpose of providing treatment. So we can talk to each other amongst, as treatment professionals, but the disclosures are, uh, to non treatment personnel are restricted to the minimum amount necessary to perform their duties.

So, uh, if I'm on your treatment team, we can talk about it. Does the secretary need to know all of your information? Probably not. So we would have team [00:27:00] meetings, uh, that would discuss the patient, but then they would not necessarily include the front desk person, uh, or something like that, or the janitor, or the something else. Disclosures mandated by laws. Most common is child abuse or elder abuse, and these are ones, again, I will refer you to check in with your state regulation, because each state will have a slightly different variation on what must be reported. And who is a required reporter? So, you're, you want to check that on the state level, since I know we have some people from different areas.

However, in general, the principle of duty to protect is most commonly known by Tarasoff v. Regents of the University of California. This was a 1976 case in which there was a question about whether this person should have, this counselor should have reported the client [00:28:00] risk. And so notice, by the way, that's a state law. So unless you're living in California, that doesn't apply to you. However, there may be a way that it does apply, and we'll talk about that in a moment.

I'm a conceptual thinker, so I always try to think about it in terms of what information is needed. We talked about that. We only give the information that's needed for the purpose of the issue. If the purpose of the issue is to collaborate care, because, uh, My substance use counselor and my mental health counselor are working on my trauma are in two different offices, and we're going to share information so you can have coordinated care. If I may need to share that, um, I'm the owner of a recovery house and you got in a fight last night with another member. And I'm sharing that with the external therapist. The purpose is of coordinating [00:29:00] of care. Okay, so you're limiting it to what's necessary. So we don't need to share. Everything that goes on, but we need to share what's useful, uh, for the purpose.

Uh, some things that might be needed, you know, for example, to an insurer is whether or not the client's in treatment. Uh, the client's prognosis, the nature of the project, uh, description of the client's progress, uh, a short statement of whether the client has relapsed into drug use. Now, I don't know if any of you have been on an insurance call before. Sometimes they ask all kinds of questions, okay? They may want a whole lot of information. It may or may not be what's needed for the purpose. What's my purpose when I'm sharing with an insurer, with a funder? My purpose in meeting with and sharing to a funder is, am I offering the service that's, that's, that I'm billing them for? And do they meet the [00:30:00] criteria for that service? You know, so the question is ensuring that it's not fraud, and so that's really important to know what the purpose is because once you know that that's the purpose, they may not need to know certain elements of it, of what's going on in the counseling.

So how do we work within the law? A couple of things that you probably have heard before but are very important. Uh, you know the phrase, I can neither confirm nor deny. So, there's a lot of ways you may want to manage this. So, for example, having a, a list of what are the, um, permitted disclosures. So, for example, if you have 10 residents, each of them might have a different set of releases saying, it's okay to talk to my sister, but please don't talk to my mom. You know what I'm saying? So some way that you're [00:31:00] going to track where do we have a release or not, and I can either, common, common stance is I can either confirm or deny that this person is here, happy to take a message, you know, that sort of thing. You can also use permitted disclosures, which I've been talking about.

That's a release of information. Uh, the good cause court order would be another one that, that if they wanted to go and get a court order, if that was legitimate. Uh, they could do that. And you also want to make sure that you, uh, refer to and develop relationships with programs that you trust. So, for example, um, it's very common for Recovery House to be coordinating, for example, with the, um, counselor. Or with, um, with a job services, uh, program, or with a, uh, some other, uh, employment service, or a wide range of services. [00:32:00] So develop those con those relationships with programs that you trust, because that will also help in a number of ways. Applicability. So, I'm going to give my, my disclaimer here, uh, you know, clearly.

Uh, consult your local lawyers to confirm the applicability of your state, federal, and local regulations. So, I've already mentioned, for example, especially state regulations. So, this is

not covering the state element. In addition to federal laws, there can also be other state laws that are on mental health, substance use disorder, HIV, other elements of the confidentiality.

That said, let's take a look through these applicability elements. So I'm going to go back to 42 CFR, and I am not going to read this whole thing because it's written in that, you know, that Regulatory language, right? So, but this is the section of 42 CFR that says whether or [00:33:00] not, you know, you, you, uh, are, it applies. So, it applies to, uh, a restriction of disclosure, any records that would identify a patient as having a substance use disorder, either directly or by reference. If you are, if your website says you are a substance use disorder, recovery house.

Would a disclosure that they are living there, uh, identify the individual as having a substance use disorder? Okay, so things to think about. That's applicability one element. There is also a restriction is on use so that they can't, um, use, that information cannot be used to initiate criminal charges against the patient. Okay, so there's a protection there that. If I'm going to go to [00:34:00] therapy and tell you that I used heroin, I don't know about, I don't know about in Texas, but you know, in most places, using heroin is still illegal. And so if I disclose my record now, you just confessed to a crime. You see what happens here.

So this is a protection so that you can talk about the things you need to talk about in therapy without going to jail. Okay, they can't cause a new charge to you because of that. For example, uh, it's restriction is on use to initiate or substantiate criminal charges. Um, if it is a federally assisted drug abuse program, what does that mean? Well, federal assistance means, by the way, this is, this is also a part of applicability here, that you're, is, you may be asking yourself, is my program receiving federal, federal assistance? You would know because it is, for example, participating in Medicaid, Medicare.

Uh, [00:35:00] it is, uh, contracted by an agency of the United States. So you might be, um, authorizing, uh, maintenance or withdrawal medications. Are you doing any maintenance or withdrawal medications? Are you having registration to dispense a substance? Are you getting funds, uh, from, or financial assistance in any form, including financial assistance, uh, that does not directly pay for substance use disorders? If you are assisted by the IRS so that you have a tax exempt status, then 42 CFR could be, that, that would be a federal assistance. So, 42 CFR could apply to you. So again, I'll refer you back to your lawyer to make sure and talk through, uh, do you, does your particular program meet one or the other of these criteria?

So that's 42 CFR. HIPAA is a little bit different. It has different criteria for whether or not you [00:36:00] meet. You're probably not a health plan listening to this. You're probably not a health clearinghouse listening to this. But you may be a health care provider. HIPAA, by the way, is the Health Assurance Portability and Accountability Act. So, quick question, are any of you taking insurance? And if you're taking insurance, are you, uh, transmitting that information? electronically. So that would be a health care provider who transmits health information in electronic form in connection with a transaction. And then these are the transactions that you want you have to do one of these.

And again, I'm not going to read all of these, but if you are doing some sort of, uh, billing, uh, for insurance, that would trip the HIPAA regulations. So there may be some of you that 42 CFR applies and HIPAA doesn't apply or vice versa. Okay, so you need to think about [00:37:00] whether which one of these applies to you, if either one.

There is a third prong here, that even if neither one of them technically applies to you, there may be an ethical issue, which we need to consider the standards of care. So, if you get called into court and someone says, they violated my HIPAA rights, and you said, I don't do health insurance portability, so HIPAA doesn't apply to me. They will say, well, you're violating what the, what the standards of care are, okay? So, what are the standards of care? Do you think that confidentiality is one of the standards of care? Yes. So, consider how other professionals might handle situations, and also consider liability. So, very, very briefly, uh, liability means, you think about the four Ds.

There's a dereliction of duty that directly [00:38:00] causes damages. So, I didn't do something that I was supposed to do. that directly hurts somebody. So if I was supposed to maintain confidentiality and I didn't do it and somebody gets hurt, got it. If I didn't get my, my confidentiality training and so I did it wrong simply because I wasn't trained or I have a staff member that hasn't been working, that hasn't been working with me for five years and never been trained on confidentiality. Okay. Did I not do something that would be expected of most professionals in the field? So what do most professionals in the field say? Just a real quick overview. Uh, National Association of Recovery Residents, uh, their, uh, number six of their code of ethics says to protect the privacy, confidentiality, and personal rights of each resident.

I love it. They say it in English. I [00:39:00] can understand it. You know, it's very clear, but I don't know what that rule is. I don't know how to protect it. I don't know what the contours of that are. So without having that, that clarity, it doesn't tell me how to do that. So if you are a recovery residence and you say that we don't, it doesn't apply to us, then The confidentiality, the ethical standards of the association, which is what other professionals that would be relevant to you say, you should be protecting the client and confidentiality.

So, next, NAADAC Code of Ethics, that's the National Association of Counselors. Addiction professionals understand that confidentiality and anonymity are foundational to addiction treatment. So they're saying the same thing that Congress said. Providers shall communicate, uh, the parameters of confidentiality in a culturally sensitive manner. Notice how they get, they start getting human here. They're [00:40:00] talking about individuals here and cultural differences. Disclosure. Professionals shall not disclose confidential information regarding the identity of the client. Or that would potentially reveal the identity of the client without written consent.

And where disclosure is mandated or permitted by federal law, uh, verbal authorization shall not be sufficient except in emergencies. And notice they have a very similar language. You're going to start hearing the theme here. Addiction professionals shall only release essential information. Only essential information. You hear a theme starting to talk about what do we disclose? Minimum necessary information. It's not saying, I'm not going to tell you, you

know, it's not being about being catty or coy. It's about protecting the clients and the relationship. The American Psychological Association gets a lot more lengthy. They say that psychologists have a primary [00:41:00] responsibility to maintain the laws and rules of confidentiality. We want to discuss the limits of that. We have a duty to tell the clients what will or will not happen with their information. Usually you have an intake form of some sort that will have an informed consent.

We want to make sure that we, uh, include only the information germane to the purpose of the communication. Sounds, sounds like they're all saying the same thing, doesn't it? And we don't, uh, disclose that only with appropriate places. So I'm going to add another layer here. What about telecommunications? So you really want to make sure you attend some proper trainings on technology and data security. Many of the breaches that we were talking about before were data security breaches. Did somebody have a password? Do you change the passwords?

Do you have, uh, uh, Strong passwords, uh, how you have training that talks to you about phishing. Uh, and, uh, I don't, that's [00:42:00] not the thing going, looking, looking for trout. It is the, the emails that come in that say, click here, uh, or mask themselves to look like this is, this is an important, uh, message from your CEO open now. And then you open and then it get, gets them access, uh, to your files. Um, or, uh, they can lock down the computer, uh, and, and, uh, demand, um, ransom. Okay, uh, consider if my technology is HIPAA compliant. So this is a much larger conversation. It's another element of the HIPAA requirements about having, um, how do we store materials.

So you want to think about is your video or audio technology, uh, uh, compliant? Uh, what about email? So, it said that email is kind of like sending a postcard, you know, what happens with a postcard? Anybody that walks by can read it. Not that they are, but could. So, are there ways to manage email? Do we give lengthy discussions of certain [00:43:00] things in email? What about cell phones? So, what I'm saying goes off through the air. What about video? Is the video encrypted, by the way? Is Zoom considered HIPAA compliant? Oh my gosh. Oh, did I just step into something? And you see why this is why I suggest always check in with your lawyer because it gets complicated. Uh, short answer to that one, by the way, uh, uh, no, HIPAA is, uh, Zoom is not HIPAA compliant.

Unless, uh, you have a, uh, qualifying, uh, business agreement, uh, with Zoom, they do that. So there's a way to make it so, you have to have, the, the, the data sharing is only permitted under the context of, um, of, uh, business agreements. So, for example, you may have an outside lawyer, you may have an outside accountant, et cetera, you, you have a business agreement with them, [00:44:00] and that's one of the permitted ways also to share. That kind of brings them under the umbrella of your business. And so they then agree to maintain the confidentiality of whatever they receive, and they still only get the minimum necessary for what's necessary for the purpose. And other, other area to consider is consider other ethical privacy issues with telecommunications.

So, for example, um, I'm sitting here talking, is my daughter in the next room, and they can overhear things. And then all of a sudden we get out of session and, oh, I didn't mean to let

them know that this happened. You see what starts to happen. So you want to make sure that on the other end of this line, are you having conversations that it's your responsibility as the client to maintain a private area because I can't do that from my end of the, of the Zoom or phone call or whatever.[00:45:00]

Things to think about. Now, this is the part of research, just to be warned. Don't worry, I'll make it easy. So, the research section says that we have 50 years of studies that say that the, that the length of stay in treatment is the number one predictor of outcome in, in this work. And I often say, do you want 20 percent success rates or 80 percent success rates? Because it is completely different. So, and what we know from the research is that if I, someone goes into treatment for a few days, less than a week, their outcomes are 20%. It's not very good. And the longer you're in treatment, it directly goes up, up to, in this case, graduating. Uh, this is months later.

Months [00:46:00] later. Uh, more than 17 weeks later. So, direct relationship. So, if you want to go into treatment for several months, you have a much higher success rate. By the way, Where does much of that happen sometimes? Recovery housing. So as you think about your continuum of care, you have options there to, uh, help support, uh, individuals to get where they need, and it's, it's desperately needed. Um, this has been, this is not just, oh, that's an old site, that's from 1970s, that doesn't count, right? Uh, this has been done in the 80s, in the 90s, in the 2000s. Study after study, you see this same pattern of the direct linear relationship. The longer they are in treatment, the more, the better the outcomes.

Um, critical element. This is not about an insurance company saying you've had three days. You were cured. You can be managed at a lesser level of care. We want to make sure that we have that full amount. Uh, and, uh, this is true. [00:47:00] Um, the way the research is written, it is either it is 90 days minimum. And I'll get to that next slide. Actually, it's 90 days minimum, uh, at any level of care. So that's not 5 days of detox plus 30 days of residential, um, um, um, level 3. 5, uh, and then another 60 days of recovery housing. All right, that's 90 days at outpatient, that's 90 days at residential, it's 90 days at care. And if you think about what we talked about before, it's all about not only the secrecy, but it's about I'm having privacy so that I can develop a relationship.

And that relationship doesn't happen in five days of detox. The relationship doesn't happen, it's not the same depth and quality when I'm at two weeks in a, in a, in a program. That relationship builds over [00:48:00] time, and so, uh, NIDA took a look at this and they said for each drug of choice, less than 90 days or more than 90 days. You know, it's, it's double, sometimes triple, uh, is that triple? Uh, almost triple. Uh, you know, the better benefits, the long, when they're in treatment longer. Uh, they, they say that, uh, the therapeutic community shows improvement in recidivism and relapse rates, as well as in engagement and employment. These improvements are correlated with the highest lengths of treatment, with the highest rates of improvement with those of nine months of treatment, and reduced effectiveness for treatment less than 90 days.

Oh, that's old too, that's the 2002. Uh, we now have 2018, they've re updated this, uh, and said most individuals need at least three months to significantly reduce their drug use.

Research is unequivocal that good outcomes are contingent on that adequate treatment length. So, again, [00:49:00] recovery housing. Thank you, thank you, thank you. This is a critical element, uh, in, in our continuum of care and our systems, okay? We know that if you don't get the le Think about what an antibiotic. You're supposed to take it for 10 days, you start feeling better after 2. Then you start feeling worse after 5 as your stomach gets upset. If you don't take the appropriate proper dose and the proper duration, it doesn't work.

And what happens is, as we all know, you get Sicker, and people give up. They think, I had that treatment thing and it didn't work. You've been to treatment five times, it didn't work. Well, you had five treatment episodes of three days each. That's not the same thing as having a 90 day treatment program, or a 6 month treatment program, or a 9 month treatment program, or a 9 month treatment continuum episode, okay? So, I like to think about, uh, this as a continuum of where is someone at in [00:50:00] their, in their process, from most people in the top left there having no addiction, to moving through an early addiction process, to, I don't have a problem, but it's becoming, creating problems in my life, to, I'm getting to the point where I I'm impacted severely, and I cry uncle.

Then we get into recovery, and obviously there's some spiral here that can happen. But you're moving from length of stay in treatment is the number one predictor of outcome. Notice what's happening in early recovery, we're doing different work at week one from my opioid use, than we are from month six, than we are at Year five. And some of you know that the recovery rates continue to improve the longer you're in recovery up to five years, much like cancer. By the way, something to think about. We're off the research part. See, [00:51:00] see, I told you I'd make the research video. Okay, so now we're going to move on to the brain because that's much better.

So the top one This is your brain, okay? This is your normal, healthy, top down brain, and notice how it's nice and symmetrical and smooth and, uh, it's not all that colorful, but, you know, that's the imagery. Uh, the one on the lower left is, uh, your brain during substance use, and your one on the lower right is the one year drug and alcohol free. So, we recover. As we stop poisoning the brain, the brain will recover, particularly in the first year. It's very important. Okay? So, much like any other brain injury, if I have an injury in a car accident, the brain will recover quickly. It will continue to recover over the course of the year. It may not get to full functioning, but it Recovery is the expectation, and it gets a whole lot better than day one.

By the way, this is true across systems, [00:52:00] so you can see the one there from long term alcohol use, from marijuana use, from heroin use, and the last one there is heroin use. They stopped the heroin, and they've had seven years on methadone. So, think about the impacts of the substances, and how it is limiting our abilities to function. And this is why recovery is so important, and why time is so important, because we need to build the relationships, and we have to have time for the brain to heal. So think about, uh, I'm doing alcohol every day, and then all of a sudden, uh, I stop. Now, I may have not, may not be in alcohol today, but I'm in withdrawal. Acute withdrawal. My acute withdrawal could have post acute withdrawal for several months later. So now let me tie this back to the confidentiality. So in light of the brain development, what happens when somebody's in the

emergency department and they're intoxicated? [00:53:00] And we're now going to ask them about confidential information. And they're slurring. How are they Now, you saw how you felt how your eyes were rolling over over some of the, um, some of the regulatory stuff? Oh, I didn't understand This is an individual whose brain is impaired and we're asking them to make these decisions. What about they're in acute withdrawal management? So they're a day in, they're shaking, saying, yeah, please give me the medication, make me feel better. I'll sign away anything. Just give me the medication. What about it one month later? What about five years later? Some decisions about my, my private information may be better if I can decide it myself at the time that is appropriate. And I may be more willing to share some of my recovery story at years later than I am at two days out there. [00:54:00] Very important.

Other important laws to know about that you should just know is the Mental Health Parity and Addiction Equity Act. This one is from 2007. It says that substance use disorder must be treated equivalently to other medical conditions. And there is also the Patient Protection Affordable Care Act. Um That which requires that substance use disorder must be treated as an essential benefit. So every, um, every insurance out there must have it. It is an essential benefit. So if anything happens to the, to the, uh, uh, Affordable Care Act, one of the things we lose, risk losing is that coverage for treatment for substance use disorder.

So these, these laws interact with each other. So I come back to this screen and think about what are the needed information versus the information that may be wanted. And so. In the middle of that, that's where we've got the trust and [00:55:00] collaboration. And this is conversations I have with funders all the time and, and think about who I'm referring to, uh, for collaboration of care. You know, making sure that it's a proper length of stay and duration, uh, is, uh, is there, is it treatment or am I adding the housing? Am I adding the, the job readiness? Am I adding whatever other elements? Has the individual had time for the brain to heal and stabilize the changes? And so somebody is the first day in the house.

Uh, some, I didn't mention this, uh, some programs, uh, only use recovery housing after they've been through a residential program and it's a step down. Other areas, uh, accept clients who may be on day one of their, uh, uh, not using a substance. And so that's a housing support while they're doing their outpatient therapy. It's a little different. Okay. So think about still need to think through these things about where has their brain had time to heal [00:56:00] to actually function and make certain decision making. All right. I'm going to quickly say a couple of reminders of some simple steps you can do. I always say that trainings are wonderful, but if you go back to your business this afternoon and tomorrow, and you don't do something differently.

Then, what do we do here? So, a couple of simple things that you may want to do. Check on your local regulations on confidentiality. Check with your lawyer about the applicability of your particular program to make sure which one or ones do or do not apply. Confident the, um, the ethics most likely applies, whether or not a specific one of the regulations does. We want to attend ongoing trainings on confidentiality. Like I said, it's an evolving state. So we want to keep up with that and learn communication skills within the confidentiality laws. And so we talked a little bit about that today. You know, the, I can either [00:57:00] confirm or deny. Uh, I can think about what I can say to the judge or the police officer.

I can think about what I can say. You know, if I've got a vocational services that I'm coordinating with, they don't need to be done about my client's trauma. You know what I'm saying? We need to know what you need to know for coordinate job services. Yes. They're going to be there this week. No, they're not going to make it this week. They're not feeling well. You see what I mean? Uh, share, uh, based on permitted disclosures. So, uh, you may have a disclosure which is the release of information. You may have a disclosure which is based on a business agreement. So, for example, I have a business agreement with my accountant. And always sharing the minimum information that's necessary for the purpose.

So, If you hadn't caught on, I love this stuff. I'm always happy to chat more, and it looks like we might have a question or two out there, so I'm going to hang a moment for, for that, and if you, if you are, [00:58:00] um, like me, I often think of questions after the fact, so it's okay. This is my contact information. I'd be happy to chat further afterwards if you think of a question afterwards, but otherwise, uh, questions that we've got here.

[00:58:13] **Karen Coburn:** Thank you, Dr. Martz. This has been an amazing presentation. Um, we do have a couple of questions and we've got just a little bit of time. So, um, my, my, my 1st question would be, uh, can you repeat all that for me?

[00:58:29] **Dr. Ken Martz:** (Laughter) Um, no, it would take an hour.

[00:58:32] **Karen Coburn:** Um, so, uh, 1 of the questions we have is, do the CFRs restrict non DMH facilities from disclosures? An example would be NARR recovery residences.

[00:58:45] **Dr. Ken Martz:** So, excellent question. Uh, I don't know what a DMH of, uh, DMH facility is. Uh, if that is a recove, I assume from the question that is a rec one of the recovery houses would be an example. Um, and that's what I was, [00:59:00] um, kind of, um, pointing to, that it will depend on the facility.

[00:59:06] **Karen Coburn:** Department of Mental Health. Cory, popped that into the chat for us.

[00:59:10] **Dr. Ken Martz:** Got it. Thank you. Thank you. I assumed I didn't want to. So if you are, for example, uh, certified by your state, that might make you federally assisted, which may make it trip. Uh, if you are doing private cash pay only, that may not trip one of them. So that's a tricky question. It, the answer is, it depends. Okay. That's why I was spending the time to, to walk through the, uh, these are the line by line of the regulation of whether or not it applies to an individual, uh, program. And it's a little bit tricky. That's why I say that one's a good consult with lawyer. Some of you probably it does, and some might not.

[00:59:50] **Karen Coburn:** Okay. Excellent. Another question is, is the length of time and treatment limited to residential recovery, housing, and or outpatient. [01:00:00]

[01:00:00] **Dr. Ken Martz:** So, usually, usually the issue is that that is, um. Uh, all the above. So, for example, the residential programs study the residential programs.

And so they say, this is what we found in my residential time length of time. The outpatient programs study the outpatient programs. They compare. So it's not. It's usually not looked at with the context of a full treatment continuum. Uh, there's only actually 1 study that I'm aware of that does that particularly. It makes sense that that would continue over time, but I would say it's, you can't just go program hopping because you don't have time for the relationships.

[01:00:43] **Karen Coburn:** Right.

[01:00:43] **Dr. Ken Martz:** There is one study, it was the Villanova study, we call it, was here in Pennsylvania. They found that if you had two or more levels of care, you were also much more likely to have improved outcomes. And so if you need residential, then you go to residential, IOP, [01:01:00] then outpatient, and then recovery housing as needed.

[01:01:04] **Karen Coburn:** Well, we're at time. Thank you so much, Dr. Martz. I mean, this has been an amazing presentation. We really appreciate you taking the time to share with us today. I know people are, their heads are probably just spinning with everything here. So, I do want to remind everybody the recording of this webinar will be available next week on our website, www. fletchergroup.org. It's usually up there on, by Wednesday. And it's also available on our YouTube channel. Um, today's live webinar presentation has been approved for 1 hour of continuing education credit through the National Association for Alcoholism and Drug Abuse Counselors. So, please note, you have to complete the survey at the end of this webinar and send an email request to Erica Walker and her email address is Ewalker@fletchergroup.org, and that way [01:02:00] you'll be able to receive the credit. So, thank you again, Dr. Martz. Thank you. Everyone for joining us today for this webinar.

We look forward to seeing you in a brand new year 2024. How where did the time go? Um, thanks so much and have a great day.

[01:02:18] **Dr. Ken Martz:** Thanks, everybody.