



REVIEW ARTICLES

Confidentiality in Addiction Treatment: Navigating 42 CFR Part 2 Within Human Services

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Recent federal legislation, including the Mental Health Parity and Addiction Equity Act (MHPAE) and the Comprehensive Addiction and Recovery Act (CARA), has placed greater emphasis on quality integrated health care, with a focus on access, treatment options, and evidence-based practices. Changes to Federal 42 CFR privacy protections also impact individuals seeking substance use disorder treatment, either as a primary diagnosis or comorbidity. Human service professionals, as generalists in the behavioral health field, provide vital treatment, recovery, and prevention services for individuals with substance use and addictive disorders. This paper explores the implications of these legislative changes, particularly regarding privacy protections and information exchange, with practical recommendations for human services practice. Additionally, the paper discusses the educational implications for improving curriculum and training to ensure human service professionals are equipped to navigate these evolving legislative landscapes.

In recent years, more public attention has been given to substance use disorders (SUDs) and the overdose epidemic as overdose deaths continue to rise (Buck, 2011; Campbell et al., 2019; Garfield et al., 2010). Since the declaration of the overdose epidemic in 2016, the prevalence and frequency of addiction-related deaths, specifically those due to fentanyl and other synthetic opioids continue to increase with psychostimulants being associated with 31% of overdose deaths (Center for Disease Control, 2022). In 2022, the Center for Disease Control reported overdose rates increasing to 85%; a record high since 2020. In response, governmental agencies such as the U.S. Office of the Surgeon General and the President's Commission on Combating Drug Addiction and the Opioid Crisis have called for increased access to treatment access and expanded recovery services for those with SUD and comorbid diagnostic needs with increased awareness of these treatment needs as covered medical conditions (Campbell et al., 2019; Christie et al., 2017; Office of the Surgeon General, 2016).

Despite this increasing recognition of SUDs as a medical condition, federal legislation complicates efforts toward information sharing, confidentiality, and privacy protection related to SUD treatment within integrated behavioral health and medical settings (Campbell et al., 2019; Karway et al., 2022; Knopf, 2022). As generalists in the helping field, human service professionals have the option to pursue a variety of roles, including substance use-specific

and integrated behavioral health services. They work with individuals facing addiction treatment, prevention, and recovery needs across medical, behavioral health, and other service-oriented settings (Bureau of Labor Statistics, 2022; NOHS, n.d.). Given the importance of competency in addiction treatment, research emphasizes the need for human service education programs to focus on preparing professionals to effectively address the diverse challenges in addiction treatment and recovery. (Winfield et al., 2016, 2017; Winfield & Reh fuss, 2020).

Despite the critical role human service professionals play in addressing SUDs, addiction treatment education is not universally required for undergraduate human service programs seeking accreditation by the Council for Standards in Human Service Education (CSHSE) (Winfield et al., 2016). Because CSHSE does not mandate SUD education as a requirement for accreditation, research lacks the ability to determine how many human service education programs provide this training, despite its necessity in the field. The National Center for Health Workforce Analysis (2023) projects that by the year 2036, the behavioral health workforce will face a substantial shortage, with addiction counselors experiencing a current deficit of 87,630 (53%) and an elevated unmet need of 153,190 (40%), resulting in a total shortfall of 240,820 professionals. This gap in mandatory SUD education contributes to skill deficiencies for human service professionals, which in turn has significant implications for practice outcomes.

According to Pedersen et al. (2020), many health service providers, including those in human services, receive insufficient training in the treatment of SUDs. This lack of training poses significant public health concerns, leading to inadequate care for individuals struggling with addiction. Pedersen and colleagues emphasize the urgent need to train providers in SUD treatment from the beginning of their educational journey, with appropriate institutional support and motivation being critical to success. Bell and McCutcheon (2020) also highlight the need for enhanced SUD education in health service programs, noting that faculty engagement in addiction research can provide valuable opportunities for trainees to gain essential knowledge in topics such as the course of SUDs, ethical concerns, privacy and confidentiality laws, and empirically supported treatment modalities. However, research shows that a substantial gap remains in the integration of SUD training into the curricula of human service programs (Winfield et al., 2016).

The U.S. Department of Health and Human Services (2020) identified significant workforce challenges in human service programs related to addressing SUD. These challenges include limited knowledge or experience among staff in working with SUD treatment, leading to ineffective support and referrals. The report also pointed to the stigma against individuals with SUD as a major barrier that impacts service delivery and client engagement. These findings emphasize the need for targeted workforce development and education to equip human service professionals with the skills and

understanding necessary to address the needs of individuals with SUD effectively. U.S. Department of Health and Human Services (2020) underscores that professionals lacking comprehensive SUD training report lower confidence in managing addiction-related cases, which can increase the risk of ethical and legal concerns, particularly regarding confidentiality and privacy issues in client records such as those required in 42 CFR Part 2 regulations. By integrating SUD education throughout human service curricula and fostering faculty involvement in addiction research, professionals can be better equipped to navigate these challenges and deliver more effective care to individuals with SUDs and co-occurring disorders.

The 42 CFR Part 2 and SUD Treatment

In 1972, Section 42 Part 2 was established to enhance privacy protections for individuals seeking treatment for SUDs (Campbell et al., 2019). Initially focused on community-based addiction treatment, the statute aimed to address significant barriers to care, such as fears of arrest, employment discrimination, and loss of parental rights, which discouraged individuals from seeking help (Roy & Miller, 2010; Schaper et al., 2016). By mandating strict confidentiality for client information, 42 CFR Part 2 prohibited unauthorized disclosure to law enforcement or other entities, ensuring that individuals with SUDs could receive treatment without fear of legal repercussions (Hu et al., 2011; Schaper et al., 2016). However, over the years, 42 CFR Part 2 has undergone key revisions, most notably in 1992, 2017, and 2018. These updates reflect changes in the healthcare system, including the implementation of electronic health records (EHRs) and increased integration of behavioral health care into medical settings. One of the most significant changes in recent revisions has been the update to consent processes. Providers must now consider how patient information is shared across electronic systems while ensuring that confidentiality is upheld, and that clients provide informed consent for sharing information with multidisciplinary care teams (Barry & Huskamp, 2011). Additionally, the revisions aim to balance privacy protections with the need for coordination in integrated care models, allowing for more streamlined information sharing among providers (SAMHSA, 2017, 2018).

Despite these efforts, treatment providers continue to face challenges in implementing and adhering to 42 CFR Part 2 (Barnett & Connery, 2018). For example, in integrated behavioral health settings, where human service professionals work alongside medical staff, the overlap of SUD records with other medical data can create confusion regarding consent requirements and information sharing (Woods, 2018). Providers often struggle with navigating these complex privacy regulations, leading to uncertainty about what constitutes appropriate consent and how to ensure patient confidentiality without hindering care coordination (Campbell et al., 2019). For example, when a client with a co-occurring mental health disorder seeks integrated treatment, and the provider must decide whether sharing the client's

addiction treatment records with a psychiatric team requires additional consent, which can delay treatment and create ethical dilemmas (Padwa et al., 2015).

Human service professionals, who provide a range of services from addiction treatment to harm reduction, are not exempt from these challenges. As generalists in the behavioral health field, human service professionals must be familiar with 42 CFR Part 2 to ensure compliance when treating clients with substance use and co-occurring disorders (HumanServicesEdu.org, 2023; Neukrug, 2024; Winfield et al., 2016). National and international credentials in SUD and addiction treatment, such as the International Certification and Reciprocity Consortium's [ICRC] Certified Alcohol and Drug Counselor credential, help professionals maintain their knowledge and training by requiring examination, continuing education, and addiction specific didactic coursework (ICRC, n.d.). These requirements ensure that professionals stay up to date with the latest developments in addiction treatment and privacy regulations, enabling them to provide competent, ethical care post-graduation (ICRC, n.d.; Winfield et al., 2016). Prior to pursuing credentialing, integrating the updated 42 CFR Part 2 guidelines into human service education is essential for preparing future professionals to manage patient confidentiality, record keeping, and interprofessional communication in compliance with legal and ethical standards.

Ethics, Confidentiality, and Human Services

A competent and ethical human service professional is knowledgeable about the ethical guidelines of their profession, applies ethical decision-making in daily practice, and maintains ongoing professional development (Neukrug, 2024). Ethical standards, such as those outlined in the National Organization for Human Services Code of Ethics (NOHS, 2024), are crucial for guiding ethical decision-making, client care, and professional conduct (Milliken & Neukrug, 2010; Wark, 2010; Winfield et al., 2017). The NOHS Code of Ethics outlines critical standards related to client autonomy, informed consent, and confidentiality, which are central to human service practice. For example, Standard 2 stresses the importance of obtaining informed consent at the onset of the helping relationship, as well as ensuring that clients understand their right to withdraw consent unless restricted by a court order (NOHS, 2024). This standard also requires that authorized representatives be involved when a client is unable to give consent. To ensure informed decision-making, it is essential that clients, or their representatives, are provided opportunities to ask questions and fully understand the services being offered. Similarly, Standard 3 emphasizes the professional's responsibility to protect a client's right to confidentiality and privacy. This includes informing clients about the limits of confidentiality, particularly regarding disclosures related to safety concerns (e.g., when there is a risk to self or others). Together, these standards underscore the importance of safeguarding client autonomy and privacy in service delivery.

While these ethical guidelines are foundational, human service professionals working in addiction treatment and recovery must also be aware of relevant federal legislation, such as 42 CFR Part 2. This legislation governs the confidentiality and sharing of client information in substance use treatment settings. Unlike the ethical standards set forth by the NOHS, 42 CFR Part 2 imposes strict legal requirements for the protection of patient records, limiting disclosure to specific circumstances such as with written consent or in response to a court order (Barry & Huskamp, 2011). Understanding the distinction between ethical obligations and federal legislation is critical, as these legal requirements may sometimes impose additional restrictions beyond what is outlined in professional ethical codes. For instance, a human service professional in addiction recovery must navigate the tension between ensuring informed consent as required by the NOHS Code and complying with the confidentiality provisions of 42 CFR Part 2, which limits the sharing of client information without explicit consent. Training in both ethical guidelines and federal laws is essential for professionals to uphold client rights while maintaining legal compliance in practice (Neukrug, 2024).

Special attention should be given toward understanding the mandates related to unemancipated minors seeking addiction treatment and recovery services independently of their legal guardians, as well as clients with comorbid treatment needs. Both populations are governed by additional legal considerations under 42 CFR Part 2 and the Health Insurance Portability and Accountability Act (HIPAA). Historically, unemancipated minors' access to behavioral health care was authorized by their parent, legal guardian, or other legal entity legally authorized in that role under HIPAA. These individuals authorized and provided consent to participate, authorized the release of information for the minor, and had the option to participate in the minor's care (HIPAA, 1996).

Under the 42 CFR Part 2, specific guidelines are noted removing this authoritative role from parents and guardians unless the minor child did not have the cognitive capacity to provide consent (SAMSHA, 2017, 2018). Essentially, unemancipated minors with demonstrated cognitive capacity to participate in SUD and addiction treatment are considered adults, and as a result, can consent to participate, authorize treatment access and information sharing with their chosen providers despite their minor status (Eniola et al., 2024; Hamersma & Maclean, 2021; SAMSHA, 2017, 2018). As the regulations pertaining to minors in SUD and addiction treatment contrast with the established HIPAA guidelines for this population, human service professionals are encouraged to apply sound ethical decision-making and maintain their understanding of the 42 CFR and its applicability within human service practice. These mandates highlight the complexity of ensuring informed consent while also protecting a minor's right to privacy in a treatment context.

Similarly, clients with comorbid conditions often face fragmented care due to challenges in integrating addiction treatment with mental health services (Mefodeva et al., 2023). Research has shown that these individuals often encounter barriers in receiving coordinated care, with some studies indicating a lack of integration of trauma-informed care in residential settings, which can impact treatment outcomes (Mefodeva et al., 2023). Recognizing the unique needs of these populations and understanding the associated legal and ethical mandates ensures that human service professionals are equipped to provide comprehensive, client-centered care.

Overview of the 42 CFR Part 2 and Human Service Practice

In January 2017, SAMHSA released an updated rule on the confidentiality of substance use disorder (SUD) patient records, with a further rule change issued in January 2018 in response to public comments (Department of Health and Human Services, 2017; Murow-Klein & Yeung, 2018). These updates to 42 CFR Part 2 require all holders of SUD records—whether treatment providers, contractors, or legal representatives—to comply with these new disclosure standards (Murow-Klein & Yeung, 2018). The 42 CFR Part 2 regulations apply to all information that could identify a client as having a SUD, whether directly or indirectly (Murow-Klein and Yeung, 2018; SAMHSA, 2017). This applies to federally assisted programs, such as those that are operated or funded by the federal government, are tax-exempt, or are licensed to dispense controlled substances (Knopf, 2022; Schaper et al., 2016). It also extends to organizations that advertise SUD treatment, have certifications in addiction medicine, or employ addiction specialists (Murow-Klein & Yeung, 2018).

Navigating Confidentiality Laws: 42 CFR Part 2 vs. HIPAA

Human service professionals must navigate multiple, sometimes conflicting, confidentiality laws. HIPAA and 42 CFR Part 2 are both critical in protecting client information but differ significantly in their scope and requirements, particularly when it comes to substance use treatment records. Both laws aim to safeguard privacy, but 42 CFR Part 2 imposes more stringent restrictions on the disclosure of SUD information, especially regarding the need for explicit written consent from the client (Enos, 2020; Murow-Klein & Yeung, 2018). For human service providers working with clients who have SUDs and mental health needs, understanding the nuances between these two regulations is essential. The Health Insurance Portability and Accountability Act (HIPAA) allows for the disclosure of protected health information (PHI) without client consent in certain circumstances, such as for healthcare operations or payment (HIPAA, 1996). However, 42 CFR Part 2 restricts the sharing of SUD-related information unless explicit written consent is provided by the client. Even in situations where disclosure is permitted under both laws—such as during audits or for qualified service

organizations (QSOs)—the requirements for client consent remain distinct, with 42 CFR Part 2 imposing more stringent privacy protections (Modi & Feldman, 2022; Murow-Klein & Yeung, 2018).

Differences and Implications for Human Service Professionals

One of the primary differences between HIPAA and 42 CFR Part 2 lies in the revocation process. While HIPAA mandates that consent revocation must be done in writing, clients under 42 CFR Part 2 may revoke their consent verbally (Murow-Klein & Yeung, 2018). This difference can create confusion for providers who must be prepared to handle these varying requirements depending on the circumstances. Another important distinction is in the redisclosure of information. Under 42 CFR Part 2, client information cannot be shared with third parties without the client's expressed consent, and when shared, a statement must be included that prohibits redisclosure of the information (SAMHSA, 2017). HIPAA, in contrast, allows more flexibility in sharing information between healthcare providers, often requiring individualized release forms for each provider, rather than generalized releases (Murow-Klein & Yeung, 2018).

In addition, both 42 CFR Part 2 and HIPAA require that specific information about the disclosure (e.g., who the information is shared with, what information is shared, and the purpose of the disclosure) be documented. However, 42 CFR Part 2 allows a generalized release for "treatment providers," as long as the client is informed about which providers have access to their information, the purpose of the disclosure, and when it occurred (Murow-Klein & Yeung, 2018). This simplified process contrasts with the more detailed and individualized consent requirements of HIPAA. For human service professionals, these differences highlight a significant challenge in managing confidential information. Providers must stay well-informed about the interplay between 42 CFR Part 2 and HIPAA, particularly when working with clients who have complex, comorbid conditions. In such cases, both confidentiality laws may apply, and it is best practice to follow the more restrictive regulation when conflicts arise (Murow-Klein & Yeung, 2018). This ensures that clients' rights to privacy are upheld while maintaining compliance with legal and ethical standards.

Implications for Human Service Practice and Education

Human Service Practice

The demand for SUD treatment and the increasing prevalence of overdoses in the helping professions necessitate adherence to legal and ethical standards. Federal regulations, such as 42 CFR Part 2, have been enacted to protect client confidentiality while promoting treatment access and ensuring compliance with ethical and legal obligations (Knopf, 2016, 2022; McCarty et al., 2017). Specifically, 42 CFR Part 2 governs information sharing and consent within SUD and addiction recovery services, reducing barriers to treatment access for minors and individuals with co-occurring disorders

(Substance Abuse and Mental Health Services Administration [SAMSHA], 2017, 2018). Ethical standards for human service professionals emphasize the importance of informed consent, confidentiality, and appropriate information-sharing practices for all clients, regardless of diagnosis (National Organization for Human Services [NOHS], 2024). To navigate these requirements effectively, human service professionals should engage in ongoing education and professional development focused on 42 CFR Part 2 and its implications for ethical service delivery.

Confidentiality is both an ethical mandate and a legal obligation (NOHS, 2024; SAMHSA, 2017, 2018). Failure to comply with 42 CFR Part 2 regarding information sharing, record-keeping, consent, and treatment authorization can result in ethical violations, negligence, and malpractice. Ethical decision-making models can help professionals navigate these complexities. While Corey et al.'s (2023) eight-step model provides a structured approach, additional frameworks offer diverse perspectives and adaptability across human service practice settings. For instance, Rest's Four-Component Model (1986) identifies moral sensitivity, moral judgment, moral motivation, and moral character as key components in ethical decision-making, enhancing professionals' ethical awareness and their ability to make informed decisions. Similarly, the Integrated Model for Ethical Decision-Making (Tarvydas, 2012) blends ethical principles with professional standards and contextual factors, helping practitioners navigate complex dilemmas. Meanwhile, the Practitioner's Guide to Ethical Decision Making (Forester-Miller & Davis, 1996) offers a step-by-step process for analyzing ethical challenges, making it an accessible tool for human service professionals. Additionally, the Ethical Decision-Making Model (Dolgoff et al., 2009) provides a hierarchical framework that prioritizes fundamental ethical values, such as the protection of human life, autonomy, least harm, and confidentiality. By incorporating multiple evidence-based ethical decision-making models, human service professionals can ensure their approach remains flexible and applicable across diverse practice settings.

Implications for practice exist for the human service professional as it relates to ethical decision-making, documenting written and verbal consent and revocations, as well as understanding federal and state law regarding signed court orders and access to patient records for criminal justice purposes (Campbell et al., 2019; Karway et al., 2022; Knopf, 2022; NOHS, 2024). As a result, human service professionals need to have the skills, knowledge, and expertise to navigate the informed consent and release of information process to assist clients with understanding the risks and benefits of evoking their legal rights under the 42 CFR Part 2. Risk mitigation strategies such as clinical supervision, continuing ethics education, and professional liability insurance can support human service professionals in maintaining ethical integrity and legal compliance (Corey et al., 2023; Neukrug, 2024). By integrating ethical decision-making models with professional development

and risk management strategies, human service practitioners can uphold the highest standards of ethical care while adapting to the evolving legal landscape of SUD treatment services.

Human Service Education

To support ethical decision-making and overall competence in human service classrooms, practice-focused education and experiential learning centered on confidentiality and privacy laws are essential. Given the ethical and legal implications of informed consent, confidentiality, privacy, and information sharing, it is crucial to create educational environments where human service students gain hands-on experience in navigating these issues. For instance, integrating case studies that involve SUD clients into the curriculum can help students explore real-world scenarios and deepen their understanding of 42 CFR Part 2 and its application. Teaching ethical dilemmas that specifically address HIPAA and 42 CFR Part 2 will further engage students with the complexities of confidentiality and information sharing in practice. Additionally, providing experiential learning opportunities or simulations where students can practice the informed consent process and confidentiality procedures will prepare them for real-world challenges they will encounter in the field.

A variety of ethical decision-making models can be incorporated into these educational experiences to help students navigate the complex issues surrounding 42 CFR Part 2. For example, Corey et al (2023), Rest's Four-Component Model (1986) and the Integrated Model for Ethical Decision-Making (Tarvydas, 2012) all offer valuable frameworks for understanding the multiple layers of ethical considerations in practice. The use of such models helps students critically evaluate ethical dilemmas by fostering awareness, judgment, and moral responsibility. Providing students with a toolkit of ethical decision-making strategies equips them to address challenges they will face regarding confidentiality, informed consent, and ethical boundaries in practice.

Moreover, in addition to practice skills in ethical decision-making, ongoing education on topics such as stigma, client advocacy, and self-awareness regarding students' perceptions of SUD clients is crucial. Research has shown that skill gaps exist in SUD-related practice, particularly in addressing the ethical challenges related to confidentiality and informed consent (e.g., McCarty et al., 2017). By incorporating these areas of focus into human service education, students can develop a better understanding of the barriers faced by SUD clients due to unethical information-sharing practices. This, in turn, will improve their ability to adhere to the requirements of 42 CFR Part 2, ensuring that they can provide ethical and effective services to this vulnerable population.

Conclusion

With the recent changes to the 42 CFR Part 2 and its implications for privacy and confidentiality for SUD and comorbid clients, human service professionals would benefit from being fully prepared to implement these changes in their clinical practice. Unfortunately, as SUD treatment and recovery is not a required competency area for CSHSE education programs, human service professionals are at risk of violating the 42 CFR Part 2 due to lack of knowledge if education into the 42 CFR Part 2 is not obtained. Human service professionals are encouraged to pursue continuing education in the 42 CFR Part 2 and its requirements related to information sharing, privacy, confidentiality, and access to care for unemancipated minors. As human service professionals continue to remain up to date on changes in the field related to addiction treatment and comorbid clients, the profession continues to become better equipped to meet client needs and evolve to meet the legal and ethical needs of the populations they serve.

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